APPENDIX D

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
AGREED ACTIONS COMPLETED SINCE LAST REPORT

Executive Lead – Chief Operating Officer				
ABM 1920-028 **Patient Environment** **Report Issued October 2019** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2	The CHC reports were not being discussed at committee level. We would recommend reports on the "external papers" that go to the Quality and Safety Committee include those CHC reports that were issued in the period.	Reports on the "external papers" that go to the Quality and Safety Committee will include those CHC reports that were issued in the period. The Assistant Director of Strategy & Partnerships will provide the necessary details to the Head of Patient Experience, Risk & Litigation to incorporate in Committee reports.	**April 2022:** A report outlining the process for managing CHC reports was discussed and agreed at the Quality & Safety Governance Group on 4th April 2022. Noting the foregoing, this action is considered closed.
	4	Neither the Board nor any of its Committees have received assurance that issues arising from CHC reports have been actioned. However, it is noted that the COO and other Directors have regular Liaison meetings with the CHC to provide assurance that their reports are being appropriately managed. The Director of Nursing and Patient Experience should ensure that CHC reporting follows the same approach as HIW reports and appropriate information and assurance is given to the Quality & Safety Committee.	The Director of Strategy will ensure that CHC reporting follows the same approach as HIW reports and appropriate information and assurance is given to the Quality & Safety Committee.	**April 2022:** A report outlining the process for managing CHC reports was discussed and agreed at the Quality & Safety Governance Group on 4th April 2022. Noting the foregoing, this action is considered closed.

Executive Lead – Chief Operating Officer				
ABM 2021-025 **Infection Control Cleaning** **Report Issued January 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	There is no over-arching policy or strategy in place setting out roles, responsibilities and lines of accountability for cleanliness Roles, responsibilities and lines of accountability for cleanliness, should be described within a formal, documented policy for consideration at the Infection Control Committee. (There are examples at other health boards that could provide a basis for development.)	Agreed – current cleaning strategy and general cleaning plan to be prepared. Papers will be taken to Infection Control Committee with the aim of agreement in April 2021 – though this will depend on the input and views of other services. Progress (including any changes to timescales) will be reported to ICC.	**April 2022:** The strategy was approved in the meeting which was held on 31/3/22. Once the meeting had approved the strategy the Head of Infection, Prevention & Control requested a minor amendment to be made. A sub meeting was held immediately after the main meeting and the strategy updated. The document will be resubmitted to the next committee meeting for “noting”. Noting the above, this action is now considered closed.
	3	Domestic services ‘work schedules’ provide guidance on the frequencies of cleaning expected in different areas. Our review has shown that for some areas frequencies did not align with the Cleaning Standards. Out of 28 areas reviewed, four did not match for ‘full’ cleans and seven did not match for ‘check’ cleans. At another organisation, where an over-arching cleaning policy has been adopted, minimum cleaning frequencies (and those functions responsible for the elements listed) have been appended giving the expectations greater visibility for all functions responsible and for clear oversight. A) Work schedules should be reviewed to ensure alignment with cleaning frequencies of elements as outlined within Appendix 2 of the Cleaning Standards (2009). B) Frequencies should be appended to the policy document previously recommended for consideration at Infection Control Committee	A) Agreed - Project and performance manager to update work schedules. B) Agreed - Head of Support Services to include this information in cleaning strategy	**April 2022:** The strategy was approved in the meeting which was held on 31/3/22. Once the meeting had approved the strategy the Head of Infection, Prevention & Control requested a minor amendment to be made. A sub meeting was held immediately after the main meeting and the strategy updated. The document will be resubmitted to the next committee meeting for “noting”. Noting the above, this action is now considered closed.

Executive Lead – Chief Operating Officer				
ABM 2122-023 **General Dental Services** **Report Issued October 2021** **Assurance Rating Substantial**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2.1	A review of the Oral Health, Quality, Safety and Patient Experience group has shown that of the five meetings tested, three were not quorate at below 60% attendance. We note that the group has a diverse range of members including external representatives. We recommend that the Terms of Reference are reviewed to address achievability of member's attendance. We note that the health board is currently undertaking a review of service group governance arrangements as part of a broader piece of work.	This recommendation is supported. A review of the Terms of Reference (TORs) for the Oral Health Quality, Safety and Patient Experience Group has commenced and will be updated as required. The updated TORs will ensure they continue to reflect the assurance framework and set out a revised membership consistent with other Q&S Forums within the Service Group that will address achievability of member's attendance. The revised TOR will be presented to the Service Group Quality and Safety for approval.	**None Entered** Action recorded as complete 19/04/2022

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**	**Original Response / Agreed Action**	**Update/Comment**
	1	The Senior Information Risk Officer (SIRO) produces an annual report which includes reporting on compliance for IM&T across the health board and includes items related to IG, data and cyber security and as such identifies most of the key areas of required legislative compliance. This process is incomplete however as there is no consideration of the Payment Card Industry Data Security Standard (PCI/DSS) and there is no full register or record of the existing compliance requirements or the consequences of non-compliance within Digital. In addition, there is no process to fully assess the status of compliance and report upwards to committee for all items such as PCI/DSS. Consequently, the committee may not be fully aware of the assurance it needs to seek over compliance with external requirements, or indeed how well the health board is complying in its entirety. A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.	A review of appropriate compliance requirements will be undertaken (June 21) and a process for reporting to Audit Committee established (Sept 21)	**December 2021:** A comprehensive register of compliance requirements for IM&T legislation has been difficult to obtain. A request to Heads of IT across NHS Wales has been issued and the HB are awaiting a response **March 2022:** A register has been established where Cyber Security and Information Governance requirements are being listed and the team will continue to add to this and link it to the Service Catalog. Noting the foregoing, this action has been marked as complete with effect from 15/03/2022.

Executive Lead – Director of Workforce & Organisational Development				
SBU 1819-043 **Staff Performance Management & Appraisals** **Report Issued April 2019** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	The Workforce risk register recognises that maintaining current levels of PADR compliance will remain a challenge until structures are stabilised and the roll out of ESR self and supervisor self-service are complete. Whilst there has been Board level discussion of using ESR more effectively within the Health Board, timescales for implementing supervisor self-service have not been set out yet. Whilst resource is focused on the Bridgend transition arrangements at the end of March 2019, we would recommend that responsibilities and the future ownership of ESR be agreed at Executive level and that the Lead Executive agrees Supervisor Self Service rollout plans and timescales.	As part of the review of corporate executive responsibilities, it has been agreed that responsibility for ESR will transfer from the Director of Finance to the Director of Workforce and OD from April 2019. In preparation for the development of a full functionality deployment plan, the national ESR team have already conducted a site visit (November 2018) to assess preparedness and support the development of a full functionality roll out plan. A timetable and roll out plan for the deployment ESR self-service and other un-utilised ESR functionality cannot be developed without the identification and deployment of additional resource to undertake the significant digital transformation programme. ABMU is a number of years behind other organisations in Wales in respect of the utilisation of ESR and the resourcing of the ESR team will need to be enhanced to take the required deployment forward. The pace of the deployment of ESR functionality across the Health Board will be dependent on the resource investment agreed to support this programme of work. Until this issue is resolved the timescales for full deployment cannot be agreed. However, capacity issues are subject to discussion at Executive Director level currently and it is intended to provide the Workforce & OD Committee with the vision and route map for use of the system by the end of June.	**April 2022:** The transfer of the ESR team to the WOD Directorate is now complete and the Service Improvement plan is in progress. This audit action can now be closed as it becomes business as usual to progress.

Executive Lead – Executive Director of Nursing & Patient Experience				
SBU 1920-025 **Discharge Planning (DoN)** **Report Issued February 2021** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	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	Service Group Nurse directors will re-issue the information governance policy outlining what patient identifiable information can be displayed publicly.	**April 2022:** This action has now been completed at all sites.

Executive Lead – Executive Director of Nursing & Patient Experience				
SBU 2021-015 **Adjusting Services: Quality Impact Assessment** **Report Issued April 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	6	The process in place early in the year indicated that it was the role of the Reset & Recovery Coordination Group (RRCG) to identify any schemes proceeding at risk that required reporting to the QSC. The RRCG no longer exists – consideration is being given to directing QIAs to the Silver Command group of the COVID-19 pandemic response. As groups involved in this process change, the process document should be revised to indicate any committee reporting requirements and which group or individual is responsible for deciding what to report.	Accept recommendation, QIA Scrutiny Panel ToR to be updated that QIAs will go to Silver Operational Command re: reintroduction/adjustment of services. As operational requirements return to normal, post COVID-19, development of proposal to Quality and Safety Committee as to how QIA will integrate into business planning of organisation.	**Undated:** Further work ongoing - Proposal being developed with Q&S Committee as to how QIA will integrate into business planning of organisation. This will on the Agenda and discussed at the November meeting of the Quality Safety Governance Committee ND 20/10/21 **December 2021:** Unfortunately was not discussed at November meeting but will be discussed at the next Q&S meeting on the 21st December and the action will then be able to be closed Deadline amended to 31/12/21 **February 2022:** Due to staff sickness this was not discussed at the December Q&S Committee. This action has now been picked up by the Deputy Head of Quality of Safety with the expectation that it will go to the March meeting for sign off. Based on the above, deadline extended to 31/03/2022 **April 2022:** Presented and agreed at QSGG 10th March 2022

Executive Lead – Director of Finance				
ABM 2122-015 **Procurement & Tendering STA & SQA** **Report Issued October 2021** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.1	In comparison to other NHS Wales Organisations, Swansea Bay has not developed additional procedural documentation to supplement the Standing Financial Instructions (SFIs) which provide staff with more detailed guidance on how to undertake and complete a Single Tender Quotation/Action. The documents outline the roles and responsibilities of all involved within the process from the requestor to the scrutiny process. Swansea Bay should look to create a procedure / guidance document to help support staff in the undertaking of a Single Tender Quotation / Action, outlining the requirements and the employee's roles and responsibilities. The document should be made accessible to all staff on the Swansea Bay Intranet site.	Swansea Bay do not have a specific procedure relating to the completion of STA/SQA forms. A note to executives which outlines the key considerations that should be made when receiving STA/SQA forms for approval has been routinely circulated since November 2019 (with STA/SQA forms sent for approval). The procurement team will work with colleagues from corporate governance to develop a procedure which provides more detailed guidance on how to undertake and complete a STA/SQA.	**Undated:** The Head of Procurement has written a procedure for the completion of SQA and STA forms. This has not yet been made available through the HB intranet site but this will be completed in early January 2022. Noting the foregoing, the deadline has been extended to 31/01/2022 **April 2022:** The STA/SQA procedure has been uploaded to the procurement SharePoint and intranet page. Based on the foregoing, this action is now considered closed.

Executive Lead – Director of Finance				
ABM 1920-009 **Control of Contractors** **Report Issued March 2020** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	6	One instance was highlighted where a contractor had not provided a Risk Assessment/Method Statement. This is contrary to the Management of Health & Safety at work Regulations (1999) and UHB requirements. Jobs should not be permitted to commence unless a Risk Assessment and Method Statement has been provided by the contractor	Agreed. Whilst for some tasks this is required, we need to review how this will be policed as a number of firms will just provide a generic Risk Assessment, as they are the same each time work is undertaken. This should be quantified in line with risk, as generic Risk Assessment for laying flooring or fitting a sign will be the same due to the level of risk. Management will identify tasks which require a Risk Assessment and Method Statement to be reviewed.	**December 2021:** The Assistant Director of Operations (Estates) will again write to all Estates Managers reminding of the need to ensure that RAMS are provided prior to the commencement of all jobs, and reviewed appropriately. **April 2022:** As part of the Control of Contractors / Policies and Procedures Risk Assessments and Method Statements (RAMS) will be provided and reviewed by the Estates Department prior to any on site work being undertaken. COMPLETED - NEED TO CHANGE STATUS TO GREEN PLEASE. Based on the foregoing, this action has now been closed.

Executive Lead – Director of Finance				
ABM 1718-011 **Control of Substances Hazardous to Health (COSHH)** **Report Issued February 2019** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	6	There is particular need to locally test the built environment e.g. • Ventilation functioning - number of air changes etc. • Storage - adequacy for hazardous substances • Lay-out – length of carry, obstacles, trip hazards between storage and use. Management advised that these more technical reviews were undertaken only on request. Excepting an "All Wales Sterile Service Survey" undertaken by NWSSP: Specialist Estates Services, we did not identify reporting in relation to the built environment. **<u>Equipment</u>** Local calibration records were found in relation to monitoring equipment. However, a mechanism was not identified by which the Health and Safety managers / Committee could be assured that all relevant equipment had been checked. Periodic reports will demonstrate appropriate coverage including testing of the built environment and monitoring equipment.	Agreed.	**April 2022:** Having recently reviewed the COSHH list, there are no substances of significant risk that are not adequately controlled, with appropriate cabinets and consideration for ventilation is always a factor that is considered, and this will depend on the actual COSHH substance. All known substances have now been put on a central database in TEAMS that is regularly reviewed. Specific areas such as labs also hold separate list and is regularly reviewed as part of their quality accreditation. Based on the foregoing, I would recommend that this be closed.

Executive Lead – Director of Finance				
ABM 1516-008 **Health & Safety Primary Care Estate** **Report Issued March 2017** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	Other than defining the lead for Estates input, the Health & Safety Policy does not reflect the key Estates contribution to the management of Health & Safety. The Policy lacks clarity on the accountability, responsibilities, reporting lines and interaction with the Health & Safety Manager. The Health & Safety policy will be updated to clearly define the role of the Estates function (as relating to the Health & Safety Manager) – detailing any accountability, responsibilities, reporting requirements etc.	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.	**April 2022:** The Health & Safety Policy has been updated and approved by the H&S committee on 5 April 2022, this will now be uploaded to the HB intranet under the policies section. Therefore, it is recommended that this be closed.

Executive Lead – Director of Finance				
ABM 1819-007 **Systems: Declarations of Interest & Risk Management** **Report Issued October 2018** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	10	The Standards of Business Conduct policy (Appendix 7) requires a declaration of interest proforma to be completed at all procurement exercises over £5k in value. Where NWSSP Procurement Services manage the procurement exercise, they are responsible for the issuing and completion of the DoI forms, for all relevant staff involved in the procurement (including the procurement officer, Health Board client/end user and Estates/Capital Planning as appropriate). Internal procurement exercises are also separately progressed by UHB Estates staff (the audit was unable to quantify number/value of the exercises). DOI forms were not routinely completed (by Estates or other UHB staff) at these internally managed procurement exercises. The DOI proforma should be completed at all procurement exercises (including Estates, client, end users as appropriate) in accordance with Appendix 7 of the Standards of Business Conduct policy.	Agreed.	**July 2019:** This will be actioned via Estates Board to all Senior Staff - Procurement colleagues will be required to provide training (over £5k). Added to Estates Board Agenda for discussion. **December 2019:** Assistant Director of Operations (Estates) will be writing to all staff that have raised orders in January to ask them for declaration on any known interests. Meeting Scheduled 15th January 2020 for discussion. **April 2022:** Complete

Executive Lead – Director of Strategy				
SBU 2122-018 **CAMHS Commissioning Arrangements** **Report Issued December 2021** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2.3	The health board does not have a document in place detailing the roles and responsibilities for the management and monitoring of CAMHS internally, including the appropriate governance arrangements and escalation of any issues from the Commissioning group meetings through to all of the health board's committees and sub-committees. The ToR of the CAMHS Commissioning Group meetings should be updated to detail the quoracy of the meetings and how the meetings fit in with the health board's internal governance and escalation arrangements.	This will be incorporated with the work outlined in 2.4	**April 2022 (Management Board Paper 09/03/2022)** These matters are addressed in the CAMHS Commissioning Group revised Terms of Reference, which were agreed at their meeting on 17th February 2022. These were subsequently reported to the SBUHB Management Board in March 2022. Noting the foregoing, this action is considered to be closed.
	2.4	The health board does not have a document in place detailing the roles and responsibilities for the management and monitoring of CAMHS internally, including the appropriate governance arrangements and escalation of any issues from the Commissioning group meetings through to all of the health board's committees and sub-committees. Management should ensure that the ToR of the CAMHS Commissioning Group are appropriately agreed and finalised.	As stated in the report, this work was underway but delayed due to the lack of the support post for this work and the redirection of admin staff to support the pandemic.	**April 2022 (Management Board Paper 09/03/2022)** The CAMHS Commissioning Group agreed their Terms of Reference at a meeting on 17th February 2022. These were subsequently reported to the SBUHB Management Board in March 2022. Noting the foregoing, this action is considered to be closed.