APPENDIX C

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
OVERDUE RECOMMENDATIONS
WHEN MEASURED AGAINST ORIGINAL AGEED DEADLINE DATES

Executive Lead - Chief Operating Officer						
ABM 1920-038		**Patient Environment**		**Report Issued October 2019**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no overarching Policy/Procedure in place to outline how external regulator / inspection reports are being managed across the Health Board. As a result, audit noted that the process for managing these reports varied. We would recommend an overarching policy/procedure for the management of all external regulator / inspection reports that will bring together the various processes currently operating for dealing with HIW, CHC, HSE and other, to ensure that any action required is appropriately managed and the HB is assured that all actions are complete and any lessons to be learned are disseminated in a timely and robust way.	**M**	An overarching policy/procedure will be developed for the management of all external regulator / inspection reports that will bring together the various processes currently operating for dealing with HIW, CHC, HSE and other, to ensure that any action required is appropriately managed and the HB is assured that all actions are complete and any lessons to be learned are disseminated in a timely and robust way.	31/01/2020	**December 2021** This work is being taken forward by the Interim Director of Corporate Governance in conjunction with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Director of Strategy, and links with quality governance and strategy work which is currently being taken forward as part of the Board Effectiveness Assessment Action Plan. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan	31/05/2022
5	During our observation visit, we found areas that had recurring issues. Management should consider how they address issues of custom and practice that is resulting in repeat non-compliance with policies and procedures.	**M**	The policy (ref action 1 above) will set out a process for managing repeat non-compliance with policies and procedures to identify the issues and actions required by Units / specialist corporate staff / groups / committees.	31/01/2020	**December 2021** This work is being taken forward by the Interim Director of Corporate Governance in conjunction with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Director of Strategy, and links with quality governance and strategy work which is currently being taken forward as part of the Board Effectiveness Assessment Action Plan. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan	31/05/2022

Executive Lead - Chief Operating Officer						
SBU 1920-025		**Discharge Planning (COO)**	**Report Issued February 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8 D(ii)	Whilst the ABMU Clinical Portal prompts for reasons, the field is not mandatory. Neither SIGNAL nor the Welsh Clinical Portal provide fields seeking reasons for EDD changes, so wards using them may not capture the same level of information. Furthermore, limitations within Signal and the Clinical Portals do not provide the functionality to support the display of '+days' when a patient is medically fit for discharge but remains in hospital beyond their EDD. Steps should be taken to ensure the systems chosen to facilitate the management of EDD promote the completeness of information required by policy. This may require working with NHS Wales partners to develop national products.	**M**	The audit action findings will be presented to the Signal User Group to consider if further actions can be taken to improve the signal design in phase 3 to feature an improvement to assist clinical recording.	31/03/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021	31/05/2021
9	The review of 69 patients found that only one patient had an EDD recorded within patient notes and this did not provide any evidence of discussion with patient, family or carers. Through discussion at the MDT Board Round we attended at Gorseinon, there was evidence that EDDs were being discussed with patients but that this was not sufficiently recorded within patient's notes. Management should ensure that EDD is discussed with patients and families and the discussion is recorded in the patient notes.	**H**	Further engagement with Carers via Stakeholder reference group will be undertaken and a leaflet produced that outlines what communications and involvement patients and their families can expect to receive regarding the plans for their expected date of discharge.	30/05/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021	31/05/2021
	Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**H**	Comprehensive training and communication programme will be developed that includes communication with families and patients as part of the launch of the revised SAFER policy.	30/09/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this.	None Entered
15	A review of Signal at Singleton in particular, has shown that staff are populating the system with detailed patient information which is not duplicated within patient notes. Staff report the system has had a positive impact at ward levels, reducing workloads and making patient information more accessible - However, once Signal is optimised across the Health Board, it will only have capacity to store information for a maximum of 30,000 patients which translates to storing information for approximately 6 months post patient discharge. After which, all of the detailed entries within Signal will be deleted. It is noted that the introduction of electronic nursing notes will overcome some of the above, however this system only includes entries from Nurses and assessments undertaken Management should review the arrangements for documenting patient records to ensure that a full patient history is maintained post discharge	**H**	This identified risk will be escalated to the Signal User Group and any unresolved risk assessed and added to the corporate risk register for monitoring until action is identified to resolve it.	31/03/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021 **Undated** Work is progressing on this action but not yet complete.	31/05/2021

16	Discussion with management following issue of the draft version of this audit report has identified an additional action to improve the system design – the addition of an audit tool to provide management assurance regarding the implementation of revised policy. Earlier points have recommended consideration should be given to progressing as part of a quality audit & improvement initiative.	**M**	Development of a new Corporate Audit Management Tool, and standard operating procedure outlining the roles, responsibilities and expectations (including frequency) for service group audit of compliance, and to identify improvements and actions relating to the discharge policy.	31/03/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this. Please extend until May 2021 **Undated** Ongoing	31/05/2021

Executive Lead - Chief Operating Officer						
ABM 2122-013		**Planned Care Recovery Arrangements**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	The Outpatient Redesign and Recovery group includes the review and discussion of advice and guidance tools which support pathway and referral management alongside receipt of service level recovery plans. We note that the January 2022 meeting minutes and the groups highlight report to PCPB indicate that Service Group engagement, particularly from clinical leads, could be improved. Morriston has provided no medical representation in the period April 2021 – January 2022, but has designated a lead Outpatients sister to attend, whilst Singleton Neath Port Talbot has had clinical representation at just two meetings. Outpatients Redesign and Recovery group membership and attendance requirements should be reviewed with consideration given to mechanisms for highlighting any consistent gaps in attendance.	**M**	It is recognised that staff are under significant pressures currently, and that is likely to continue for the foreseeable future, whilst also recognising the need to move forward with the outpatient recovery & sustainability plans. A review will be undertaken to compare the attendance of the outpatient redesign & recovery meetings over the last 12 months with the membership outlined within the terms of reference - compliance with then be discussed with members of the Group. In the first instance the Group will consider whether or not we have the right nominations and secondly for those individuals to appoint a deputy who can attend if they are unable to do so themselves. The review will continue quarterly, and the compliance with the terms of reference escalated to the Group if required.	31/03/2022	**April 2022:** A review was undertaken to compare the attendance of the outpatient redesign & recovery meetings over the last 12 months, this has highlighted the lack of clinical attendance at the meeting. Service Groups have been asked to identify suitable clinical staff for future meetings and to ensure that appropriate deputies are available for the meetings. Based on the foregoing, the deadline date has been extended to 30/06/2022	30/06/2022
2.1	Review of the Diagnostics Recovery Group agendas and minutes note that the primary focus of the group has been on the development and monitoring of recovery plans. However, we were unable to identify any discussion at the group of the GMO requirement to 'Undertake a review of diagnostic access to primary care practitioners and develop a plan with Primary Care Clusters to enable better prevention and early intervention with urgent conditions created.' The DRG at present does not have agreed terms of reference We recommend that the Diagnostics Recovery Group receive and approve terms of reference	**M**	As highlighted in the audit, the focus of the diagnostic group during 2021/22 has been to develop and implement recovery plans to support improvements in waiting times. However, with the 2022/23 recovery & sustainability plan now agreed, the group will work strategically on the achievement of the Goals, Methods and Outcomes. The terms of reference have been drafted with this in mind, and will be reviewed and agreed at the next diagnostics meeting on the 17th February. Plans are in draft with each service on the GMOs they plan to deliver for 2022/23, and a highlight report will be developed for monthly reporting and review by the Planned Care Board.	31/03/2022	**April 2022:** Terms of Reference for the Diagnostics Group have been developed and include representation from the PCS Service Group, as a result of the review findings. The updated terms of reference were discussed at the meeting on the 17th March, however due to a change in leadership of the Group the TOR were not approved. The TOR will formally be considered and approved at the next Diagnostics meeting scheduled for the 19th May. Noting the foregoing, the deadline has been extended to 31/05/2022	31/05/2022

Executive Lead – Director of Digital						
SBU 2021-029		**Digital Technology Control & Risk Assessment**		**Report Issued January 2021**		**Assurance Rating – N/A**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8	There has been no full assessment of what skills are held within digital services and the skills and resource needed to support the organisation and implement the Digital Strategy. Consequently, there has been no identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place digital services may struggle to implement the strategy. A full assessment of the current skills within digital services, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.	**L**	The PADR process is used to identify individual training requirements but it is recognised that there isn't a holistic overview of current/future gaps in expertise/knowledge. Digital Services will work with Workforce to identify and implement an approach to identify the skill gap within the directorate. Once identified a plan to upskill staff as required will be developed.	28/02/2022	**December 2021:** The health board are in the process of completing a National Digital Services skills assessment which is due for submission at the end of December. Once the outcomes of the assessment are shared a workforce plan will be drawn in 22/23. **February 2022 :** Set new timescale for December 2022	31/12/2022
12	Although there is a continuity plan in place, alongside DR plans and arrangements. There has been no testing of the plan. Without a process for testing the plans in conjunction with stakeholders the health board cannot be fully assured that they will work properly in a real world scenarios. The BCP and DR plans should be subject to testing in conjunction with stakeholders to ensure that the plans work and any issues are identified prior to need.	**L**	Agreed – Digital Services were working with the Head of Emergency Preparedness, Resilience and Response to test the BCP but this was impacted by COVID. (Which tested the plan in a real-life scenario). Digital services will look to test the plan on an annual basis.	31/01/2022	**February 2022 Update:** Testing of the BC Plans will be built into the Health Board Training Programme for 2022, and the schedule is currently being pulled together by the EPRR Team. A working group is being set up to facilitate the above. Timescales to be amended to August 2022. **April 2022:** The Cyber Security Team have held a couple of meetings to progress this. A Digital BC Planning Bronze group has been established and one Digital Services tide meeting has been held so far with another planned. The group are focusing on BC Plans in Digital Services specifically, and updating the BC Plans. We are also still awaiting a date for the BC Table Top Exercise with EPRR.	31/08/2022

Executive Lead – Director of Finance						
SBU 1920-016		**Procurement No PO – No Pay**		**Report Issued December 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	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.	**M**	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	**December 2021:** This action has been superseded by a review of all SLA's as part of the deployment of the National Operating Model (NOM) for procurement, which is expected to be completed by April 2022. The NOM for procurement will be presented to Health Boards in February 22. Deadline extended to 30/04/2022 based on the foregoing. **April 2022:** A meeting has been arranged for the 13th May 2022 between the SBUHB Head of Procurement, the NWSSP Procurement Services Director and the NWSSP Head of Finance and Business Development to agree a timescale for the SLA review. Based on the foregoing, the deadline has been extended to 31/05/2022 for further update	31/05/2022

Executive Lead – Director of Finance						
SBU–2021-043		**Integrated Care Fund Banker Role**		**Report Issued June 2021**		**Assurance Rating – N/A**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1(b)	The West Glamorgan Regional Partnership 'Integrated Care Fund Written Agreement 2019/20 - 2020/21' details the following: “11.3 Financial management of the ICF Fund will be subject to compliance with SBUHB Standing Order Schedule 6 Standing Financial Instructions.” Our sample testing identified three items, relating to a larger "data-load" for payment to care homes for which there was no recorded of authorisation by an approved health board officer prior to funds being released. The payment was processed on the basis of the approval of the expenditure amount received from the Transformation Office only. As such, the wider data-load did not receive approval within the health board by an authorised signatory to satisfy its Standing Financial Instructions (SFI’s). Additionally, we identified two payments for which the invoices that included them had been approved by a named authorised signatory, however, both invoices were over £25k in total and the authoriser only had an authorisation limit up to £25k for the GL code. As such, these invoices were not appropriately authorised in line with the health board’s SFIs. (These invoices comprised a number of schemes for reimbursement, including the two non-ICF funded schemes 4CAB and 5CA referred to earlier.) Management should consider producing an internal document detailing the process of managing the ICF fund to ensure that it complies with the written agreement.	**L**	The health board is reviewing how ICF funds are managed within the overall governance structure of the health board and the new process will be documented.	31/12/2022	**April 2022:** Initial meeting held on 30th March to look at re-designing the approval process covering ICF and Transformation. A follow up meeting is scheduled for April to look at the process in more detail. Likely there will be further meetings along with a revised and signed off process agreed before this action can be closed. Timescales for completion in Q1 of 22/23. Based on the foregoing, deadline extended to 30/06/2022	30/06/2022

Executive Lead – Director of Finance						
SBU 2122-015		**Procurement & Tendering STA & SQA**		**Report Issued October 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.1	There is currently a lack of training available to employees who undertake procurement exercises. This was noted during the September 2021 Audit Committee meeting and the Head of Procurement has developed a draft training module which will reinforce the governance arrangements relating to the appropriateness of the SQA/STA process. We recommend that the draft training module developed is finalised and made available to all staff that require it. Completion of the training should be recorded, monitored and reported and follow up action taken for staff who have not been on the training.	**L**	Procurement training is being developed that will provide an overview of the STA/SQA process, including their appropriate use. The content of this training is complete. Materials and a training methodology will however need to be agreed. Procurement training has been delivered to executives (20/10/2021) which includes an overview of the STA/SQA process.	01/04/2022	**April 2022:** Training sessions have been planned for the 25th May and 15th June via MS Teams. These sessions will be promoted through the SBUHB intranet and via the senior leadership team. Procurement drop in clinics are being planned from September 2022 and will take place on a rotating basis at Singleton, Morriston, NPT, Cefn Coed and Corporate HQ. Based on the foregoing, deadline has been extended to 30/06/2022 in order to confirm training delivery.	30/06/2022
7.1	Our review noted that the Declaration of Interest section for three of the 15 STA forms sampled were complete, but had not signed off by the person completing the form. We also noted the forms were inconsistent regarding who should complete this section. The single tender action request form for the sample reviewed typically only required a declaration from the budget holder. It does not request the same from others who may be involved in selecting or procuring the supplier and the budget holder may not have satisfied themselves that those involved had appropriately declared any interests. Declarations of interests will be completed and signed for all individuals involved in each single tender action / quotation.	**M**	Consideration should be given to how we use existing HB declarations of interest as part of this process. It would be preferable to use existing information that is available as opposed to further increasing the administrative burden on procurement. Procurement will work with Corporate Governance to establish if this is viable.	01/04/2022	**Undated:** No progress to date, discussion and resolution with Corporate Governance to be arranged. **April 2022 (Keir Warner):** The proposed approach is impractical and will cause a significant administrative issue for both the Procurement team and the Health Board. An alternative approach is being proposed; that the STA/SQA form will be amended to require that all signatories complete a check box confirming that they have no interests to declare in relation to the goods/services/company being purchased. This form is nationally agreed and the amendments will be proposed to the All Wales procedure review group for consideration. Completion by June 2022 but is subject to All Wales agreement and may not be approved. Based on the foregoing, the deadline has been extended to 30/06/2022 for update.	30/06/2022

Executive Lead – Director of Finance						
SBU 1920-009		**Control of Contractors**		**Report Issued March 2020**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	There was no evidence available to demonstrate that competency vetting had been undertaken, or details of insurances obtained, for eight out of 14 contractors reviewed, primarily those who: – Were engaged by NWSSP Procurement via Multiquote with Estates input – Regularly-used contractors appointed to delivery sub-£5K orders All contractors should be appropriately vetted for health and safety competency and insurance arrangements prior to appointment. Evidence should be retained of checks made	**H**	Agreed. The University Health Board, in conjunction with NWSSP: Procurement Services are looking at accreditation systems that will provide this level of assurance, for example CHAS (the Contractors Health & Safety Assessment Scheme).	31/07/2021	**February 2022:** The department are adopting the CHAS contractor assurance system which will provide assurance around a prospective contractor's: – Health & safety policies – Staff training records – Insurances – Financial details This remains on track for adoption in April 2022. The department are also currently going through a competitive process to engage a second assurance company whose services will supplement/complement the above. A small delay resulting from the competitive process means that it is envisaged that this second system will be implemented from June 2022. This will allow the HB to ensure that any contractors appointed have appropriate documentation in place. Where companies do not have accreditation, they will be specifically asked for documentation prior to award. Noting the above, the deadline has been further extended to 30/06/2022	30/06/2022
3	The 2009 Managing Contractors policy specified insurance requirements for contractors, however it is noted that the 2019 policy no longer addresses the same. The UHB's insurance requirements for contractors should be included within the Managing Contractors Policy (or supporting procedures)	**M**	Agreed. The University Health Board, in conjunction with NWSSP: Procurement Services are looking at accreditation systems that will provide this level of assurance.	31/07/2021	**December 2021:** The Department are currently reviewing the Control of Contractors Policy, which will include the requirement for contractors to provide information on their insurance where appropriate. **April 2022:** This will be covered as part of the adoption of the accreditation system/process referred to at recommendation 2. Completed by 30/06/2022.	30/06/2022
4	Management advised that there were plans to introduce a more formal competency procedure within Estates. A spreadsheet template had been created, with pre-	**M**	Agreed. The evaluation spreadsheet will be introduced for use in Financial Year 20/21.	31/07/2021	**December 2021:** The introduction of the spreadsheet has been delayed due to COVID pressures, but will now be in place by the end of	30/06/2022

	determined questions to ensure that contractor information in key areas such as H&S policies, competencies, cub-contractor arrangements, risk assessments, insurances etc. has been checked. However, this was not in use at the time of fieldwork. Estates should finalise and apply the new contractor evaluation spreadsheet at all appropriate new appointments				January 2022. Going forward, the health board are looking to adopt the use of external assurance processes for 2022/23. **April 2022:** This will be included in the Control of Contractors Manual. Noting the above, the deadline has been extended to 30/06/2022 in order to align with the revised deadline for the review and update of the Control of Contractors Manual.	
5(a)	The UHB's last in-house audit of induction compliance undertaken at the time of audit fieldwork (dated March 2018) (see also finding 8), which identified that on average 36% of contractors/operatives (at the Morriston & Singleton sites), who had signed in to work on site during March 2018 had not received an induction. Whilst management advised that improvements had been made following those results, a follow-up audit had not been undertaken by the UHB at the time of this review, to determine current compliance rates. Subsequent to the conclusion of the audit fieldwork (January 2020), a new in-house audit of induction compliance rates was undertaken by the Estates team. This audit found reduced compliance from that previously reported. Contractors/operatives should not be allowed to commence work on site without having received an induction.	**H**	Agreed. Estates Managers will be reminded of the need to ensure all contractors have received appropriate induction.	21/04/2021	**December 2021:** Estates managers have been reminded of the need to ensure that all contractors have received appropriate induction. The health board are currently looking to adopt a 'swipe card' system as part of their assurance processes, which will identify on arrival any contractor who has not undergone formal induction, and send an automatic alert to estates staff who can then take the necessary action. It is anticipated that this system will be in place by April 2022. **April 2022:** This will be covered as part of the adoption of the accreditation system/process referred to at recommendation 2. Completed by 30/06/2022.	30/06/2022

Executive Lead – Director of Finance						
ABM 1920-007		**Capital Systems Financial Safeguarding**		**Report Issued November 2019**	**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	Failure to comply with SO's/SFI's and Local Framework requirements in respect of: – Failure to use formal contracts (as opposed to simple orders) for procurements in excess of £25,000 [this is regardless of whether they are on a framework or not] – Failure to undertake financial vetting for new contracts/procurements in excess of £25,000 – Failure to apply Standards of Business Conduct requirements in respect of the completion of Declarations of Interest Local Framework Procedures and SFI/SOs should be reviewed, and updated where appropriate, to reflect the Estates Department's requirements.	**M**	Discussions will be initiated with the Director of Corporate Governance and the Assistant Director of Strategy – Capital to ensure that all procedural requirements are fit for purpose (e.g. SO/SFI and Local Framework Protocols).	01/01/2020	**December 2021:** Estates management are now working with Capital colleagues in order to ensure that all procurements over £25,000 have appropriate contractual arrangements in place. SFI's have been reviewed and updated since the audit was undertaken, and no longer contain the references to financial vetting quoted within the report. The Health board's position with regard to financial vetting is currently being reviewed by Finance colleagues, with a view to clarifying requirements and processes within both the Capital and Estates Teams. The proposed utilisation of contractor assurance systems will also be considered as part of this review. It is anticipated that this work will be completed by the end of January 2022. The department now do an annual declaration of interest review with staff asked to confirm that they are not aware of any conflicts of interest. The procedure also requires staff to advise managers if they become aware of a conflict of interest as soon as it occurs. A copy of the recently revised Standards of Business Conduct will be circulated to all relevant staff, with particular reference made to the need to ensure that declarations of interest pro-forma are completed for ALL relevant procurement processes. **April 2022:** Due to ongoing work in progress, the deadline has been extended to the end of May 2022.	31/01/2022
3	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 proforma had not been completed (see also the Capital Systems report 2018/19). The Estates department utilises maintenance contracts	**H**	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	**December 2021:** A review of maintenance requirements and spends has been completed by the department. As a result, contracts are currently in the process of being put in place for the following, which represent the highest areas of maintenance spend within the health board: • Water Management Risk Assessments (Legionella Testing) – Contract awarded • Refrigeration Maintenance – Specification with NWSSP Procurement Services • Boiler Maintenance – Specification with NWSSP Procurement Services • High Voltage Maintenance – Contract Awarded It is anticipated that contracts for boiler and refrigeration maintenance will be in place by 1st April 2022 Generally, orders under £5k are placed with companies who have already demonstrated that they provide best value during previous larger competitive processes. The Assistant Director of Operations (Estates) will now write to all Estates Managers reinforcing this practice. In addition, the department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include reviewing contracts in place, and working with Procurement colleagues to ensure that we have robust systems in place. The department are adopting the CHAS contractor assurance system which will provide assurance around a prospective contractor's: – Health & safety policies	30/06/2022

	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				– Staff training records – Insurances – Financial details The department are also currently going through a competitive process to engage a second assurance company whose services will supplement/complement the above. It is envisaged that these systems will be implemented from April 2022. The department now do an annual declaration of interest review with staff asked to confirm that they are not aware of any conflicts of interest. The procedure also requires staff to advise managers if they become aware of a conflict of interest as soon as it occurs. A copy of the recently revised Standards of Business Conduct will be circulated to all relevant staff, with particular reference made to the need to ensure that declarations of interest pro-forma are completed for ALL relevant procurement processes." **February 2022:** The Assistant Director of Operations (Estates) have confirmed that whilst adoption of the CHAS contractor assurance system remains on track for April 2022, procurement processes mean that there will be a slight delay in engaging the second assurance company referred to above. Based on the foregoing, the deadline date has been further extended to 30/06/2022	
4(a)	Lack of appropriate procurement controls for cumulative spends in excess of £5,000 relating to maintenance contracts (see 3 above) An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented.	**M**	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	**December 2021:** A review of maintenance requirements and spends has been completed by the department. As a result, contracts are currently in the process of being put in place for the following, which represent the highest areas of maintenance spend within the health board: • Water Management Risk Assessments (Legionella Testing) – Contract awarded • Refrigeration Maintenance – Specification with NWSSP Procurement Services • Boiler Maintenance – Specification with NWSSP Procurement Services • High Voltage Maintenance – Contract Awarded It is anticipated that contracts for boiler and refrigeration maintenance will be in place by 1st April 2022 In addition, the department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include reviewing contracts in place, and working with Procurement colleagues to ensure that we have robust systems in place.	30/04/2022
8	We sought to confirm that financial vetting had been undertaken where appropriate (i.e. for contractual arrangements over £25k in value). Financial vetting had not been undertaken at any of the 8 procurement exercises reviewed over the £25k threshold requirement. Financial vetting should be undertaken prior to entering into any contractual arrangement above £25k in value (in accordance with Standing Financial Instructions). Estates should liaise with Finance and Capital Planning to establish requirements for financial vetting at the Local Framework.	**M**	Agreed. Advice will be sought from UHB Finance and Capital Planning, together with NWSSP Procurement Services colleagues to determine an appropriate way forward.	01/01/2020	**December 2022:** SFI's have been reviewed and updated since the audit was undertaken, and no longer contain the references to financial vetting quoted within the report. The Health board position with regard to financial vetting is currently being reviewed by Finance colleagues, with a view to clarifying requirements and processes within both the Capital and Estates Teams. The proposed utilisation of contractor assurance systems will also be considered as part of this review. It is anticipated that this work will be completed by the end of January 2022.	31/01/2022
13	No documented procedures in place for the management of Estates Stores. Formal procedures should be developed and	**H**	Agreed. Appropriate procedures will be implemented and management will undertake periodic	01/01/2020	**February 2022:** The department are in discussions with NWSSP Procurement and health board Finance colleagues to re-instigate independent end-of-year stocktakes. It is anticipated that a stocktake will be undertaken by the end of April 2022. The department are also currently in the process of recruiting a Procurement	31/12/2022

	implemented for the management of Estates stores (in accordance with SFIs).		checks/audits to ensure compliance.		Officer, whose responsibilities will include the production of formal procedures for the management of estates stores. This will include the review and implementation of best practice in this area. The initial recruitment exercise was unsuccessful. The job description and responsibilities of the post will now be reviewed, and a further recruitment exercise undertaken. It is anticipated the position will now be filled by August 2022. Based on the above, the deadline date has been extended to 31/12/2022 in order to take account of the recruitment process and a period of local induction and familiarisation for the appointed Procurement Officer	
14	Issues which reduced the effectiveness of intended controls, and SFI breaches were noted, including: • No annual stocktake at Morriston • Singleton stocktake not independently verified • 'Not stock' items on shelves at both stores, but not recorded on Planet FM Stores practices should be reviewed and enhanced in line with audit findings and SFI requirements.	**H**	Agreed. Appropriate procedures will be implemented and management will undertake periodic checks/audits to ensure compliance.	01/01/2020	**February 2022:** The department are in discussions with NWSSP Procurement and health board Finance colleagues to re-instigate independent end-of-year stocktakes. It is anticipated that a stocktake will be undertaken by the end of April 2022. The department are also currently in the process of recruiting a Procurement Officer, whose responsibilities will include the production of formal procedures for the management of estates stores. This will include the review and implementation of best practice in this area. The initial recruitment exercise was unsuccessful. The job description and responsibilities of the post will now be reviewed, and a further recruitment exercise undertaken. It is anticipated the position will now be filled by August 2022. Based on the above, the deadline date has been extended to 31/12/2022 in order to take account of the recruitment process and a period of local induction and familiarisation for the appointed Procurement Officer	31/12/2022

Executive Lead – Director of Finance						
ABM 1617-012			**Neath Port Talbot Operational PFI**	**Report Issued July 2017**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4.1.1a	Whilst it is noted that a significant element of the risk is transferred to the partner in PFI deals, it is imperative that there are arrangements in place to monitor those risks. A risk register will be prepared to monitor Trust/ partner/ shared risks.	**M**	Agreed **Updated Response – July 2017** The outcome of the legal services review by NWSSP Legal & Risk Services will inform future requirements.	December 2007 30/11/2017	**February 2018 Update** The service directorate have a risk register for Health Board risks [Management considered the action to be complete at that time] **Estates Assurance Follow-Up (SSU-SBUHB-2021-07) - Partially Implemented** Management advised that whilst a risk register is currently not in use, health and safety risks / issues are discussed at the Liaison Group meetings and any significant risks are dealt with promptly. However, evidence of management of wider risks has not been provided. It is further noted that risk management is not a standing agenda item at the liaison meetings.	31/07/2021
4.1.1b	Whilst it is noted that a significant element of the risk is transferred to the partner in PFI deals, it is imperative that there are arrangements in place to monitor those risks. Clause 55.10 of the risk matrix requires that a risk sub-group be established that is accountable to the Liaison Group. We were advised that such monitoring would best be undertaken as a standing item at the Liaison Group as the attendance for both would be the same. Noting the above, the terms of reference for the Liaison group have yet to be revised. Additionally, there is no evidence of a risk register having been presented to the liaison group. The Liaison Group or Risk Sub Group will be responsible for monitoring the risks as standard agenda items.	**M**	Agreed. To be reviewed quarterly as a standing agenda item. **Updated Response – July 2017** The outcome of the legal services review by NWSSP Legal & Risk Services will inform future requirements.	December 2007 30/11/2017	**February 2018 Update** The service directorate have a risk register for Health Board risks [Management considered the action to be complete at that time] **Estates Assurance Follow-Up (SSU-SBUHB-2021-07) - Partially Implemented** Management advised that whilst a risk register is currently not in use, health and safety risks / issues are discussed at the Liaison Group meetings and any significant risks are dealt with promptly. However, evidence of management of wider risks has not been provided. It is further noted that risk management is not a standing agenda item at the liaison meetings.	31/07/2021

Executive Lead – Director of Finance						
ABM 1617-009		Backlog Maintenance		Report Issued October 2017		Limited Assurance
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management 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	**H**	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	**February 2022:** Work has commenced on the completion of the six facet survey which is scheduled to be completed in April 2022. **April 2022:** The production of the Estates Strategy has yet to be received, but is well advanced. The results of the Six Fact Survey is expected in May 2022, and will support the facilitation of the Estates Strategy. Based on the foregoing, the deadline has been extended to 30/06/2022 for further update	30/06/2022
4	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	**M**	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	**February 2022:** The department transferred its significant and high risks from the Oakleaf system into the DATIX system. The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Assistant Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting. April 2022: Meeting with the Assistant Head of Risk and Assurance has taken place, and a copy of the revised departmental risk register has been provided. This will be reviewed by the Assistant Head of Risk and Assurance, who will provide further feedback and comment - Estates strategy and 6 facet survey paper submitted to Space Utilisation Task and Finish Group on 21/4/2022. The deadline date has been extended to 30/06/2022 for further update.	30/06/2022

7	The last recognised date for the completion of a condition survey is circa 2005. Consequently, backlog maintenance costs are not properly stated. The UHB is in the process of developing a specification for the requirement of completion of a full condition survey on a room by room basis. The development of the specification will be finalised as soon as possible to facilitate the provision of a current 'market' backlog maintenance cost. This information will further assist in identifying the significant capital projects required to ensure the UHB sites are 'fit for purpose'	**M**	The Health Board is seeking to commission a six-facet survey this financial year. The Health Board is developing a specification for the completion of the survey, which will allow the Health Board to take an informed view of the estate under its control. The Health Board had approached the Welsh Government for central funding, for the provision of the survey, as it 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.	01/10/2018	**December 2021:** Following meetings with the Chief Executive and Director of Strategy in August 2021, it was agreed that the Health Board will go to tender for the provision of the Six Facet Survey including DDA review. The contract for this work has been awarded to a company on the NHS Shared Business Services framework, and initial meetings have taken place. It is anticipated that the work will be completed by 31st March 2022. **February 2022:** Work has commenced on the completion of the six facet survey which is scheduled to be completed in April 2022. **April 2022:** Currently awaiting the results of the Six Fact Survey recently undertaken, which are expected in May 2022. Noting the foregoing, deadline has been extended to 30/06/2022 for further update.	30/06/2022

Executive Lead – Director of Finance						
ABM 14-15-003	**Disability Discrimination Estates Compliance**			**Report Issued March 2015**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	Costs to achieve compliance with DDA identified in Estates Facilities Performance Management System (EFPMS) data could not be reconciled to previously commissioned disabled persons access reports. Procedures will be established to demonstrate the derivation of EFPMS declared compliance costs (including reconciliation to surveys)	**M**	Agreed - However, the DDA act requires the Health Board to make services available to all patients, visitors and staff. Therefore in some cases there is no need to take action until a concern is raised over the accessibility to the service provided. Whilst it is important for the Health Board to address the fundamental accessibility issues such as disabled access through doors, hearing loops etc. More specific actions are only required if the Health Board cannot provide those services within its existing estate.	31/08/2018	**December 2021:** Following meetings with the Chief Executive and Director of Strategy in August 2021, it was agreed that the Health Board will go to tender for the provision of the Six Facet Survey including DDA review. The contract for this work has been awarded to a company on the NHS Shared Business Services framework, and initial meetings have taken place. It is anticipated that the work will be completed by 31st March 2022. This work will quantify the value of the health board's maximum exposure under DDA in terms of repairs and new provisions. **February 2022:** Work has commenced on the completion of the six facet survey which is scheduled to be completed in April 2022. **April 2022:** Currently awaiting the results of the Six Facet Survey recently undertaken, which are expected in May 2022. Noting the foregoing, deadlines extended to 30/06/2022 for further update.	30/06/2022

Executive Lead – Director of Finance						
SBU 2021-008			**Water Safety**	**Report Issued June 2021**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8(a)	The Water Safety Plan documents the training requirements for key officers, including the requirement for training to be refreshed at least every three years. Training was in date for the current Responsible Persons and Authorised Persons. However, training for Competent Persons (Estates Officers) was out of date with the last training recorded as February 2017. Management advised that the provision of the required face-to-face training had not been possible due to COVID restrictions. It is acknowledged that some Authorised Persons training has now been arranged (noting this takes place offsite); but securing on-site training (for Competent Persons) remains difficult. It was noted that whilst a training matrix for Estates officers was held for those working at the Singleton estate, the same was not evidenced for the Morriston estate. Training should be updated for relevant staff as soon as possible, COVID restrictions permitting	**M**	Agreed. Training will be updated as soon as possible.	31/07/2021	**August 2021:** The health board are trying to commission additional training. However due to COVID there are availability issues. However, that these OAPs are having training updated in accordance with the WHTM's opener.	31/03/2022
9(b)	Water-related risks are recorded by Estates management in the Datix risk management system in line with the wider corporate risk management procedure, escalating to the Corporate Risk Register should the score be sufficiently high. There were no corporate-level water risks reported at the time of the audit. The Water Safety Management Committee's terms of reference state that it should: – Provide a forum in which high level Water System monitoring outcomes and risks can be reported to, evaluated, so that appropriate reduction or elimination action is agreed; and – Consider identified risks, set priorities and produce action plans for each site. Whilst a number of appropriate risks were seen to be discussed at the Water Safety Management Committee, the risk register itself (as recorded in Datix) was not shared. On review of the current Datix recorded water-related risks, it was noted that some high-risk issues discussed at the Water Safety Management Committee had not been recorded (e.g. the absence of up to date risk assessments), whilst other risks, recorded in Datix, had not been discussed at the same (e.g. 'provision of resilience for the [Morriston] site'.	**M**	Agreed. As explained at the time of the Audit, the Estates element of DATIX has not yet gone "live". The Governance Department are arranging for a review of the Estates Risks and have also been working with the Department to allow us to put Health Board wide risks into the database. The reason that the risk assessment having just gone out of date is not entered, is because we were having to enter it for individual buildings. We are currently in discussions with Governance about giving us the capability to enter this information across the Estate rather than by building. The Health Board is in the process of awarding the risk assessment contract WATER SAFETY.	31/07/2021	**August 2021:** The Governance department are reviewing the estates risk register in September with the Estates team, which will also consider how the risks are allocated across the health board. This will then be presented to the October scrutiny panel suggested new date. First of November **February 2022:** The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Assistant Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting.	28/02/2022

	Management should resolve the current Datix usability issues to ensure water-related Estates risks can be accurately captured, monitored and reported.					

Executive Lead – Director of Finance						
ABM 1819-009	**Safe Water Management (Including Legionella)**			**Report Issued May 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
12	WHTM 04-01 states: "Legionella monitoring should be carried out where there is doubt about the efficacy of the control regime or where the recommended temperatures, disinfectant concentrations or other precautions are not consistently achieved throughout the system. The WSG (Water Safety Group) should use risk assessments to determine when and where to test." Whilst noting the same, the UHB's Water Safety Plan (approved by the UHB Quality and Safety Committee in May 2018) states that: "The Health Board is seeking to commence a program of Legionella testing based on the table below (See Appendix B) for the area identified as requiring Legionella testing to take place the frequency of testing will be as follows: – Three samples will be taken within the area identified these being the system Sentinel outlets. These outlets will be tested for Legionella on a monthly basis. If there are three clear sets of readings sampling will reduce to bi monthly (retests that are negative will be treated as a clear result). If there are three sets of clear readings sampling will move to 3 monthly sampling. Sampling will never reduce further than three monthly." Infrastructure risk assessments assess "water risks on all buildings owned or occupied by the Health Board and its equipment…in accordance with the guidance in ACoP L8 (2013), BS8580 (2010), and relevant HTMs in order to identify risks and assess water quality issues from work activities and water sources on the premises and to organise any necessary precautionary measures." At the time of the current review, the infrastructure risk assessments were out of date and were not being referenced. However, a specialist water management company had recently provided revised risk assessments for all ABMU properties which were to be applied. Noting the above, whilst recognising that the WHTM recommends the use of risk assessments to determine when and where to test, at the time of the review, the same were not being applied. Additionally, noting lapse of the testing contract, the audit did not evidence legionella testing in accordance with the above. Legionella testing (in accordance with the agreed Water Safety Plan) remained to be formalised with the public health laboratory via a Service Level Agreement. A service level agreement / contract for water testing should be appropriately concluded.	**H**	Agreed. The Water Safety Plan states that we would routinely test for legionella, although under the WHTM guidance there is no requirement to test for legionella as it is based on an assessment of risk. Whilst the Health Board is aspiring to implement a programme, current practice is that we test for legionella where we have an adverse result or as part of a commissioning / decommissioning process. The water safety plan was not being adhered to at the time of audit.	31/07/2019	**June 2021 (Follow Up Report) - Partially Implemented** An original deadline of July 2019 was agreed for this recommendation. The follow up audit (June 2020) determined that no progress had been made and a revised deadline of September 2020 set. At the time of the audit, a draft tender specification for water testing had been developed, but not finalised and agreed. In the meantime, some water testing has still been undertaken, with the limited resource available (both within the UHB and at the testing laboratory); and focused on high risk areas (e.g. augmented care units). It is acknowledged that wider testing is not mandatory but is a goal for the UHB. It is recognised that the COVID pandemic has impacted both laboratory service delivery and availability of resources within Estates **February 2022:** The department have developed a tender for the provision of legionella testing which is due to go out to the market by the end of February. Based on the above, the deadline date has been extended to 28/02/2022 for further update. **April 2022:** The Tender document was issued to Procurement colleagues some time ago and the interview process has been undertaken. However there were further clarification issues around number of samples and this has now been sent to procurement to continue the process. Based on the foregoing, the deadline has been extended to 30/06/2022 for further update.	30/06/2022

Executive Lead – Director of Finance						
SBU 1718-011		**Control of Substances Hazardous to Health (COSHH)**		**Report Issued February 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	Monitoring and reporting arrangements in relation to COSHH were not defined. However, good practice was noted at the annual Health and Safety report which outlined a process of “periodic audits” of each aspect of Health & Safety. External audits were undertaken of departmental practices by parties such as the Health & Safety executive, and Health Inspectorate Wales. Additional to these, reports were also noted by the “Authorised Engineer” (role provided by NWSSP: Specialist Estates Services) relating to specific areas e.g. medical gases. However, such a formalised approach to the “periodic audits” as outlined at the Health and Safety report was not evidenced. Operation of COSHH systems will be audited and reported in accordance with the requirements outlined within the annual Health and Safety report.	**H**	Agreed	Following Appt. of H&S Resource	**Estates Assurance Follow-Up (SSU-SBUHB-2021-07) - Outstanding** COSHH system audits have not been undertaken in the last year. Management are currently preparing a business case to increase the resource within the Health & Safety team, with plans for one role to have responsibility for managing COSHH. This role will then take forward this matter further. Identified issues will then form the H&S action plan. **February 2022:** Awaiting decision on H&S resources following business case for additional resources, however, several actions have taken place; risk assessments are being reviewed; risk assessment training has and continues to take place virtually via teams and all relevant information will be captured in the annual report and recommend that this be extended to 30/06/22. **April 2022:** The Health Board have agreed to recruit a health and safety advisor post, this will be advertised in Q1 2022/23 and once in place will be implementing audits during 2022/23	30/06/2022

<table>
<tr><th colspan="6">Executive Lead – Director of Finance</th></tr>
<tr><td colspan="2">ABM 2021-009</td><td colspan="2">Fire Safety Management</td><td>Report Issued April 2021</td><td>Limited Assurance</td></tr>
<tr><th>Rec Ref</th><th>Findings & Recommendation</th><th>Priority</th><th>Original Response / Agreed Action</th><th>Original Agreed Deadline</th><th>Most Recent Update/Comment</th><th>Revised Deadline</th></tr>
<tr>
<td>4</td>
<td>The Chief Executive of NHS Wales wrote to all NHS organisations on 13th February 2020 emphasising:
“organisations assess and provide appropriate levels of investment in relation to fire safety measures.” with direction to “discuss.. implications with organisations via the regular Capital review meetings”
i.e. investment sources should be confirmed, including the need to submit capital business cases to Welsh Government.
Site level reports undertaken by management in November 2020 detailed the following with regard the sampled sites:
<table><tr><th>Hospital Site</th><th>% compliance with Firecode</th><th>Projected compliance date</th><th>Cost to achieve compliance</th></tr><tr><td>Singleton</td><td>70%</td><td>2025</td><td>£5m</td></tr><tr><td>Morriston</td><td>75%</td><td>2021</td><td>£5m</td></tr><tr><td>Cefn Coed</td><td>75%</td><td>2022</td><td>£0.3m</td></tr></table>
There was no apparent strategy to achieve required compliance (particularly recognising the 2021 projected compliance date for Morriston Hospital).
Management should develop an appropriate strategy targeting funding to address fire safety requirements.</td>
<td>H</td>
<td>Agreed.
£37m has recently been made available across NHS Wales (as part of the National Capital Programmes in 2021-22 for Infrastructure, Fire Safety, Mental Health, and Decarbonisation, of which, £5.456m was allocated to SBUHB, with £0.261m being specific to Fire Safety). These monies were requested under general themes rather than specific investment projects, and allocations within this for items such as £84k for electric panels will also contribute to fire safety.
A more detailed plan will be created with 5 – 10 year horizons, and the Health and Safety Fire sub-group will undertake detailed assessment of bids going forward.</td>
<td>30/06/2021</td>
<td>February 2022: Estates, Capital and Fire Safety manager are developing a longer term strategy for fire, building in fire management to the discretionary capital, this will cover compartmentation, fire alarms, fire doors, fire dampers and other fire related elements. Additional funding other than the annual allocated capital will be required to ensure capital schemes identified in the plan can be achieved. The initial 2-3 year plan is targeted to be in place by Q1 2022/23 and will include the information from the 6 facet survey.
Based on the above, the deadline date has been extended to 30/06/2022.</td>
<td>30/06/2022</td>
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<td>12</td>
<td>In accordance with the Fire Safety Policy, there are enhanced fire responsibilities for key staff groups e.g. fire wardens, ward managers etc.
Data for enhanced training, notably Fire Wardens was not identified across the UHB. However, management were able to evidence that the overall figure trained as of February 2021 was 75% (benchmarking below other health bodies that have recently been audited).
However, there was also need to ensure adequate numbers of Fire Wardens / those with enhanced duties are trained (noting their key roles in outbreak and feedback).
Noting the local and dynamic nature of training compliance, this is best monitored at a local level, with summaries to corporate management. This would also free limited central resource. Annual audits undertaken by central management (as required by WHTM 05), can focus on ensuring effective operation of such local controls.
Fire safety training in the UHB should be prioritised for all staff.</td>
<td>M</td>
<td>Agreed. All face 2 face training was put on hold initially in wave 1 of the pandemic and has continued due to operational pressures to deal with COVID-19. All new starters have been provided fires safety training as part of the HB pathway for new and redeployed staff in response to the pandemic. Where staff have been able, they have undertaken on-line fire safety training with compliance of 75% at the end February 2021. As part of the transition to business as usual, there will be a focus on training (on-line) initially and then a combination of face 2 face and on-line learning.</td>
<td>31/05/2021</td>
<td>August 2021: No changes at present and will probably be reviewed in readiness for the new financial year (2022/23)
February 2022: Fire safety training has been delivered primarily on-line due to the on-going challenges of COVID-19, with some face to face training being delivered more recently, with plans to provide a more blended learning model going forward in 2022/23. Virtual training is being developed on an all Wales basis, this will be scenario based and provide a more realistic training platform for our staff. The current lead time on this is Q2 2022/23. Noting the foregoing, the deadline has been further extended to 30/09/2022
April 2022: There is a all Wales Fire safety group that are looking at all Wales training programmes to provide a consistent approach, this will involve a blended approach. Currently SB are conducting a number of face to face focussed training geared to the environment that they work, this has been well received with positive feedback</td>
<td>30/09/2022</td>
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Executive Lead – Director of Finance						
ABM 2021-004		**Health & Safety Framework Follow Up**		**Report Issued January 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
6(i)	Review of the health boards health & safety intranet page confirmed that content and links had not been updated to be consistent with approved policies published on the health board main policies page (i.e. some out of date policies were accessible via this route e.g. lone working). Whilst this is the case updates policies can be found within the Corporate policy library. Management should undertake a review of all Health & Safety intranet pages to ensure they are refreshed to reflect the latest information and policies or links to the main corporate policy page so that alignment is ensured.	**M**	The health & safety webpage has been reviewed by the Assistant Director of Health & Safety, and a request has been made to update the webpage and remove the policy links and to insert: To access the latest versions of health and safety policies use this link: http://howis.wales.nhs.uk/sites3/documentmap.cfm?search=true&metatype=&filetype=&libraryid=14715&keywords=&orgid=743&go=FindJust Waiting for confirmation that this has been completed	31/01/2021	**August 2021:** Have contact IT to be able to gain access to the H&S page and not had any success, will continue to follow this up to either temporary take it off line or update as required. **February 2022:** The Health Board is in the process of launching a new intranet page and once launched H&S will develop a H&S section on the new platform. 16/02/22 Noting the foregoing, the deadline has been extended to 30/06/2022 for further update **April 2022:** The HB continue to develop the new intranet and once complete, the H&S Team will develop the H&S webpage.	30/06/2022
7(i)	Our previous report highlighted that of the 78 actions contained within the 2019/20 Improvement Plan only 17 were listed as complete, and that as part of closure of 2019/20 and as part of developing longer term strategies, the status of those actions remaining outstanding should be reported. The pandemic has had an impact both on the resource with which to address plans early in the year, and on the need to refresh the content of plans. It is apparent from our review of papers that there has been ongoing discussion on the development of the Strategic Action Plan for 2020/21 which has been received at HSC meetings in June, September and December 2020. Meeting notes of both the HSC and the Health & Safety Operational Group do not record effectively how the original 2019/20 improvement plan was closed. We note though that it is intended that an operational plan to support the strategic plan will be developed to support the SAP. We recognise that priorities have changed this year and new approaches and fresh plans may be appropriate. A plan has been presented to HSOG setting out how the health & safety function will support wider services. It has been too early to demonstrate the effectiveness of monitoring of progress against plans, noting that the development of the SAP has been ongoing during 2020/21 – so the principle of our previous recommendation remains to be addressed. We have none the less updated the recommendation as detailed below. Additionally, we would note that the term 'action plan' is often used interchangeably in papers and agendas making the distinction unclear and the content of minutes of	**H**	Due to the on-going challenges with COVID-19 and priorities being focussed in other areas and the realisation of the SAP original dates being over optimistic, the SAP has been updated and presented to the HSC in December 2020, it was agreed that the plan will be for 2021/22 financial year. This will be relayed to the HSOG in the meeting scheduled 03/02/21. The SAP will be monitored through the HSOG and updates provided to the HSC for scrutiny	31/3/2021	**February 2022:** The H&S strategic action plan has been further reviewed due to challenges around COVID-19, the amended version is being submitted to the H&S committee in April 2022, this will cover 2022/23 & 23/24, this replaced the previous action plan. From the strategic action plan an operational action plan will be produced and provide a more detailed plan to be submitted through the HSOG. Based on the foregoing, the deadline has been extended to 30/04/2022 for further update April 2022: The updated plan was presented to the H&S Committee on 5th April 2022. Noting the foregoing, the deadline has been extended to 30/09/2022 in order to evidence progress reporting.	30/09/2022

	discussions and decisions at the HSOG does not assist clarity. This has been reflected in the revised recommendation for point 7(ii). From December 2020, update reports to the HSC on the Health & Safety Strategic Action Plan should include a clear indication of progress against actions, with a summary position to aid oversight. The reports should include information on delay against original timescales and/or record where there are changes to original target dates clearly.					
7(ii)	Review of agendas and minutes confirmed that the Health & Safety Strategic Action Plan 2020/21 has been included within HSOG agendas at a number of meetings throughout 2020 as it was developed and timescales amended in light of the impact of the COVID-19 pandemic though it is too early to demonstrate review of progress. As noted at 7(i) above, discussion of the 2019/20 improvement plan was not clear. We note that whilst the Strategic Action Plan was not presented to the HSOG in November, the group received a 'Health and Safety Plan 2020-21' outlining the areas the corporate H&S team would prioritise for 2020-21. Consistent terminology should be used when referring to the Strategic Action Plan and any supporting plans for clarity, and that progress against each be reported clearly at HSOG meetings.	**M**	The HB take on board the points raised and the confusion this may cause and moving forward there will be the SAP that will outline the strategic view and the HSP (HSWP) that will have a more detailed operational plan to assist in implementing the SAP, both will be reviewed by the HSOG with updates provided to the HSC.	30/06/2021	**February 2022:** The H&S strategic action plan has been reviewed due to challenges around COVID-19, the amended version is being submitted to the H&S committee in April 2022, this will cover 2022/23 & 23/24, this replaced the previous action plan. Form the strategic action plan, From the strategic action plan an operational action plan will be produced with more consistent terminology. Based on the foregoing, the deadline has been extended to 30/04/2022 for further update **April 2022:** Following on from the presentation of the SAP to the H&S committee, it was agreed to develop a single action plan, this will now be developed in Q1 2022/23 and suggest this be extended to 30/06/2022	30/06/2022

Executive Lead – Director of Finance						
SBU 1819-007		**Systems: Declarations of Interest & Risk Management**		**Report Issued October 2018**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
14	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.	**M**	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	**December 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. **January 2020:** Meeting took place. Work is ongoing. It is planned to have transfer complete of High and Significant risks by May. **Capital Assurance Follow-Up (SSU-SBUHB-2021-004) – Outstanding** An update has not been provided by Management on this issue. Revised Timescale – 31/08/2021 **April 2022:** Discretionary Allocation for Estates 22/23 based on risk assessment and priority list of requirements covered in allocation and signed off by Board in March 2022. Noting the foregoing, the deadline date has been extended to 30/06/2022 in order to obtain confirmation that Estates Operating Procedures have been updated in line with the agreed action.	30/06/2022
16	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.	**M**	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	**February 2022:** The department met with the risk Governance group and were asked to revisit the format of the risk assessments to provide themes for the risk register. Working with the Assistant Director of Health & Safety this work has been completed in January 2022 and we are now arranging to review these revised risks with the Neil Thomas Head of Risk & Assurance. Revised deadline date of 28/02/2022 for further update following the above meeting **April 2022:** Meeting with the Assistant Head of Risk and Assurance has taken place, and a copy of the revised departmental risk register has been provided. This will be reviewed by the Assistant Head of Risk and Assurance, who will provide further feedback and comment. Based on the foregoing, the deadline date has been extended to 30/06/2022 for further update.	30/06/2022

17	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.	**M**	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	**July 20219:** 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. **January 2020:** Reports have been presented at H&S Committee on Estates issues. The new WEB meeting will further enhance this operational H&S group. **April 2020:** The Estates risk register has been reviewed and presented to Management Board. Capital discretionary plan based on the updated Estates risk register signed off by board. Noting the foregoing, the deadline date has been extended to 30/06/2022 in order to obtain confirmation that Estates reporting has been updated in line with the agreed action.	30/06/2022

Executive Lead – Director of Finance						
SBU 1819-038		**Strategy & Planning Directorate**		**Report Issued October 2018**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2(i)	Most staff had objectives set for 2017/18. However, the objectives provided for Estates supporting managers related to delivery in 2015 & 2016. Additionally, whilst Capital Planning staff had objectives which included delivery in 2017/18, for some (including the Assistant Director) there were also objectives with delivery dates in preceding years - suggesting objectives had not been refreshed annually. We would recommend that Capital Planning & Estates refresh objectives annually, setting new targets for the year(s) ahead.	**M**	PADRs will be held with all staff to set objectives and targets	21/12/2018	**July 2019:** PADRs are reviewed via Estates Board, objectives have been set on a reactive basis to date. Moving forward objectives will be set at the start of financial year to align with budget allocations.	21/12/2018

Executive Lead – Director of Finance						
SSU-SBU 2122-005		**Waste Management**		**Report Issued February 2022**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	It was confirmed during the site visit to Morriston Hospital (see MA5), that the public / general staff areas observed (main entrances, visitor waiting rooms, staff rest areas, canteens) provided domestic waste bins for disposal of general waste, including masks. In the clinical areas observed, only orange (infectious waste) bins were provided. Management confirmed that the UHB does not currently use the offensive (tiger stripe) waste stream in its hospitals, therefore, is unable to comply with the current guidance. Management should report the costs/benefits of the introduction of the offensive (tiger stripe) waste stream to an appropriate forum/department (e.g. Infection Control), for onward consideration of the matter outside Estates.	**M**	Agreed. This will initially be reported to the Director of Finance & Performance, and then to the Operational Service Group Boards.	31/03/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022
6a	A process of action tracking and reporting was not evidenced for Pre-Acceptance audit non-conformities. a) Recommendations / non-conformities arising from Pre-Acceptance audits should be monitored via the central tracker.	**M**	a) Agreed, we will prepare a RAG-rated summary log of all audit findings.	31/01/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022
6b	A process of action tracking and reporting was not evidenced for Pre-Acceptance audit non-conformities. b) Pre-Acceptance audit non-conformities, and progress towards actioning the same, should be reported to a relevant forum/s (e.g. Estates Board / Hospital Management Boards).		b) Agreed. Recognising that Morriston has recently established a Management Board (with the same anticipated for Singleton), the presentation of relevant audit findings could be directed to these forums (rather than the Estates Board, which only has the ability to influence Estates issues), to enable appropriate oversight and action by the relevant responsible officers (i.e. ultimately the Service Directors). The Assistant Director of Operations (Estates) will liaise with the Service Directors to confirm how they wish for relevant issues to be reported. Where pre-acceptance audit findings relate to Estates, these will be incorporated into the existing Environmental Report. It is also noted that Estates are in the process of developing a Compliance Manager post, which would play a key role going forward in the monitoring of audit recommendations.	31/01/2022	**April 2022:** Due to operational challenges (COVID) this requires extending to 30/08/2022.	31/08/2022

Executive Lead – Director of Workforce & Organisational Development						
ABM 1718-046	**European Working Time Directive Portering Services**		**Report Issued May 2018**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	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.	**H**	Agreed. A policy/guidance will be composed.	01/09/2018	**February 2022** A guidance document has been drafted and will be circulated for comment (31/03/2022) Based on the above, date further extended to 31/03/2022.	01/03/2022

Executive Lead – Director of Workforce & Organisational Development						
ABM 1819-042	**Junior Doctors Bandings Follow Up**		**Report Issued April 2019**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	On the recommendation of a previous audit review, Medical HR composed a draft document giving guidance on Junior Doctors Hours. The guidance outlined: - The requirements of junior doctors in terms of WTD compliance and Natural Breaks. - The need for operational service support for the monitoring process. The document was presented to the Local Negotiating Committee (LNC) where, we were informed, there was disagreement to some of the content (exception forms) by some attendees, so the guidance was not progressed any further at that time. It was also noted that a guidance document for handover procedures was also drafted, but also progressed no further. There was no progress on a policy/guidance on the use of hospital pager bleeps. We would recommend that the Medical Director, with the support of the Director of Workforce & OD, consider review of draft policies and procedures and progress their development and formal adoption.	**M**	This action is agreed by management. It should be noted there has been extensive resistance from the LNC to the adoption of the guidance and in particular the use of the exception form. We need to liaise with the newly constituted LNC for Swansea Bay UHB and junior doctors reps but after this, irrespective of views expressed, the documentation will be implemented.	30/06/2019	**November 2021** Action yet to be progressed due to workforce pressures and other priorities. Aim is that matters progress Q1/2 2022/23. It should be noted Wales is currently exploring a new junior doctor contract and if adopted this will remove the need to monitor under the New Deal arrangements	30/06/2022

Executive Lead – Director of Workforce & Organisational Development						
SBU 1920-042		**Disclosure & Barring Service (DBS) Checks**		**Report Issued January 2020**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	The WODC action plan has an action to "Commence roll out of DBS plan" but no milestones or target date for its completion. There is a lack of quantitative detail in the high-level WODC action plan updates. Progress reported to WODC through the action plan does not include key information such as the number of DBS checks that have been completed against those required, the numbers in progress, or are yet to be started. We recommend that: i) Additional milestones and a target completion date be agreed for the completion of DBS clearance of staff currently employed but not previously checked. ii) Future reporting to WODC record progress against these milestones/targets including clear quantitative information such as: – the number of DBS checks that are required; – have been completed; – are in progress; – or are yet to be started.	**H**	i) Additional milestones and a target completion date has been agreed for the completion of DBS clearance of staff currently employed but not previously checked for end of March 2020. Documentation will be reviewed and amended in line with recommendations. ii) Future reporting to WODC will record progress against these milestones/targets including clear quantitative information such as the number of DBS checks that are required; have been completed; are in progress; or are yet to be started.	28/02/2020	**November 2021** Action not yet progressed due to workforce pressures. To progress Q1/2 2022/23. Noting the above, deadline extended to 30/06/2022 for update.	30/06/2022

Executive Lead – Director of Workforce & Organisational Development						
SBU 1920-032		**WOD Directorate**		**Report Issued August 2020**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	We were provided with details of WOD directorate staff PADR status. Performance to October 2019 indicated the directorate was 14% below the Health Board average of 67%. Analysis against directorate staff individual status highlighted that the majority listed as expired were overdue by only a few months - 85% of staff were either in date or with 3 months of expiry. Whilst management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit). We recommend management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit).	**H**	It is noted that the Trade Union Officers PADR is not completed by the WOD function. Following the audit targeted work began to ensure all WOD PADRs were completed. This meant that compliance rose to 73% in January 2020. Due to the COVID-19 pandemic it is recognised that the WOD PADR compliance has fallen to 55%. The funding to ensure that WOD are able to continue to function which was agreed early 2020 has been on hold meaning that gaps remain in management structure. Due to the uncertainty of the situation, the redeployment of people and reassignment of tasks PADRs may not take place at due dates. Management can reassure that discussions around wellbeing and tasks are continuing. The completion of PADRs will be dependant on no second wave of the pandemic, a return to a more normal way of working and recruitment into posts.	01/03/2021	**February 2022** Completion of outstanding Workforce PADR completion ongoing with target date of Q1. Overall review of PADR compliance scheduled for next WOD Committee. Noting the above, deadline extended to 30/06/2022	30/06/2022

Executive Lead – Director of Workforce & Organisational Development						
SBU 2122-024		**Staff Wellbeing & Occupational Health**	**Report Issued September 2021**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
5.1	The majority of OH referrals are made via management. However, an individual can also self-refer, to seek advice before becoming ill and absent from work. On referral to the service the individual is triaged to assess and determine the appropriate clinical support before an appointment is offered. Following this appointment, the OH team issues a report to the individual and/or manager with their findings and recommendations for reasonable adjustments as required. The Occupational Health Team maintain monthly figures on the number of referrals received, the specialty assigned after triage and the average number of working days for triage and the first appointment. However, the team informed us they do not typically hear back from staff and managers once reports are issued. Therefore, they do not receive feedback from stakeholders on the effectiveness of the service and in order to identify areas for improvement and development The OH team should seek to evaluate the effectiveness of the service from various stakeholder's perspectives, including line-managers, employees in receipt of the service and HR colleagues/Business Partners, to identify areas for improvement and service development. The team could explore working with the Workforce and Organisational Development Service to see if OH is having a positive effect to reduce sickness absences.	**M**	The OH team will seek to evaluate the service from various stakeholder's perspectives, including line-managers, employee's in receipt of the service and HR colleagues/Business Partner's. This may help identify areas for service development and improve the effectiveness of the service. OH&WB representative will be gained at the monthly Workforce sickness strategy meeting where a review of the Service Group sickness action plans is undertaken.	31/10/2021	**November 2021** A lead has been identified to progress work in this area. In order to ensure that the evaluation referred to in the original response is robust, and based on a sufficient amount of representative stakeholder feedback, it is proposed that the deadline for this work be extended to 30/06/2022. **February 2022** Clinical outcome measures and staff feedback forms are used to evaluate service however the requirement to implement a robust evaluation mechanism is included as part of additional funding business case.	30/06/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2122-002		**Quality & Safety Framework**		**Report Issued December 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1	The health board has an agreed Quality and Safety Process Framework (QSPF). We note that whilst the QSPF was approved, it was shortly before the onset of the first wave of the COVID-19 pandemic. Whilst necessarily focussing on the operational pressures which followed, there is little evidence to support that there has been any further implementation of the framework beyond the establishment of the QSGG. A number of key steps included within an improvement plan were not progressed including: • Creation of an 'iHub' to support trend analysis and support quality improvement initiatives. • Mapping of reporting groups and subgroups to support the Quality and Safety Governance Group (QSGG). • Mapping of Executive Directors reporting portfolios. • Establishment of a QSGG business cycle/work programme. • QSGG Subgroups and Service Group quality and safety groups to amend terms of reference to reflect the QSPF process. Additionally, the QSPF will now need refreshing to consider the impact of Covid-19, the health board's new Quality Priorities, and the recently issued national Quality and Safety Framework. The health board should consider refreshing the Quality and Safety Process Framework to incorporate the impact of COVID-19, national guidance and its new quality priorities.	**H**	Health Board will run two externally facilitated Q&S workshops to review Q&S arrangements which will support a refresh of the Framework.	01/04/2022	**February 2022:** Worksop dates arranged for Feb and March 2022. Independent internal review of QSGG commenced. Outcome of workshop and findings of review will inform potential revision/relaunch of Quality and Safety Framework **April 2022:** Quality and Safety Patient Services Group Revised Framework proposals on the agenda to be discussed at the Management Board 20th April 2022. Based on the foregoing, deadline extended to 30/06/2022 to receive feedback from Management Board and take any further required action.	30/06/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1920-020			**Falls**	**Report Issued September 2019**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
5	There are a number of "Gold Command" focus Groups active within the Health Board but there are no gold command policies or protocols in place that are linked to the performance management framework. Consideration should be given to establishing an operating protocol for "gold command" focus groups which is aligned to the performance management framework to ensure that these groups are effective and can demonstrate improvement.	**M**	Agreed. The policy provides details of management responsibility for key policy areas e.g. Security, asbestos, transport etc. however it will be reviewed for adequacy in light of the recommendation.	31/03/2020	**December 2021** The Interim Director of Corporate Governance is working with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Chief Operating Officer to review and update structural arrangements as part of the quality governance and strategy review work. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan	31/05/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1920-025		**Discharge Planning (DoN)**	**Report Issued February 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
9 iii	The review of 69 patients found that only one patient had an EDD recorded within patient notes and this did not provide any evidence of discussion with patient, family or carers. Through discussion at the MDT Board Round we attended at Gorseinon, there was evidence that EDDs were being discussed with patients but that this was not sufficiently recorded within patient's notes. Management should ensure that EDD is discussed with patients and families and the discussion is recorded in the patient notes. Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**H**	The all wales newly developed and piloted digital clinical risk assessments includes Expected date of discharge and will be rolled out across the health Board – this will improve recording of EDD and engagement with families and carers.	31/03/2022	**Undated:** A Head of Nursing (Patient Flow) has only very recently taken up post and will be working on this.	None Entered
14	There were mixed findings in relation to Information Governance with different wards having different concepts relating to the amount of patient data permitted to be displayed within patient and visitors view. However, in general, full patient names were visible on most Signal PSAG Boards with some Wards displaying dates of birth, area of residence and detailed health information. These screens should be switched off when not in use for Board Rounds to limit the visibility to patients and visitors, however there were several instances when a Board was left unattended by staff and visible to passers-by. Clarity should be provided to staff across all sites on the detail permitted and required to be visible on the PSAG Boards in line with GDPR	**M**	The Quality & Safety Governance Group will develop a standard for inclusion of key requirements and management of PSAG "know how you are doing" boards.	31/05/2021	**February 2022** QSGG in March is to receive an update from the Head of Patient Flow on their work programme Deadline revised to 31/03/2022 based on the foregoing	31/03/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2021-027		**Safeguarding**		**Report Issued June 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	We note that the health board has developed a Quality & Safety Dashboard, which provides a tool for corporate/service group triangulation & oversight of key incident levels at ward and hospital level. Management indicated that when the safeguarding module of Datix is implemented, safeguarding cases will also be included in the dashboard. The dashboard does not currently include workforce issues. Management should consider the development of monitoring information further to triangulate data on concerns with workforce matters such as grievances, suspensions, and sickness absence to provide broader indication of service areas with potential safety and safeguarding risks. Consideration should be given to how the review of this can be best implemented and demonstrated. This recommendation may require action outside the corporate safeguarding team.	**L**	• The Head of Nursing has emailed the Head of Patient Experience, Risk & Legal Services and the Head of Quality & Safety, Corporate Nursing to arrange to meet and discuss the recommendation • Safeguarding module on Datix work is progressing, there is no date as yet for the completion of this work	01/09/2021	**Undated:** The Safeguarding module on Datix work is progressing, led by NST, PHW and the NHS Wales Shared Services Partnership, there is no date as yet for the completion of this work. **August 2021:** This work is still ongoing with no completion date yet **December 2021:** The Safeguarding module is to be piloted by Hywel Dda UHB in the New year. Based on the above, deadline has been extended to 30/04/2022 for further update **February 2022:** The work is still ongoing, with no completion date. **April 2022:** Hywel Dda continue to pilot this work and no further update at this stage. Based on the foregoing, deadline has been extended to 30/06/2022 for further update	30/06/2022

Executive Lead – Director of Public Health						
SBU 1819-012		**Vaccination & Immunisation**		**Report Issued August 2018**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4(b)	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.	**M**	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 back log 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	**February 2022** The development of an intended business case to undertake data cleansing across primary care and child health record systems has not progressed. Noting the time which has lapsed since this issue was originally raised, the Director of Public Health will now revisit this issue and establish the current situation and necessary action in terms of the accuracy of immunisation records (30/06/2022). Based on the above, date further extended to 30/06/2022	30/06/2022

xecutive Lead – Director of Strategy						
SBU 2021-004	**Environmental Infrastructure Modernisation Programme (S2P2)**		**Report Issued August 2021**			**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: “Boards .. will need to identify a Senior Responsible Owner (SRO) for each project with the capacity and expertise to lead and challenge.” There is particular need therefore for the SRO to be able to exercise scrutiny and challenge at the project informed by appropriate project information. The Service Director (Morriston Hospital Service Delivery Units) was the allocated SRO for this project (as defined at the Project Execution Plan). An email trail was supplied in June 2021 of the Project Director obtaining SRO approval of Compensation Events (contractual changes) at the project. She was also copied minutes of the July Project Board (by the Project Director), requesting her approval to items approved within the meeting. However, the most recent attendance of the SRO to project meetings was to part of a Feb 2021 Project Board meeting. A prior Project Execution Plan (PEP) had indicated the operation of a Programme Board. This no longer operated and was not defined at the current Project Execution Plan. There was therefore particular need to ensure effective linkage of the Project Board to senior committees via its summary reports accountable officers (as designed at the PEP). While summary financial reporting was provided to the Capital Monitoring Group, the SRO did not attend this group. Formal information linkage to the Executive via the SRO was therefore not identified. It is recognised that technical issues at the Project Board may not involve the SRO. However, there was need to define any such delineation as to notifications and approval by the SRO e.g. partial attendance, or approval of action or decision logs. There was therefore a need for linkage to the Senior Responsible Office and Executive team to be defined at the Project Execution Plan. The Project Execution Plan (as approved by the Project Board) should define monitoring and reporting arrangements for both the Senior Responsible Officer, Project Board, and Executive Team via the project and committee structures (particularly where the SRO is unable to attend key meetings).	**M**	Agreed. We will look to utilise action / decision logs, potentially delineating user related actions requiring SRO approval, and look to better define SRO and executive interactions at the Project Execution Plan.	31/10/2021	None entered	None entered

2	Welsh Government Guidance “Guide to developing the Programme Business Case” states: “The Programme Business Case is a working document which must be revisited and updated upon completion of each tranche of the programme, prior to obtaining approval to commence a further tranche”. A Programme Business Case was originally produced in 2013 and updated in 2018. The project phases have developed considerably as the programme has progressed. There was a need therefore to re-appraise the Programme Business Case alongside the revised business case for this stage. Any such revision will need to be factored into timing and costings of the phase. In this case management stated any revision to the Program Business Case would need to reflect the Site Strategy, Clinical Service Plan and Estates Strategy (all of which are in process of revision). For this reason, this has not presently been factored in as a required task for approval of the business case. Management should confirm the waiver to refresh the Programme Business Case at the Welsh Government Capital Review Meetings, else factor in appropriate time and cost to the project for this task.	**M**	Agreed. We will look to confirm the need for a refreshed Programme Business Case potentially at the Welsh Government Capital Review Meeting in order to obtain Welsh Government funding.	30/11/2021	None entered	None entered
4	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: “Risk registers for each individual project/programme must be completed, shared and monitored, with reference… to time, cost and quality”. The risk register is intended to act as a key project management tool. Risks should progressively be managed down as the project progresses, and contingency is utilised to address issues i.e. enabling comparison of residual risk with residual contingency. The register itself was not costed, impeding its use for managing project costs and comparison with residual contingency. For the purposes of managing the risks, it may be prudent to differentiate risks between stage 3 and stage 4. In accordance with NHS Wales Infrastructure Investment Guidance, the risk register should be costed to allow it to be assessed against available contingencies.	**M**	Agreed. The monitoring of risk is undertaken during monthly CRL meetings between the Health Board and Cost Advisor and as part of the monthly reconciliation of forecast and actual expenditure. The Change Control Register also records the up-to-date contract value for the SCP. The Health Board will, with the Cost Advisor, review with the monitoring of the cumulative value of risks and contingency against the funding approval.	30/11/2021	None entered	None entered
6	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires up to date financial monitoring of projects. Project cost reporting presently suffers from certain anomalies and limitations: – Non-works costs were provided only in total – While the capital monitoring report showed in-year expenditure, the “Level 2” cost report also showed prior year expenditure but labelled the combined total as a forecast. Neither report therefore provided a forecast i.e. including future expenditures. – The capital monitoring report showed in-year	**M**	Agreed. Cost reporting will be developed with the health board cost advisor and will report against contract and budget, including forecast outturns.	31/10/2021	None entered	None entered

	variance against expected spend. However, noting a lack of priced activity schedules by the Supply Chain Partner and advisers, the basis of this expected spend profile was not clear. – The Supply Chain Partner report monitored actual and forecast expenditure against their own contact sum, but there was not similar monitoring of the overall project (including Health Board, non-works, and adviser sums). – No reporting against contracted sums or approved funds allocated was identified for the project. It is recognised that there was detailed in-year monitoring of expenditure, including reporting to the Capital Monitoring Group. It is also recognised that this was in context of final assessment and agreement of budgets for the current phase with Welsh Government only being concluded in July 2021 (the point of audit conclusion). However, there was a particular need for reporting against budget, and forecast out-turn. Cost reporting should include forecasts to the end of the project stage, including current and forecast variance to contracted sums and funding.					

7.1	The Project Execution Plan states that the Project Board is the body "responsible for the overall direction and management of the project through to completion." While project changes were authorised via correspondence between the Project Director and the Senior Responsible Officer, the Project Board had no defined role scrutiny or challenge of project changes. Testing was undertaken as follows: **Authorisation** While approval by the Senior Responsible Officer was obtained for one recent Compensation Event, Project Board approval was not evidenced. Neither the Senior Responsible Officer, nor the Project Board had a defined role in approving Compensation Events at the Project Execution Plan (the Project Board being the accountable body for project control). Signed approval at the Supply Chain Partner Compensation Events was only provided by the external Cost Adviser. This was contrary to the requirements of the Project Execution Plan, which requires Health Board approval. In all 9 cases sampled, Compensation Events were well substantiated by calculations of time and resource. (Observations relating to the need to align resource charged to project tasks has made at MA 6). For the 6 sampled changes in respect of the advisers, they were signed by both the requesting adviser and the Health Board Capital Planning lead in accordance with his delegated limits (£25,000 as specified at the Project Execution Plan). The Project Execution Plan should define the role of the Project Board in scrutiny and approval of project changes.	**M**	Agreed. We will update the role of the Project Board in respect of approval of Compensation Events.	31/10/2021	None Entered	None Entered

	Total Compensation Event's	Total no. of Compensation Events to date	Sample value	Sample no	Substantiated	Appropriately Authorised?	Timely approval?
Supply Chain Partner	£282,696	8	£178,239	3	Yes	See comments	Yes
Adviser	£65,570	6	£65,570	6	Yes	Yes	See comments

7.2	The Project Execution Plan states that the Project Board is the body "responsible for the overall direction and management of the project through to completion." While project changes were authorised via correspondence between the Project Director and the Senior Responsible Officer, the Project Board had no defined role scrutiny or challenge of project changes. Testing was undertaken as follows: **Timeliness** The Project Execution Plan reflects the contract in requiring agreement within stipulated time frames (response to Compensation Event requests within two weeks). This is required to avoid agreement by default due to breach of these time limits. All three Supply Chain Partner Compensation Events were agreed within the required time frames, but similar monitoring was not found for agreement of adviser Compensation Events. Only four of the six adviser Compensation Events to date were provided (hence sample size. Of the remaining two (which could not therefore be sampled), one was raised two months earlier, and the date the other was raised was not recorded. There was a need therefore to monitor timely approval, additional to appropriate authorisation. There was also a need to monitor timely response for Requests for Information (RFI) from the Supply Chain Partner, to avoid compensation claim for delay. Timely agreement of Compensation Events and Requests for Information should be monitored and reported.	**M**	Agreed. We will ensure that both Compensation Events and Requests for Information are monitored for timely approval.	31/10/2021	None Entered	None Entered

	Total Compensation Event's	Total no. of Compensation Events to date	Sample value	Sample no	Substantiated	Appropriately Authorised?	Timely approval?
Supply Chain Partner	£282,696	8	£178,239	3	Yes	See comments	Yes
Adviser	£65,570	6	£65,570	6	Yes	Yes	See comments

Executive Lead – Director of Strategy						
SBU 2122-003		**Elective Orthopaedic Unit**		**Report Issued October 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3.1	The Project Initiation Document details that the Project Manager will provide monthly highlight reports to the recently refreshed Steering Group. The new terms of reference for the refreshed Steering Group additionally confirm that the Steering Group will report monthly to the Planned Care Delivery Board. Recognising the recent implementation of the refreshed governance arrangements, only one formal highlight report had been produced for the new Steering Group, for its initial meeting in September 21, with Flash reports produced in the last two months for the Planned Care Delivery Board. The content of reporting included: – high level detail of key risks; – progress to date; – planned actions for the coming period; and – an overall 'RAG' (red/amber/green) rating of the project (which had been assessed as 'Red' at the reports reviewed). However, the reports did not provide supporting detail as to how this RAG rating had been determined. The reports also did not provide narrative of progress against timeline. It is understood that whilst early expectations for delivery timescales were communicated, a formal delivery programme has not yet been defined. Whilst recognising a detailed programme will be prepared once approval is received, highlight reports should be clear on overall progress against original expected timescales, to ensure group members are adequately informed on any slippage (which may affect key matters such as achievement of expected benefits). Highlight / Flash reporting to the Steering Group & Planned Care Delivery Board should be enhanced to include: – Reporting of progress against expected timelines, including any slippage incurred to date against original targets, and ongoing reporting against a more detailed delivery programme once this has been agreed; and – A clear summary of the factors influencing the overarching RAG rating.	**M**	Agreed. Over the past few months, we have hoped that we have demonstrated that we have significantly strengthened the governance arrangements around this project. Audit's recommendations have been noted and will be implemented going forward.	30/11/2021	None Entered	None Entered

4.1	UHB submitted a bid to the Welsh Government COVID Recovery Fund on 7 September 2021, setting out the capital funding requirements for the project as follows: – A total capital requirement of £6.3m, for enabling works and equipping; – £5.928 to be expended in 2021/22, and a further £0.410m in 2022/23. The capital submission also indicated that an additional funding bid would be submitted to Welsh Government for revenue support, with the covering letter indicating the revenue needs as follows: – An initial revenue requirement of £20.522m in 2022/23, including building and operational costs; – An estimated recurring revenue requirement for annual running costs at £20.099m (primarily comprising staffing costs). The letter indicated that these were maximum costs and further work was ongoing to refine and confirm actual costs. Welsh Government approval for £5.928m capital funding was received on 23 September 2021. At the time of the audit, the funding of the recurring revenue requirement had not yet been confirmed. The UHB remained in dialogue with Welsh Government to clarify the position. It is noted that, on presentation of the long-term revenue solution to the Board in August 2021, the Chair stated that the level of recurrent revenue expenditure would not be affordable to the UHB without external support. The UHB should confirm the funding route/s for the recurring revenue requirement across the life of the modular unit, prior to any procurement commitment being made.	**H**	Agreed. Subsequent to Audit undertaking their fieldwork on this project, the Health Board received an email from Welsh Government [13 October 2021] stating that the Minister has endorsed this project and we will receive a formal letter within the next few days confirming the funding. This email has been shared with Audit.	30/11/2021	None Entered	None Entered
5.1	At the time of reporting, the Strategic Outline Case (SOC), presenting options for a permanent capital solution, was awaiting approval by the Welsh Government. The SOC also confirmed that an interim 'service bridging' revenue solution, to address immediate needs, was being developed. Following SOC submission, options for the 'service bridging' solution had been further refined with the potential for a long-term (10 years+) revenue solution, via leased modular build on the Neath Port Talbot site, being assessed. Whilst noting the 'service bridging' solution was referenced in the SOC, a longer-term revenue solution was not presented as one of the delivery options considered within the Case and as approved by the UHB Board. A paper was presented to the UHB Board in August 2021 setting out the costs associated with the long-term revenue solution, the proposed procurement approach (which may potentially include a direct award from the modular build framework) and the anticipated timeline. The paper did not however highlight the deviation from the business case requirements set out in the NHS Wales Infrastructure Investment Guidance and UHB SFIs.	**M**	Agreed. This is a unique project which has not been developed in our usual way. The project is continuing to evolve and therefore we acknowledge that our usual processes that we follow are not in place. Discussions have been held with the Project Director and it has been agreed that once further clarity is known, a paper will be prepared and submitted to the Health Board which will detail any deviation from the NHS Wales Infrastructure Investment Guidance and the UHB's SOs/SFIs in the business case / approvals route taken. Additionally, the paper will include the case for the preferred option including the value for money provided and assurance that procurement regulations will be applied.	30/11/2021	None Entered	None Entered

	The paper was noted by Members, with an agreement that a case could be submitted to Welsh Government for project funding. Welsh Government has now awarded the required capital funding to support the enabling works and equipping elements of the project, from the COVID Recovery fund. However, confirmation of the recurring revenue requirement (and any associated business case requirements) remained outstanding at the time of reporting. Whilst acknowledging the Welsh Government has not (to date) provided any indication of business case requirements, the full details of the project should be presented to the Board, including the value for money provided by the preferred option, to enable an informed approval to be granted before the project progresses to the procurement stage. A paper should be submitted to the UHB Board, setting out: Any deviation from the NHS Wales Infrastructure Investment Guidance and the UHB's SOs/SFIs in the business case / approvals route taken; and – The case for the preferred option, including the value for money provided, and assurance that procurement regulations will be applied.					
6.1	The development of a potential long-term revenue solution has progressed through the investigation of the feasibility of a number of options following the initial reference to a temporary bridging solution within the SOC. Key changes to the original proposed solution include: – Location of the modular build: from the Morriston site to the Neath Port Talbot site; – Duration of the lease arrangements: from a three year 'bridging' solution until the capital solution was developed, to a longer-term 10+ years model, which may negate the need to progress the capital investment set out in the SOC; – The number of theatres to be provided by the modular solution: from two to four; and – The preferred model of supply: from a company which would provide both the building and staffing, to a company with a supply only model, following concerns raised by UHB clinicians. It is recognised that it is normal practice to investigate the feasibility of a range of options before selecting the best fit for the UHB's needs. However, a clear audit trail has not been identified to support the directions given or decisions made during this process to date, which have influenced the development of a preferred solution. Whilst a RAID (Risks, Actions, Issues, Decisions) log had been maintained during 2020, no issues/decisions had been logged for the period January to July 2021; reflecting the period in which the above changes in project direction occurred.	**M**	Agreed. Audit have acknowledged that there is evidence from email trails and minutes that demonstrate that issues have been escalated to the appropriate people and that decisions have been taken in suitable ways; however, this information has not been captured on a formalised decisions log. The Project Manager is to, as is reasonably possible, go through the backlog of emails / minutes relating to this project and capture the decisions and reasons as to why made.	30/11/2021	None Entered	None Entered

	As part of the refreshed governance structure initiated from September 2021 onwards, a new Decisions Log has been implemented. This will be supported by the minutes of formal Steering Group meetings held going forward. The Decisions Log should be backdated to provide a clear audit trail of decision points in the direction of the revenue solution, including where formal instruction was given to pursue a particular option.					
7.1	The project risk management procedure was clearly defined in the Project Initiation Document, with a new risk register recently prepared to align with the refreshed governance arrangements and to reflect the current stage of the project. Whilst a range of risks had been appropriately identified and recorded at the time of review, the Project Manager recognised that further development was required, both through the involvement of the Steering Group and the supporting work streams (for example, recruitment and blood bank risks have been highlighted as areas requiring more detailed consideration). It is also noted that the revenue funding requirement for the project remained to be confirmed. This and other risks, such as procurement matters, were not captured on the risk register reviewed. The further development of the risk register will support existing reporting processes to the Steering Group and Planned Care Delivery Board, and ensure members can provide scrutiny and direction as to the management of the key risks affecting the project. The risk register should continue to be developed to ensure all relevant risks are captured.	**M**	Agreed. Going forward, the risk register will support existing reporting processes and will ensure that all relevant risks are captured so that members can provide scrutiny and direction as to the management of the key risks affecting the project.	30/11/2021	None Entered	None Entered
8.2	The development of the SOC was led by the Business Planning Manager (Capital Planning) and the Project Manager, with discussions held via the project Steering Group. In accordance with standard UHB practice at this stage, formal governance arrangements (including a project board) had not yet been implemented. Whilst recognising this standard approach, a TOR for the Steering Group, and minutes of discussions held, have not been identified – reducing the audit trail of the business case development and sign-off process. Whilst a number of email communications have been reviewed to support the involvement of key stakeholders (including clinicians, Finance, Capital Planning) in the development and finalisation of the SOC, specific sign-offs / agreements from these parties have not been evidenced. Noting the potential difficulties in maintaining a central audit trail when documents are retained within email systems, a central log would be beneficial to summarise the process at this project, including the issue of the various iterations of the business case and confirmation of sign off received from the key parties.	**M**	Agreed. Audit's recommendation has been noted and is deemed to be both reasonable and achievable.	30/11/2021	None Entered	None Entered

	A central log should be maintained of the SOC development process, recording the issue of each iteration and where final sign-offs have been received from key stakeholders; with reference to related email evidence as appropriate.					
9.1	Once formal approval has been granted for the preferred way forward, any subsequent changes to the approved option need to be carefully managed, via a formal process of assessment and approval (in line with the UHB and project delegated authorities relevant to the quantum of the change in question). The ability to effectively control project changes will depend on the clarity with which the agreed project scope, design, objectives and benefits have been defined. However, the Project Initiation Document did not define a change management procedure to be applied. The Project Initiation Document should define the change management procedure to be applied at the project.	**L**	Agreed. The Project Initiation Document will be amended to define the change management procedure that will be applied at this project.	30/11/2021	None Entered	None Entered

Executive Lead – Director of Strategy						
SSU–SBUHB–2122-01		Singleton Hospital Replacement Cladding 21/22		Report Issued October 2021		Reasonable Assurance
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires up to date financial monitoring of projects. This project formed part of a joint business case together with enabling works to the car park. However, these were separately funded and contracted relating to a separate building, with associated works concluding in June 2021. Individually funded projects within a wider programme of works are typically monitored separately. The requirement at Welsh Government returns is to require outcomes to be monitored against funding approvals. However, reporting continues to include enabling works in respect of the car park. August project Board minutes reported the project as "£400k underspent, minus the £55k (car park) overspend totals £360k underspend which is the total contingency for Cladding." However, the car park continued to be integrated to reporting at the August 2021 Project report, with a joint under-spend. Exclusion of these costs would facilitate understanding the position as relating to the main façade project. Indeed car park reporting would now be static figures, and both separate and combined reporting would show both completed, ongoing and total performance. The audit was not able to reconcile the main scheme cash flow at the Welsh Government Project Progress Dashboard with supporting project cost reports (reconciliation to supporting project reports being a requirement of the Welsh Government return). Project reports should include separate reporting of the car park and main scheme, in addition to combined summary reporting.	**M**	Agreed	31/12/2021	None Entered	None Entered
5.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires effective financial monitoring of projects. The project benefited from detailed cash flow reporting and forecast out-turn against budget, together with monthly monitoring of expenditure against a time profiled budget. Associated variances were discussed at the Project Board. The project was subject to ongoing assessment of the time and cost impact of expert witnessing of cladding replacement (to inform any legal claim in respect of the prior cladding). These visits had yet to be assessed and costed into the programme. The first such event caused a one-week impact to the programme. Circa 26 such events scheduled which have been estimated at £750k based on this experience. However, the approach and number of visits remain under assessment to determine if efficiencies	**M**	Agreed. A meeting was held in September with the Contractor and the Health Board to review the spend profile for the current financial year which highlighted any uncertainties relating to in year forecasts and was reported in October's Project Board meeting. Regular financial meetings are held with WG in addition to them receiving the monthly Cash Resource Limit reports. A financial report is received at Project Board for additional assurance and scrutiny. Any anticipated cashflow variances will be highlighted (within "Notes") at future dashboards.	31/12/2021	None Entered	None Entered

	can be derived (such as use of remote CCTV monitoring). Similarly, there were other “high risk” / likely events including stoppage due to high winds, and additional discoveries relating to the building fabric. Some of these may also escalate costs, while delay impacts may slow cash flow. The net effect on cash flow may therefore be difficult to predict. Capital Cash Resource Limits should be finalised with Welsh Government in October each year, with monies spent by the end of the financial year. Accordingly, the forward position has been subject to detailed estimation (as above). However, while Welsh Government Project Progress Dashboards highlighted project risks, they did not highlight uncertainties regarding cash flows. Cash flow reporting to both Welsh Government and internally should highlight uncertainties relating to in-year forecasts.					
7.1	As previously noted, NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires that: “Risk Registers for each individual project/programme must be completed....and monitored,”. Key risks identified at the Project Manager’s Report corresponded with those listed at the Welsh Government Project Progress Dashboard. However, these differed from those at the Risk Register. Of only 4 "red" risks at the Risk Register, one related to the potential for the neo-natal strategy to change (e.g. due to noise, or service pressures and availability of decant areas – which were no longer available as of July 2021). However, this risk did not feature at either the Project Manager’s Report, or the Supply Chain Partner Client listings of risks. The Risk Register (version 18 - 6/9/21) also included an early warning risk in relation to car park surveys, though that project was completed in June 2021. The Project Manager’s Report also identified "quality of surveys", and the need for major structural repairs as “high” risks. However, these featured as a "low" and "medium" risk respectively at the Risk Register. Risks at the Risk Register should be regularly appraised for currency and magnitude.	**M**	Agreed. Whilst the car park is being completed, there is still Japanese knotweed external works etc which are still being undertaken. Tree planting is continuing and Japanese knotweed is an ongoing treatment regime for five years. However, all car park risks have now been removed from v19 of the Risk Register.	31/12/2021	None Entered	None Entered
7.2	As previously noted, NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires that: “Risk Registers for each individual project/programme must be completed....and monitored,”. Key risks identified at the Project Manager’s Report corresponded with those listed at the Welsh Government Project Progress Dashboard. However, these differed from those at the Risk Register. Of only 4 "red" risks at the Risk Register, one related to the potential for the neo-natal strategy to change (e.g. due to noise, or service pressures and availability of decant areas – which were no longer available as of July 2021). However, this risk did not feature at either the Project Manager’s Report, or the Supply Chain	**M**	Agreed. Neo natal risk is sensitive to noise & dust & lot of services running along inner façade. This was perceived as being a red .risk, but not was not covered in PM report as such as there are ongoing discussions as to how to approach this. We are currently in the process of formulating a plan as to how best to deal with it e.g. whether to fully or partial decant. However, we will look to align reporting to the Risk Register.	31/12/2021	None Entered	None Entered

	Partner Client listings of risks. The Risk Register (version 18 - 6/9/21) also included an early warning risk in relation to car park surveys, though that project was completed in June 2021. The Project Manager's Report also identified "quality of surveys", and the need for major structural repairs as "high" risks. However, these featured as a "low" and "medium" risk respectively at the Risk Register. Risk reporting should accord with the current Risk Register.					
9.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: "All Welsh Government construction and infrastructure contracts valued at £2m or more which are delivered directly on behalf of Welsh Government Departments are required to apply a Project Bank Account unless there are compelling reasons not to do so. NHS Organisations should liaise with Welsh Government Officials and NWSSP-SES Framework Managers to determine whether individual projects are required to utilise Project Bank Accounts". The June 2021 Project Board minutes noted that: "Whilst the Project Bank Account has not been set up on this scheme (works had already commenced and required payment). The Project Director noted that Welsh Government are expecting Health Boards to continue to progress their implementation on future schemes. However, it is acknowledged that contractors have been slow to engage with this process". These accounts are intended to provide greater control to the contractor and transparency in on-time payments, including facilitating timely payments to sub-contractors. At the Environmental Infrastructure project (sub-station 6), currently under design, provision has been made in the draft construction stage (Stage 4) contract for provision of a Project Bank Account (at Clause "Z" 27A). "Z" (bespoke) Clauses at the Singleton Cladding contract mirror this contract with the exception of this clause i.e. this requirement has not been specified at the agreed Cladding contract. It is noted therefore that non-provision of a Project Bank Account would not represent a breach of that contract. Both the July and August 2021 Project Reports stated that there was a requirement for "clarification" (from Welsh Government) "on whether the Project Bank Account will be required – the contract is progressing without a Project Bank Account and is waiting for further direction". Management should confirm treatment of a Project Bank Account in accordance with Welsh Government direction.	**L**	Agreed. The Health Board welcomes WG directive in the use of Project Bank Accounts as a means of addressing poor payment practices in public sector supply chains by facilitating fair and prompt payment. Project Bank Accounts (PBAs)will ensure best practice going forward and this is something that the Health Board is currently working towards with both the banks and contractors. The Head of Capital Finance is involved with meetings with regards to PBAs as within Wales we are aware that there have been issues with the Banks in establishing them as they are a still a relatively new concept. With regards to the Cladding Project – the sub-contractors had already been appointed with payments already commenced with the main contractor prior to audit undertaking their fieldwork. A PBA could not then be retrospectively put in place as it was deemed to have no benefit.	31/12/2021	None Entered	None Entered

Executive Lead – Director of Strategy						
SBU 2122-012	**Annual Planning Approach**		**Report Issued October 2021**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3.1	The Executive Steering Groups terms of reference include clarity of purpose and detail is included relating to its role in plan development. However, it appears that it has not been refreshed for some time with a number of individuals listed within the membership having left the health board or taken on different roles. Membership also included the Director of Nursing & Patient Experience and Director of Public Health but we could not see evidence that this remained the case currently. Other aspects including key stakeholders would also benefit from refreshment. We recommend terms of reference for the Executive Steering Group be refreshed to reflect current membership and stakeholders. Consideration should be given to inclusion of senior quality & safety representation.	**L**	Executive Steering Group Terms of Reference will be refreshed.	04/10/2021	**Undated:** Updated Terms of Reference to be discussed at the Executive Steering Group (ESG) being held on 6th January 2022. The ESG meetings held in November and December 2021 were solely used for the review of R&S priorities. **April 2022:** To be discussed at the next meeting which is being held on 5th May 2022. Based on the foregoing, the deadline has been extended to 30/05/2022 for further update.	30/05/2022

Executive Lead – Director of Strategy						
SBU–2122-018	**CAMHS Commissioning Arrangements**		**Report Issued December 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3.2	The health board has not identified any quality measures in respect of the service being provided to the CAMH patients or the outcomes for those patients. The health board's Mental Health Legislation Committee highlighted that the CAMHS governance report provided by CTMUHB as at August 2019 did not provide any assurance to the committee. We understand from discussion with key staff that the health board has not received a CAMHS governance report from CTMUHB since November 2019. The health board should ensure that it receives regular updates on quality that meets the expectation of the health board in order to provide the appropriate level of assurance to the board and its committees.	**M**	The information provided to the Mental Health Act Legislative Committee from CAMHS was developed and agreed with CTM based on the reports they produce for the CTM MHALC. Further information was requested from the Swansea Bay Committee regarding what further information was required to give assurance. This will be followed up and addressed as the reporting arrangements restart following the pandemic.	31/01/2022	**February 2022:** 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. The deadline for this action will need to be extended to the end of March 2022. **April 2022:** The need for robust performance and governance reports has been made clear, with both now on the agenda of each monthly meeting of the CAMHS Commissioning Group. Further work is ongoing to improve the quality of the governance report, working with the Swansea Bay Mental Health Legislative Committee. Noting the foregoing, the deadline for this action has been extended to 30/06/2022 for further update.	30/06/2022

Executive Lead – Director of Strategy						
SBU–2021-006		**Capital Systems**	**Report Issued November 2020**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	The Capital Manual states: “Service Delivery Units and Corporate Directorates will need to approve all appropriate capital bids, considering the potential funding source and the overall scope and purpose of the funding bid prior to submission to the appropriate corporate forum for approval (Capital Management Group and Investments and Benefits Group)." At the five projects reviewed, excepting Ward G where the business case was still in development, formal business case submissions had not been made at any of the projects. Submissions had instead been via various other means and the WG had approved the project on the basis of the information provided in each case: • Perinatal - an expression of interest; and • CT Simulator and Anti-Ligature Phases 1 & 2 - cost forms. Evidence has also been provided to confirm Chief Executive and Board approval of the current year’s capital priorities (including the above projects, excepting Anti-Ligature Phase 1 which progressed during 2018/19). However, in respect of the earlier internal scrutiny process, prior to submission of the bid to WG, we have only received evidence for the Perinatal project (demonstrating scrutiny and approval at the IBG). Whilst recognising that formal business cases were not developed for these projects, the objectives, benefits and costs (including revenue implications) should still be subject to internal scrutiny and sign-off, before any bid is submitted to WG. A clear audit trail of internal scrutiny and approvals, and WG instructions/agreement, should be centrally retained in relation to each project.	**M**	Agreed. The Capital management team recognise that whilst the approvals had been received on the schemes too much time was spent locating this information as not all documentation is retained centrally. Time has been set aside in December to review the Capital Manual. The revised version will incorporate the recommendations within this report as suggested by Capital Audit, one being that in future all documentation will be centrally retained.	01/04/2021	None Entered	None Entered
2	During the audit testing it was noted that a number of processes required by the Manual either no longer aligned with current operational practices or would benefit from review to bring enhanced efficiency to the project management process e.g.: • The requirement for a Statement of Need (SON) to be produced at the outset of a project, and approved by Finance, to facilitate the commencement of work. Whilst SONs had been produced at all the projects reviewed, only one (Ward G) had been approved by Finance in accordance with the Manual. Management advised SONs were issued to Finance to obtain a job number to enable a job to commence. However, this has previously resulted in multiple SONs being	**M**	Agreed. As already mentioned, this has already been acknowledged by the Capital management team and following the review of the manual it is anticipated that the manual will become more streamlined in order to ensure a more efficient project management process.	01/04/2021	None Entered	None Entered

	prepared as fees/costs progressed on projects; therefore is now seen as an onerous process and no longer consistently applied in line with the Manual; • Retention of the 'Brief Acceptance Certificate' from the appointed consultant. This certificate was not evidenced as completed for the Anti□Ligature Phase 1 project; • Completion of the 'Request for Consultant Appointment from the Local Framework' proforma. This procedure was originally designed to ensure fair rotation of consultants from the Local Framework. However noting, under the new Framework arrangements, there is only one consultant per category, this procedure would appear redundant; and • The issuing of letters of appointment to consultants prior to entering into formal contract. The letters issued did not always contain the full information required by the Manual. Further discussions with management highlighted the question as to whether this step is still required noting a formal contract will follow. The Manual should be reviewed to ensure all procedures/proformas remain relevant to current operational practices, and facilitate the operation of an efficient project management process.					
3	The Manual was last updated in 2018, and states its purpose as "… to provide a toolkit for managing all capital projects and must be read in conjunction with the Health Board's Standing Orders and Financial Control Procedures. However, it is not intended that all aspects of the manual will be implemented on all projects and each project will be assessed individually to ascertain the level of compliance required." The Manual applies to all capital projects, from minor discretionary schemes to major projects. It comprises the main narrative, and an associated project checklist. It was noted during the review of the Manual, and testing against its requirements, that there are some key areas lacking clarity of instruction and some degree of contradiction between the main narrative and the project checklist. These include: • The Manual does not provide sufficient definition of what constitutes a major / minor project. Whilst the main narrative references a £1m major project threshold above which full governance arrangements are required, the project checklist uses a £500k threshold for the major/minor distinction; • The Manual does not confirm whether these threshold values relate to works costs, or whole project costs. For the projects reviewed during this audit, the threshold had been applied to works costs only. Whilst recognising that the complexity/size of a project can often be determined from the works value alone (and will certainly dictate the complexity of Capital Planning	**M**	Agreed. The Capital Manual is to be reviewed over the forthcoming weeks and will be updated to reflect the recommendations within this report. The recommendations will be implemented in future working practices.	01/04/2021	None Entered	None Entered

	department's involvement), other issues may impact from a Service perspective i.e. equipping, training, decanting and other associated costs which sit outside the works contract. The decision, therefore, as to whether to apply full governance arrangements may be more nuanced than currently detailed within the manual (and as such, should involve early sign-off by the Project Director); • Whilst the Manual states that Project Boards are required for major projects over £1m, it does not provide clarity as to whether the assignment of the key roles of Senior Responsible Owner and Project Director are similarly restricted to major projects. The project checklist indicates a Project Director appointment is not required for projects under £500k; and • Whilst the main narrative is clear that the roles of the Senior Responsible Owner, Project Director and Project Board are key from project initiation, to provide appropriate direction, ownership, oversight and scrutiny, the project checklist includes the initiation of these roles in Workstage 3 (i.e. post business case development, design and tender). a) The Capital Manual should be updated to provide clarity as to: • the threshold between major and minor projects; • whether this threshold relates to works costs or whole project costs; and • which governance arrangements are required for projects in each category. b) The Capital Manual should be updated to remove contradictory elements between the main narrative and the project checklist					
4	The Manual provides clear guidance (in line with best practice), that key project roles should be in place from project initiation to provide appropriate direction, ownership, oversight and scrutiny through each stage. Key roles are defined in the Manual as follows: • Senior Responsible Owner (SRO) • Project Director • Project Board For the projects reviewed, where they had been classified as major and therefore requiring full governance arrangements, the allocation of the Senior Responsible Owner and Project Director roles, and initiation of the Project Board, did not / was not planned to take place until after the project had progressed through the business case, design and approval stages. Whilst this aligns with the approach mapped out at the project checklist, it is non-compliant with the purposes of these key roles as set out above. Key project roles, including SRO, Project Director and	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered

	project boards should be initiated at the outset of a major project / programme, to provide overall direction through each stage					
5	Noting that these key roles were not in place from the outset of the projects, the appropriate sign-off of key decisions in relation to the governance arrangements was not evidenced. This included the application of the 'minor project' classification at projects with wider cost implications: • The CT Simulator project: classed as a minor project with works costs of £540k, but a whole project value of circa £2m; and • The Anti-Ligature Phase 1 project: again determined as a minor project, with the initial works cost of circa £500k, but part of a wider circa £6m programme of works. Whilst recognising that full governance arrangements were being considered for Phase 2, these should have been in place from the outset to provide overall programme control. Where minor projects fall within larger programmes, formal governance arrangements (SRO, Project Director, Project Board, PEP etc.) should be put in place to oversee the overarching programme, from the outset.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered
6	Noting that these key roles were not in place from the outset of the projects, the appropriate sign-off of key decisions in relation to the governance arrangements was not evidenced. This included the application of the 'minor project' classification at projects with wider cost implications: • The CT Simulator project: classed as a minor project with works costs of £540k, but a whole project value of circa £2m; and • The Anti-Ligature Phase 1 project: again determined as a minor project, with the initial works cost of circa £500k, but part of a wider circa £6m programme of works. Whilst recognising that full governance arrangements were being considered for Phase 2, these should have been in place from the outset to provide overall programme control. Where the required governance arrangements lack clarity, such as at projects with large variances between works and whole project costs, the Project Director / Assistant Director of Strategy (Capital) should sign off the proposed governance structure/controls at the outset.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered

7	Project Teams had been formally defined within the project governance structure at applicable projects, with minutes provided for the Anti-Ligature Phase 1 project. However, recognising the current operational constraints (due to COVID-19), meetings have more recently been held via Teams, with minutes not always maintained due to the availability of support staff. Project Team meetings should be minuted wherever possible, even if taking place electronically.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered
8	Other examples were also noted where the project control processes defined in the Manual were not being applied at the outset of a project. These included: • Preparation of the Project Execution Plan (PEP). Whilst PEPs were in place / in development for the major projects included in this review, they had not been developed until some way into the project; and • Completion of a Management Control Plan (MCP). MCPs were evidenced at three of the five projects reviewed, however, a MCP was not prepared for Anti-Ligature Phase 1, and had not yet been prepared at Ward G. PEPs and MCPs (where required by the Manual), should be developed at the outset of a project with further updates as required throughout the life of the project.	**M**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered
9	The Manual does not specify at which stage highlight reporting should commence. Whilst acknowledging management's advice that this is intended primarily for the construction phase, it does take place earlier at some larger schemes to monitor and report progress during the business case development phase. The Manual should provide clarity as to when Capital Highlight reporting is to commence.	**L**	Agreed. Recommendations 4 to 9 have been noted and will be reflected within the manual. Project Managers to implement on future schemes.	01/04/2021	None Entered	None Entered
10	The Manual requires that: "For all appointments for Consultants with a value over £5,000 a Professional Services Contract must be completed by both parties." At the projects reviewed, whilst contracts had been appropriately issued, it was noted that three contracts (related to two different projects: Ward G and CT Simulator) had not yet been returned by the consultant (the longest outstanding had been issued for signature in March 2020). Project Contract Date issued: • CT Simulator QS contract 20 August 2020 • Ward G QS contract 2 July 2020 • Ward G M&E contract 24 March 2020 Non-return of consultant contracts should be regularly chased, with performance considered as part of the Local Framework monitoring process	**M**	Agreed. This has been discussed within the Capital management team and the agreement has been that without a signed Consultant contract, work cannot begin on site. It is hoped that this approach will improve the speed at which the signed contracts are returned on future schemes.	01/04/2021	None Entered	None Entered

Executive Lead – Executive Medical Director						
SBU 1920-028		**Discharge Summary Communication: Improving Performance**		**Report Issued June 2020**		**Assurance Rating – N/A**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	Early in the audit it was established that the original intent expressed in September 2019 to develop a recovery plan did not progress as it was decided to pause whilst an interface between the MTeD and TOMS systems was developed nationally. Following confirmation of implementation of an upgraded version of MTeD, we would recommend that the recovery plan be developed as originally conceived and arrangements be put in place to monitor and report on progress and outcomes	**M**	Update of recovery plan (including monitoring and reporting) to be developed to be agreed at next Exec MD/UMD meeting on 14th July 2020. The target date is the best estimate given the current trajectory of NWIS developments and it may require adjustment in line with any changes to NWIS timescales.	17/07/2020	**December 2021** The focus on the recovery of services and return of operational functions has taken priority. Request extension to deadline.	31/05/2022