APPENDIX C

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
OVERDUE ACTIONS 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	**September 2022:** It has now been agreed that this work will be centralised with the Assistant Head of Risk & Assurance and his team. Production of the Policy/Procedure document has been delayed due to staff absence – request that the deadline for this work be revised to November 2022.	30/11/2022
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	**September 2022:** It has now been agreed that this work will be centralised with the Assistant Head of Risk & Assurance and his team. Production of the Policy/Procedure document has been delayed due to staff absence – request that the deadline for this work be revised to November 2022.	30/11/2022

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**
1	All patients we reviewed had some form of clinical plan in place promptly following admission, but the detail of plans varied from ward to ward, and the clear documentation of clinical management plans with content as expected by section 7.9 of the SAFER Policy was not common. Management should take steps to improve the consistency of practice in the documentation of clinical management plans and compliance with policy. Consideration should be given to progressing this as part of a quality audit & improvement initiative. Additionally, there may be merit in the implementation of standard template documentation to prompt key requirements.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of clinical management plans and include actions to provide assurance regarding implementation. Anticipated first draft for consultation end of February 2021.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
2	The methods used across wards for setting EDDs was inconsistent - on some wards, EDDs were set by Ward Managers, and some by Ward clerks, but there was little evidence within patient notes of medical input in determining the EDD. Management should take steps to ensure that the setting of the initial EDD is undertaken as part of the initial clinical management plan documentation within patient notes.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new policy and re-audit against new policy	30/11/2022
3	Testing at Ward E, Neath Port Talbot Hospital, showed that EDDs are not always set within 24 hours having identified 9 patients that did not have an EDD after being admitted between 2 to 14 days earlier. Management should review the process for setting EDDs at Neath Port Talbot Hospital Ward E to ensure that they are set within 24 hours of admission in line with Policy	**M**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new policy and re-audit against new policy	30/11/2022

4	Several observations identified divergence from policy requirements across wards: • Records did not demonstrate senior medical review occurring on a daily basis. Discussion with the Senior Corporate Matron has identified that a senior review might not always be required for some patients on some wards. • Patients at Gorseinon and Neath Port Talbot Hospitals did not receive a daily consultant review and there were also gaps between reviews by junior doctors too, but it was considered that patients on the wards visited here did not require daily medical input. The Policy does not indicate where variation from the daily requirement would be acceptable. • Often, the times of patient reviews recorded in notes fell after midday. • Reviews undertaken at weekends were very inconsistent across all wards with the majority of patients not receiving a senior or junior review. Management should consider these areas of divergence from policy. Where they are considered acceptable we would recommend policy be reviewed to accommodate them appropriately. Otherwise we would recommend action be taken to reinforce policy requirements and improve compliance.	**M**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the frequency, timing and recording of senior medical review, and include actions to provide assurance regarding implementation.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework. Within this ABMU will need to incorporate that all acute clinical areas have a daily senior review, non-acute areas have bi-weekly reviews. Also to include Version 3 of SIGNAL in ABMU policy.	30/11/2022
5	Ward 8 at Singleton used a Weekend Handover Sheet which outlined the criteria for patient discharge over the weekend to enable nurse-led discharge. Management should consider the implementation of weekend handover sheets across all wards	**L**	The standard for handover will be reflected within the revised policy version.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
6	There was non-compliance with policy in that the reason for changing the EDD was not always recorded within the Clinical Portal (or SIGNAL) which meant that it was not always possible to establish if all of the changes to the EDD were appropriate. Additionally, we noted differences between EDD dates recorded in the portal and those within SIGNAL (with one ward inputting only to SIGNAL). SIGNAL being a relatively new development is not currently covered by policy. Management should clarify what is expected of staff in respect of populating systems with the EDD data and reasons for changes, particularly where more than one system is in operation. Awareness of expectations should be reinforced and policy updated to reflect systems in place.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework and launch of SIGNAL V3	30/11/2022

7	Of the 55 patients tested there were ten patients where the EDD was updated beyond a patient being medically fit for discharge with the reason being related to Social Worker, Continuing Healthcare/Funded Nursing Care applications or repatriation. These do not fall under clinical reasons for change of EDD and therefore the EDD should not have been changed. Five patients at Singleton Hospital were identified as being medically fit for discharge within patient notes but this was not recorded as such within the Clinical Portal or Signal and so the EDD continued to be updated. Management should ensure all staff are trained and made aware of the appropriate reasons for updating the EDD. Consideration be given to a programme of improvement work across wards to coach staff in effective use and recording of the EDD to monitor better compliance & outcomes.	**H**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Await new framework.	30/11/2022
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. 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**	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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. In line with new revised policy	30/11/2022
		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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. In line with new revised policy	30/11/2022

10 (I)	Within Signal, the 'MDT d/c planning' column is utilised to record details and actions in relation to a patients discharge. There were wards at Morriston that had no comments this column in and very little detail recorded within patient's notes. We would recommend that the expected use of PSAG Boards (whether manual or electronic) be reinforced by management and direction be given to staff on expectations in respect of 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**	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Is in place in V3 of SIGNAL. Rollout September 2022 with training programme in place.	30/11/2022
11	On ward 6 at Singleton there was evidence to suggest that arrangements for patients discharge would wait until after the patient is medically fit for discharge rather than this process being ongoing from admission. Management should ensure that discharge planning is undertaken by ward staff from the point of admission in line with policy.	**M**	The standards will be reflected in the rewording of the revised policy	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
12	There was a low level of compliance with the Red / Green Day aspect of Policy. Two of the five wards tested at Morriston Hospital did not utilise the Red to Green columns on their PSAG Boards and the remaining three did not use them as intended, instead using them to show that a patient was Medically Fit and waiting for a process (e.g. Social Worker, CHC assessment). There was no evidence of use of Red to Green days at Singleton Hospital or NPTH. Management should ensure that the Red to Green Days element of the policy is understood and implemented at Ward level. Consideration should be given to progress this via a quality improvement programme approach.	**M**	To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	31/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
13	Staff at Singleton ward 8 highlighted that patient notes available at ward level were not comprehensive - interventions provided by staff from Therapies were held separately. We recommend that management take steps where necessary to ensure that ward-level patient records provide a comprehensive, up-to-date account of the patient's care and steps taken to ensure a safe discharge.	**M**	Revised policy will clarify how discharge planning will be recorded following the introduction of new systems.	01/05/2021	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Version 3 of signal contains new icons and a standardise approach on all PSAG boards with a training programme in place (Sept 22).	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022

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**
1.2	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 identified two forms of recovery plans submitted to the ORR group. Initial plans used Transformation format highlight reports and included a format of Goal Method and forecasted outcomes across the October 2021 – March 2022 period and overall projected outcome. The highlight report also included requirements to include the scoring and mitigating actions for key risks and an outline of current month and planned forecast actions. The completeness of returns and level of detail provided varied across services. To address Welsh Government urgent and long waiter targets further recovery plans were requested and received at the December 2021 ORR group meeting. Review of these plans again highlighted variation in levels of detail across returns. We note that Ear, nose & throat (ENT), oral and maxillofacial (OMFS), and urology contained a number of intended actions across validation, waiting list initiatives, additional clinics, use of consultant connect and alternative pathways but not necessarily projected trajectories. The return from trauma & orthopaedics indicated that the Service Manager had recently commenced in post and provided narrative rather than performance outcomes. Minutes of the January ORR Group did not highlight detailed discussions of the service plans. Additionally, 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. We recommend management review arrangements for receipt and monitoring of service/specialty recovery plans for appropriate approval and monitoring.	**M**	The governance within the service groups should be revisited and will be discussed with members of the outpatient's redesign & recovery group. Each service group have historically had their own outpatient's group, this provides the opportunity for a wider management review of service/ speciality plans, prior to submission to the Health Board wide group. Reassurance will be sought from service groups that these groups are still active and if they are not, they should be re-instated to provide an additional level of assurance at a speciality level. A review of the overall management structure of outpatients has been initiated to ensure that the correct reporting mechanisms are in place. In addition, steps are being taken to improve access to demand and capacity and performance information with a bespoke dashboard for outpatients.	30/04/2022	**June 2022:** Morriston and Singleton service groups have re-instated management meetings. Additionally, a monthly meeting with all service managers across the health board has been established with a focus on developing and delivering plans, providing data and shared learning opportunities. The Health Care Systems Engineering team are working closely with the services to develop demand and capacity modelling, alongside the development of data within the Outpatient Power BI Dashboard. Each Service Group has now established its own performance monitoring group with oversight of outpatient activity. The review of the outpatient management arrangements is ongoing with a recommendation that the function is centralised under once Service Group or within the Chief Operating Officer's team. Deadline moved to 31/07/2022. **September 2022:** A paper outlining the proposed new management arrangements is currently with the CEO and is to be discussed further with the Chief Operating Officer and her Deputy. Request that deadline date be extended to 31/10/2022 in order to facilitate the foregoing.	31/10/2022

Executive Lead – Director of Corporate Governance						
SBU 2122-001		**Risk Management & Board Assurance Framework**		**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	We noted service groups work with bespoke versions of the Datix risk register reports to conduct their in-service group risk reviews. Practices vary between the service groups in the way in which they review their risks but we noted the following anomalies across the service group registers that we examined: • Risk scoring is not consistently applied and there is a wide range in the instance of high scoring risks (>=16) across the four service groups (116 max, 18 min). • There is a low level of evidence of the detailed regular review by service groups of all the high scoring risks in their registers; • Not all service group register risks consistently record mitigating actions, action owners and target dates; • There is a lack of clarity in the registers as to whether mitigating actions recorded have been carried out or remain outstanding; • In many cases, due dates of the actions recorded had expired. Our prior year report noted that Singleton and Mental Health & Learning Difficulties service groups had a high number of risks overdue. The Datix risk database has been the subject of a recent internal scrutiny review in which issues were raised over the completeness of actions related data fields but at the time of our audit these had not been rectified. This links to an RMG review of the health board risk management process in August 2021 in which was observed a need for further work on risk articulation and SMART actions to assist with completion of actions and help reduce scores. We recommend that improvements are made in service group risk registers to provide more consistency in the application of risk scores and better clarity over the documenting of risk mitigating actions.	**M**	Agreed. A series of risk workshops for clinicians and managers, in specialty-related sessions, was completed within Neath Port Talbot & Singleton Service Group in the late summer. The sessions provided training on risk management principles, health board arrangements and opportunity to apply this to local risk register entries. Arrangements are being made to roll the training out to the other service groups during the next two Quarters and progress will be reported to the Risk Management Group and Management Board. A review of Service Groups will also be undertaken and reported on. We anticipate completion by September 2022. A programme of service group risk register presentations for 2022 has been agreed at the December Risk Management Group meeting. Service Groups will be asked to report on processes in place to manage & scrutinise registers at a local level, and present their registers with a focus on their top risks. This will commence from March 2022 and the programme will complete by the end of the calendar year.	30/09/2022	**October 2022:** In Progress. Nearing Completion. Service Group workshops have been completed in 3 of the 4 service groups (NPTS, PCT and MHLD). In respect of the final service group, Morriston: Training has been provided to the most senior management tier and a session has been provided to its Clinical Cabinet. Workshops are being arranged to cascade training to managers within each of its Divisions in November, with a view to completing the programme by the end of December 2022. Ongoing training for new staff and refresher training will continue to be provided via monthly sessions (already in place).	31/12/2022

2.1	We noted that the HBRR, by comparison with other health boards in Wales, contains a relatively high count of risks, some of which may be operational in nature. Typically corporate level risk registers have 12 to 20 risks. A focus on only the health board's top risks would improve the process of risk management at health board level. We recommend that the health board explore separating: i. Strategic risks (those threatening the achievement of principal objectives) in a reduced and more focussed Corporate Risk Register and ii. High scoring operational risks with a corporate wide impact, and review these separately and thereby streamline and increase the effectiveness of the review of corporate level risks.	**M**	Agreed. A review of the Health Board Risk Register and underpinning high scoring operational risks will be carried out and the HBRR refreshed.	30/04/2022	**June 2022:** This remains open. Focus has been delivery of workshops in the recommendation above. Aiming to take forward during June/July. Noting the above, deadline extended to 31/07/2022	31/07/2022

Executive Lead – Director of Corporate Governance						
SBU 2122-017		**Safety Notices & Alerts**		**Report Issued June 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.1a	Review of the process document highlighted that the required document review date has since passed (23rd November 2021). The current version of the document holds a number of blank areas, including author job title, approved by, and publication date. We were informed that the review commenced in January 2022 and remains ongoing at the time of fieldwork. The main SOP: Safety Notices and Important Documents Management Procedure should be reviewed updated, and contain standard elements such as author, approval and publication date. It should also be ensured that it is subject to an annual review going forward	**M**	The Safety Notices and Important Documents Management Procedure document will be reviewed and updated, and incorporate detail of the author and approval date. Once approved, the document will be subject to review in line with the Health Board's Policy on Policies.	30/09/2022	**September 2022:** A Task & Finish Group has been put in place to review the system/process for dealing with safety notices and alerts across the Health Board. This includes the creation of a Policy/Procedure to replace the current SOP document. Given the scope of this work, it has not been possible to complete the re-write by the originally agreed deadline. A revised deadline of 31/12/2022 is therefore proposed.	31/12/2022
2.1a	We selected a sample of 30 notices and alerts and found that, with the exception of one MDA, all were recorded in Datix. We found that alerts and notices have been entered within the Datix system in a timely manner, although our testing revealed that completion deadlines, in line with the timeframes required e.g. by WG, were not formally set within the system. We recommend that formal deadlines are set, to complete the necessary actions in relation to safety notices and alerts. These deadlines must be in line with the specifications stated in the safety notices and alerts and, if there is no such specification, then the deadline should be formally set by the relevant Level 0 Responsible Person.	**H**	Deadlines for action will be set and communicated for each safety alert and notice received by the health board.	30/09/2022	**September 2022:** This is linked to the overall review of the system/process for dealing with safety notices and alerts across the Health Board, being undertaken by the Task & Finish Group referred to above (see 1.1a) Given the scope of this work, it has not been possible to complete this action by the originally agreed deadline. A revised deadline of 31/12/2022 is therefore proposed.	31/12/2022
3.1	Distribution lists are in place to cascade alerts and notices through the health board. We tested two distribution lists in Datix and found that appropriate levels of representation were included. The main SOP requires that the distribution lists are subject to a review. However, we found no evidence that the distribution lists were circulated (as minimum annually) to the Service Group Directors for confirmation or amendment changes. The health board SOP does not require identification of any substitutes or alternative contacts for level 0 and 1. As such, there is a risk that safety notices and alerts may not get recorded in Datix or cascaded further within the health board. The distribution list should be subject to regular reviews, and these reviews should be formally evidenced. We also recommend that substitutes are formally identified for level 0 Responsible Person.	**M**	Distribution lists will be subject to regular review. Detail regarding timeframes, together with the management trail to be maintained and retained to evidence checks undertaken will be set out in the relevant Procedure document(s). All Level 0 Responsible Persons will be asked to nominate deputies to act in their absence.	30/09/2022	**September 2022:** This is linked to the overall review of the system/process for dealing with safety notices and alerts across the Health Board, being undertaken by the Task & Finish Group referred to above (see 1.1a) Given the scope of this work, it has not been possible to complete this action by the originally agreed deadline. A revised deadline of 31/12/2022 is therefore proposed.	31/12/2022

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 **October 2022:** National Digital Services skills assessment is still outstanding. This may delays action further	31/12/2022

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	**M**	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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented:** Whilst and external party has been commissioned to assist with the development of the strategy; and the 6-facet survey work was successfully tendered; at the date of fieldwork, the work had not been completed and consolidated to further inform the wider Estates Strategy. The output of the 6-fact survey should be reviewed to assist in the development of an appropriate Estates Strategy to address the management of the backlog maintenance. The priority rating on this recommendation has been reduced from High to Medium, recognising the progress made. This will be undertaken once the 6-facet survey is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review **October 2022:** The six fact survey is now complete, and production of the Estates Strategy is progressing. However this has been delayed by the need to confirm final Development Control Plans for Singleton and Morriston, and to share the same with the relevant site management teams. Request that deadline be extended to 31/12/2022 in order to facilitate this.	31/12/2022

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 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	**September 2022:** Whilst progress has been made, overall performance in respect of the completion of PADR reviews has been adversely effected by staffing/resource issues within the Department (vacancies and sickness absence). Following appointment to key vacancies, it is anticipated that 100% compliance in respect of the completion of PADR reviews will be achieved by the end of the financial year.	31/03/2023

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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** At the date of fieldwork, the contract for water testing had not been finalised. See also Financial Safeguarding previous matter 3. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review **August 2022:** The tendering process for this service was completed and a preferred company selected, however the Health Board has received notification from the Minister that the outsourcing of services should be avoided. Therefore, the Health Board have approached Public Health Labs to provide this service, using the same specification used for the tender. The Health Board is awaiting confirmation of costs from PHLS.	30/11/2022

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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented** Whilst it is recognised that the UHB is taking steps to introduce contractor assurance systems i.e. CHAS, this has yet to become 'live'. Once the contractor assurance system is implemented, the Local Framework Procedures and SFI/SO should be reviewed and updated to reflect the changes to the governance procedures. A cost-free solution (assurance system) was identified but this is taking longer to establish than anticipated. Once complete, the required updates to the governance procedure will be processed. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
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 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.	**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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented:** Work has been undertaken to review the areas of highest spend. Of the areas identified, including water sampling, legionella testing, refrigeration, boiler maintenance and high voltage maintenance, at the date of fieldwork, contracts had only been awarded for two (legionella testing and high voltage). Contracts should be finalised for the identified maintenance areas. There have been issues experienced in the support being received to address. Two of the contracts have been with procurement since the end of last year to tender, however, due to staff shortages within procurement these have not been let. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022

	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					
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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Partially Implemented** See previous matter arising 3. No evidence of the central reporting referred to in the recommendation was supplied during the follow-up review. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022
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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Partially Implemented** See previous matter arising 2, noting that the proposed use of the CHAS system will address the requirement for vetting, risk assessment etc. A cost-free solution (assurance system) was identified but this is taking longer to establish than anticipated. Once complete, the required updates to the governance procedure will be processed. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
9	In order to monitor and report any inadequate/ unusual procurement activity, it is considered sound practice to prepare periodic/ annual procurement activity reports, for consideration by the appropriate UHB forum / sub-committee. Such reports should consider key aspects of Estates procurement activity, with particular attention to areas that may signal fraud or failure to achieve value for money. Aspects should include, for example: • Compliance with SFIs in respect of quotation and tender exercises undertaken; • Analysis of the volume / pattern of single quotation / single tender actions; • High volume use of single contractors; • Analysis of use of contractors by individual Estates officers; • Status of maintenance contracts; • Use of frameworks. Management report all single tender / single quotation	**M**	Agreed. Procurement activity reports (for Estates activity), will be requested from NWSSP: Procurement Services. These will be used to inform reporting within the UHB.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The UHB internal audit tracker notes this recommendation as complete, stating that Procurement Services had provided the reports. However, no evidence was provided during the course of fieldwork to confirm the recommendation had been addressed. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee. The Procurement team is having issues supporting the process. Discussions with the Head of Procurement are to be scheduled to agree a way forward. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review	30/11/2022

	actions to the Audit Committee for scrutiny. Financial procurement information is also provided to the Estates Department for budget monitoring purposes. However, the wider analysis / reporting of procurement activity was not identified. Good practice has been evidenced at other UHBs/Trusts involved NWSSP Procurement Services contributing to the same. Periodic procurement activity reports should be prepared and reported to an appropriate UHB forum/sub-committee.					
13	No documented procedures in place for the management of Estates Stores. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs).	**H**	Agreed. Appropriate procedures will be implemented and management will undertake periodic checks/audits to ensure compliance.	01/01/2020	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The procedures have yet to be developed; and, at the date of the audit fieldwork, whilst requested, the stock count for the Estates stores had yet to be scheduled. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs). The Department is looking to appoint a Procurement Officer whose role will include stores management. Permission has been given to proceed with the recruitment process. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022
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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** **See previous matter arising 13.** The procedures have yet to be developed; and, at the date of the audit fieldwork, whilst requested, the stock count for the Estates stores had yet to be scheduled. Formal procedures should be developed and implemented for the management of Estates stores (in accordance with SFIs). The Department is looking to appoint a Procurement Officer whose role will include stores management. Permission has been given to proceed with the recruitment process. A revised deadline of 31/10/2022 has been agreed as part of the follow-up review	31/10/2022

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	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002): Outstanding** No evidence was provided by the UHB as to the action taken to address the agreed recommendation. Estates Operating Procedures should be updated, to set out the required process associated with the recording of identified risks, and in the risk-prioritised allocation of discretionary capital. **October 2022:** Re-written procedures will be produced by the end of November 2022.	30/11/2022

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	**June 2022:** The SBU Head of Procurement met with the NWSSP Procurement Services Director and the NWSSP Head of Finance and Business Development on the 13th May 2022. No firm timescale was agreed for the review of SLAs, with an agreement to revisit this in September 2022. **August 2022:** The SBU Head of Procurement met with the Assistant Director of Procurement Services on the 18th August 2022 and SLAs will not be updated until the end of October 2022 at the earliest.	31/10/2022
SBU 2223-016		**Health & Safety**	**Report Issued September 2022**		**Limited Assurance**	
9.1	Priority two within the Strategic Action Plan outlines steps towards the development of training to support managers within the health board. Milestones include: 1. Identify appropriate managers to undertake IOSH Managing Safely or equivalent. 2. Identify course provider or develop internally. 3. Schedule initial dates for pilot course completion. This potentially will be 10-year programme. During fieldwork we were informed that there has been consideration of the method of programme delivery, including review of training provided by neighbouring health boards. However, identification of managers remained outstanding outside of links to specific bandings and we note there is opportunity to link this to the identification of site leads currently being progressed by the health board The health board should undertake an assessment to ensure there is identification of managers, and those with health and safety responsibilities for specific sites, to ensure the rapid progression of training once the course and its delivery method are agreed.	**M**	The Health Board have commissioned a course for the Executive team and these are scheduled for 14th & 16th September 2022.	30/09/2022	**October 2022:** The IOSH for Executives took place on 14th and 16th September 2022. Managers within the HB will be covered initially by the pilot scheduled for December 2022. Through the all Wales H&S group CTMUHB have developed an on-line version of managing safely that will be on ESR, it is expected for this to be evaluated in Q4 2022/23 by all HB's/Trusts in Wales with the intention to adopt as an all Wales training system to ensure consistency throughout Wales. Hoping to adopt as an all Wales passport longer term.	31/01/2023

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. **October 2022 –** Development of the revised Health & Safety pages for the new Health Board intranet site continues, with Manual Handling pages now live. It is anticipated that this work will be completed by the end of the financial year.	31/03/2023

ABM 2021-009	Fire Safety Management	Report Issued April 2021	Limited Assurance

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
4	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 Gov. 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.	H	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.	30/06/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004) – Outstanding** At the date of fieldwork, management confirmed that the 6-facet survey had been commissioned by the UHB and that it was due to be completed by the end of the financial year. The output of the survey will identify the scope of the works required to enable the UHB to develop the strategy accordingly. This will be undertaken once the 6-facet report is finalised. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review **September 2022:** Consolidation of the output from the 6-facet survey and compartmentation surveys is required to assist in the development of an appropriate strategy to address the fire safety requirements. As such, a revised deadline of 31st December 2022 has been agreed with management.	31/12/2022

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.	31/12/2021	**June 2022:** We have had a number of meetings within the Finance Function in the last 2-3 months. At the last meeting in May it was noted that the wider RIF/ICF process was under review within RPB. Therefore, agreed we would await publication of this information to ensure any changes proposed are aligned to the wider work. Waiting outcome of response. Chased for response 22/6/22. Therefore deadline for completed needs to be moved to end August 2022. **Aug 2022** Governance work being undertaken by the RPB still not completed and shared with HB. Therefore item remains outstanding at the end of August. **October 2022: A** Financial Control Procedure (FCP) has been drafted, and is currently undergoing quality assurance review within the Finance Directorate. It is anticipated that this will be brought to the January 2023 meeting of the Audit Committee.	31/01/2023

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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** Whilst it is recognised that the UHB is taking steps to introduce contractor assurance systems i.e. CHAS, this has not yet become 'live'. The implementation of the contractor assurance system should be finalised to enable a central repository of the required vetting arrangements for contractors, upon appointment. A cost-free solution was identified but this is taking longer to establish than expected. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review **August 2022:** The cost-free solution was not delivered by the company who had initially presented it to the Health Board. The Assistant Director has written to all Estates staff involved in placing service contracts, and instructed them to seek CHAS accreditation as part of the procurement process. If they do not use a company with this accreditation, they must ensure that all appropriate insurance and competency checks are undertaken.	30/12/2022
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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** At the date of fieldwork, the available Managing Contractors Policy (dated December 2020) had not been updated in accordance with the agreed recommendation. The UHB's insurance requirements for contractors should be included within the Managing Contractors Policy (or supporting procedures). Agreed. The Policy will be updated accordingly by the Estates team. A revised deadline of 30/09/2022 has been agreed as part of the follow-up review **September 2022:** Work on completion of the revision of the Managing Contractors Policy has been adversely effected by staffing/resource issues within the Estates Department. The revised Policy will be presented to the H&S Ops Group in November 2022, and subsequently to the January 2023 meeting of the H&S Committee for approval.	31/01/2023
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	**H**	Agreed. Estates Managers will be reminded of the need to ensure all contractors have received appropriate induction.	21/04/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** Management confirmed that work remains ongoing as the UHB investigates the use of an electronic system	30/11/2022

	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.				which will enable monitoring of contractors which have/have not received inductions: and details of contractors who have signed in/out of site. The implementation of an automated system to record inductions and site attendance should be finalised; with appropriate manual controls implemented for the interim period. Agreed, however until such a system is implemented, the induction process was being managed by the department's Health & Safety Officer who has since retired. A recruitment process for their successor is ongoing. A revised deadline of 30/11/2022 has been agreed as part of the follow-up review **August 2022:** Application process has been completed for the replacement of the Health and Safety Officer's role. Shortlisting is due to take place in early September with a view to having someone in post from October.	
8	The Estates department undertakes periodic in-house contractor compliance audits, as part of the ISO14001 environmental standard process (as opposed to being specifically for health and safety/contractor monitoring purposes). An in-house audit was last carried out in March 2018 (whilst scheduled annually, an audit had not yet been undertaken in 2019 at the time of audit fieldwork in September 2019). Upon review, it was found that these in-house exercises focused on only two areas in relation to contractor management: • Site induction compliance for the month preceding the date of the audit; and • Signing in/out compliance for the month preceding the date of the audit. In order to improve the information provided to Estates management, the Estates Board and the wider UHB (e.g. Health & Safety Committee), the audit process should be reviewed and enhanced, to encompass: • A specific focus on contractor compliance (as opposed to an indirect focus stemming from the ISO14001 work); • More frequent audit reviews, to provide ongoing assurance to management; and • Wider audit scope, to encompass other key areas of the Managing Contractors policy/HSE requirements. This may include appointment checks, RAMS processes etc. in addition to the existing checks of induction and signing in. Estates in-house contractor management audit processes should be reviewed and enhanced to ensure: • The audit scope represents an appropriate range of HSE and UHB Policy requirements; • Audits are undertaken more frequently, to provide ongoing assurance of compliance throughout the year; • Results are reported to relevant forums/committees for scrutiny and action (e.g. Estates Board/H&S Committee).	**M**	Agreed. An audit was completed in December/January and will be repeated 6 monthly and reported to Senior Team. The reporting to the H&S Committee will be the responsibility of the Head of Health & Safety.	31/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The UHB internal audit recommendation Tracker reports this recommendation as complete. However, no supporting information was provided during the course of fieldwork in order to support this status. The in-house contractor management audit process should be reviewed, enhanced where appropriate and reported to an appropriate forum for endorsement. Plans were for contractor compliance to be audited bi-annually, however this has proved challenging due to staff vacancies. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review **September 2022 (DK):** Biannual audit undertaken in March 2022, with findings reported to the Estates Board. Further audit undertaken in September 2022, the findings of which will be reported to the next Estates Board meeting. Further work is required to review and widen the scope of the audit reviews. Following discussions with NWSSP Audit & Assurance colleagues, if has been agreed that the deadline will be extended to 31/03/2023 in order to facilitate and evidence the foregoing	31/03/2023

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	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The Water Safety Plan includes two appendices relevant to training [1] Training Matrix and [2] Training Status. However there is no evidence of update reporting being provided to the Water Safety Management Committee or the Health & Safety Operational Sub Group; Water Safety Management to confirm the status of training provision for relevant staff, as per the recommendation. Training should be updated for relevant staff as soon as possible. Staff are being booked on courses, however, due to a lack of availability (owing to demand post-pandemic) there are gaps in compliance. Further, courses have increased in cost significantly – most Authorised Persons duties require a training course of either 1 or 2 weeks, which can vary in cost from £4k to £8k. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review **August 2022:** The Assistant Director of Estates, Morriston Estates Manager, the Singleton Estates Manager and one of the Estates Officers at Singleton have all completed refresher training. The Health Board will now seek to commission training for CP as it becomes available. **September 2022:** On-site awareness training for Competent Persons has commenced and is ongoing. It is envisaged that all required water safety training will be delivered/refreshed by the end of December 2022.	31/12/2022
8(b)	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.	**M**	Agreed. The required detail will be incorporated into the Water Safety Plan.	30/07/2021	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): Outstanding** The Water Safety Plan includes two appendices relevant to training [1] Training Matrix and [2] Training Status. However there is no evidence of update reporting being provided to the Water Safety Management Committee or the Health & Safety Operational Sub Group; Water Safety Management to confirm the status of training provision for relevant staff, as per the recommendation. Training requirements, and compliance, should be captured in a training matrix for all staff with water safety responsibilities (including both Estates and Departmental/Ward staff). Staff are being booked on courses, however, due to a lack of availability (owing to demand post-pandemic) there are	30/11/2022

	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 requirements and compliance should be captured in a training matrix, for all staff with water safety responsibilities (including both Estates and departmental / ward staff) (O).				gaps in compliance. Further, courses have increased in cost significantly – most Authorised Persons duties require a training course of either 1 or 2 weeks, which can vary in cost from £4k to £8k. A revised deadline of 31/08/2022 has been agreed as part of the follow-up review **October 2022:** Following discussions with NWSSP A&A colleagues, it has been agreed that further consideration will be given to what would be the most appropriate mechanism by which evidence of training can be captured and recorded. It has been agreed that the deadline date will be extended to 30/11/2022 in order to facilitate this.	

Executive Lead – Director of Finance						
SBU 2122-003		**Financial Reporting & Monitoring**		**Report Issued May 2022**	**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	Budget delegation letters are issued to the four Service Group Directors. The Standing Financial Instructions states budget holders must sign the accountability letter formally delegating the budget. We note that of the four letters issued to Service Groups, the corporate Finance Team did not receive any responses. We also note that budget holders appear to be working to the budgets delegated to them, and the health board is on track to deliver the year end position. The importance of signing and returning delegation letters is re-iterated to budget holders to formally recognise budget accountability.	**H**	Accepted. Following the publication of the 2022/23 letters, which will include a deadline for replies, the Finance team will ensure there are regular checks on the receipt of responses and where necessary ensure reminders are issued. Where no responses are received within 4 weeks of the deadline this will be escalated to the DOF. Formal responses will be held on file by the Finance Team.	31/07/2022	**October 2022:** It has not yet been possible to issue final delegation/accountability letters, due to the need to clarify detail around certain elements of the overall HB allocation.	30/11/2022
3	Our review of Financial Control Procedure 6 - Budgetary Control Procedures noted that this document was last updated in November 2019 and was due for review in 2020/21. A paper taken to Audit Committee in November indicates review of these procedures was planned for quarter 4. We also recognise that the document is currently undergoing national review and recognise the impact of COVID-19 FCP 6 - Budgetary Control Procedures should be updated to reflect current working practices	**L**	Noted. Agreed the FCP6 needs to be updated and aim for completion during Q2	30/09/2022	**October 2022:** The review/rewrite has commenced, however it has not been possible to complete this by the originally agreed deadline due to the volume of work involved. It is anticipated that this will now be completed by the end of the calendar year.	31/12/2022
6	Authorised signatory listings are maintained in relation to the Oracle system as well as for manual non-pay transactions. Monthly checks are undertaken against ESR records to ensure leavers are removed from the approval hierarchy. Periodic checks are also undertaken at a Service Group level, although the frequency and formality vary. As part of our review, we undertook a comparison of the arrangements in place at a sample of other health boards. This determined that annual confirmation checks are circulated to Service Groups to ensure that the authorised signatories listing is complete and that cost centres and approval limits are appropriate. We recommend that this good practice annual confirmation check is completed across all Service Groups and corporate delegates and that a central listing is maintained by the Finance Team.	**L**	Noted and agreed. A list per Service Group/Directorate will be issued annually for review by Service Group Directors and the tier below to include FBP.	31/07/2022	**October 2022:** Due to the ongoing organisational/structural changes resulting from implementation of AMSR, it has been agreed that it would be more beneficial to delay the introduction of this process until that implementation is complete, and a more stable structure is in place. As such, it is envisaged that the first of these annual checks will be completed by the end of the financial year.	31/03/2022

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**
1	Whilst the waste policy was found to be generally comprehensive and in accordance with the guidance provided by WHTM 07-01 (6.4), it was noted that some areas had not been incorporated. The policy was supported by a series of procedural guides reflecting the current WHTM 07-01. Whilst comprehensive, these were last updated in 2015 and therefore required review to ensure information remains relevant to current UHB operations. It was further noted that the UHB's intranet site contained some out-of-date and superseded policy and procedural documents, which should be removed. a) At the date of the next review of the Waste Management Policy, it should be ensured that all key elements of WHTM 07-01 guidance, and enhanced information regarding governance and training arrangements, are incorporated. b) Waste management procedures (UHB-wide) should be reviewed and updated where necessary, via an appropriate forum(s). c) Out-of-date policy / procedural documents published online should be removed.	**M**	a) Agreed. We will incorporate the suggested elements at the date of the next review. b) Agreed. Work has now commenced on the review of the procedures. Initially, we are targeting those areas where issues in compliance have been identified. There needs to be a wider consolidation of all waste procedures across the UHB to ensure consistency in the approach. c) Agreed. We will ensure superseded documents are removed from the intranet. B and C to be completed by the end of June 2022	30/06/2022	**September 2022:** The Policy review is ongoing, but has been hampered by staffing/resource issues within the Department. The revised document will be presented to the H&S ops Group before going to the next meeting of the Health & Safety Committee for approval in January 2023. The process of reviewing and updating the supporting procedures has commenced and is ongoing, with anticipated completion by the end of November 2022. All out of date/superseded procedure documents have been removed from the intranet.	31/01/2023
2	Environmental awareness / recycling training had been removed from the UHB's Corporate Induction programme. Management recognises the need for wider awareness/recycling training provision within the UHB, and acknowledged they have sought support from the Learning & Development team to implement an online training module. However, progress has been slow, recognising COVID priorities. Support from the recently launched Sustainable Swansea Bay forum may be possible to take this forward, noting the potential benefits to improved waste reduction / recycling rates. Management should engage with the Sustainable Swansea Bay forum (or appropriate alternative) to present the benefits of wider awareness/recycling training across the UHB.	**M**	Agreed. We will engage with the forum to present the benefits of cross-UHB awareness / recycling training, to support the UHB's recycling targets	30/04/2022	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues within the Department, and delays in the production of WG guidance. The Environmental Factsheet section of the staff handbook has been reviewed and updated. A meeting with Learning & OD colleagues and the Sustainable Swansea Bay Forum is planned for October to discuss further options, including the possibility for an ESR Module.	31/01/2023

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	**October 2022:** A draft report has been prepared, and is currently with the Assistant Director of Estates.	30/11/2022
5	Whilst some examples of good practice in waste minimisation were provided by management, it was not evident that a UHB-wide critical review has been undertaken in recent years. A critical review of waste volumes and types across the UHB should be presented to the Sustainable Swansea Bay forum (or appropriate alternative), to identify potential for waste minimisation in line with WHTM 07-01(5.3).	**L**	Agreed. We recognise the benefits of such an exercise, but the ability to facilitate the same sits outside Estates – recognising that key parties would include e.g. NWSSP Procurement Services and Infection Control. We will present the option (of e.g. a review of the largest consumable items within the UHB), and provide a critical review of 2021/22 data, to the Sustainable Swansea Bay forum for consideration by the relevant parties.	30/04/2022	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues within the Department. A paper summarising waste volumes by type/category will be presented to the Forum by December 2022. The Department are currently working with NWSSP Procurement colleagues in order to identify the most common consumable items purchased by the Health Board in order to further refine and focus this work/reporting going forward.	31/12/2022
6	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. 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).	**M**	a) Agreed, we will prepare a RAG-rated summary log of all audit findings. 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	**September 2022:** The ability to progress this action has been hindered by staffing/resource issues within the Department. Following the next Pre-Acceptance audits, which are due in November/December 2022, a dedicated Tracker will be put in place to deal with any recommendations/non-conformities highlighted. This will then be reported to the Estates Board, and periodically return for update and progress monitoring. It will also made available to the Sustainable Swansea Bay Forum.	31/01/2022

7	There was minimal evidence of waste management issues being reported to the Health & Safety Committee during the period reviewed (April 2020 onwards), aside from a brief reference to waste risks within the Health & Safety Operational Group Key Highlights Report. There was no formal reporting evidenced from Estates. a) The Environmental Report (or alternative appropriate report) should be enhanced to widen the scope of reporting of waste management issues. (see also recommendation 6.1.b). b) The relevant Board-level Committee should receive periodic waste management updates. (see also recommendation 1.1.a).	**M**	a) Agreed. See also management comments above at 6.1.b regarding widening the scope of reporting outside the Estates Board to ensure Service Unit Directors are appropriately sighted on issues arising within their areas of responsibility. Further, from January 2022, waste is now included within the Estates update to the Health & Safety Operational Group. b) Agreed. We will incorporate a summary on waste management into the next Estates report to the H&S Committee, which is due before April 2022.	30/04/2022	**September 2022 (HS):** A bespoke paper on Waste Management will be presented to the October 2022 meeting of the Estates Board, and will be standing agenda Item thereafter. Estates reports to the Health & Safety Committee now include updates on Waste Management.	30/11/2022

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	**August 2022:** Draft proposed guidance has been developed and shared with staff side. HB awaiting feedback. Aim to circulate agreed guidance internally in early September. **September 2022:** The EWTD Guide remains with staff side for comment. Clearance has not been possible, as no sub-group meeting has taken place since the draft document was shared.	30/11/2022
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. **June 2022:** Fresh scoping required due to the impact of the pandemic and identification of appropriate funding to support the completion of this work. Target deadline to complete scoping exercise and identification of funding end of September 2022. Noting this, deadline extended to 30/09/2022 **September 2022:** Completion of this work has been impacted by capacity issues due to the AMSR project and other pressures. A scoping exercise is underway from the information available on ESR for all the employees who have no record of a DBS check and require once for their role within the HB. In relation to the frequency of DBS checks, this is being benchmarked on an all-Wales basis. It is anticipated that this work will be completed by the end of October.	31/10/2022

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	**October 2022:** The Acting Director of Corporate Governance is working with the Director of Finance to further review and explore alignment with the health board Performance Management Framework. The deadline has been extended to 30/11/2022 in order to facilitate the above	30/11/2022

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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan.	30/11/2022
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	**August 2022:** NHS Wales Delivery Unit are developing an All Wales optimal patient flow framework, SAFER and D2RA will be integrated and form the basis of patient flow throughout the patient's hospital admission and beyond. Version 1 will be ready to be launched in October 2022, ABMU can then update our policy in line with WG guidelines along with a training plan. Version 3 of SIGNAL, new icons and a standardised approach on all PSAG boards with a training programme in place.	30/11/2022

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 **August 2022:** Hywel Dda UHB area are continuing with the pilot of the Safeguarding Datix module. Progress and feedback from this pilot will be reported to the all Wales Network meeting, chaired by the National Safeguarding Team, Public Health Wales.	30/11/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2122-002		**Quality & Safety Framework**		**Report Issued January 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1.2	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. In refreshing the QSPF, the health board should consider developing an action plan to support the implementation of a new framework, to be monitored at QSGG and QSC periodically	**H**	The work programmes of the Q&SGG and Q&S Committee will be amended to include a review of the implementation of the framework (as a minimum three times a year)	01/05/2022	**February 2022:** A review of the role and function of QSGG is underway. This will be considered in line with the implications of the WG Duty of quality Act and an action plan developed and implemented to reflect this. **Undated:** Quality Strategy currently being developed. Please extend deadline to 30/9 in line with the development of the Framework **June 2022:** Welsh government draft Quality Framework due for publication Sept 22. This will inform our Framework development	30/09/2022
2.2	Established just prior to the onset of the pandemic, the QSGG has modified its approach and agenda to compensate and support reporting and escalation to the QSC. The QSGG Terms of Reference include 42 objectives (including one duplicate objective). Our review identified that the group has not met all of these, with those related to monitoring the QSPF and receipt of terms of reference/annual plans from subgroups representing an ongoing gap. The supporting structure of the QSGG indicating reporting groups and subgroups remains outstanding. The Group otherwise had sufficient coverage of subject areas against its ToR, but we were informed that due to the large agenda there can be challenges in keeping the meeting within its timings whilst allowing contributors	**M**	Agreed	01/06/2022	**June 2022:** Mapping complete. Work programme being developed and to be presented at QSPGG 21st June 2022	30/06/2022

	adequate scope to present reports and highlight key issues. A number of other objectives including monitoring of licensing standards, agreement of Patient Experience Plan and review implications of confidential enquiry reports could also be considered if still appropriate as objectives for the group. The QSPF includes that the QSGG 'acts as the first layer of corporate oversight, which exists to provide appropriate oversight to the devolved Service Delivery Units own quality and safety meetings, together with other formed groups and sub committees.' The current exception report in use provides coverage of performance but does not prompt information on the operation of service group quality and safety groups. We recommend that there is mapping of the QSGG sub-groups and reporting groups. Following this there should be a work programme/business cycle created to ensure all relevant information and reporting are addressed and distributed throughout the year.					
2.3	Established just prior to the onset of the pandemic, the QSGG has modified its approach and agenda to compensate and support reporting and escalation to the QSC. The QSGG Terms of Reference include 42 objectives (including one duplicate objective). Our review identified that the group has not met all of these, with those related to monitoring the QSPF and receipt of terms of reference/annual plans from subgroups representing an ongoing gap. The supporting structure of the QSGG indicating reporting groups and subgroups remains outstanding. The Group otherwise had sufficient coverage of subject areas against its ToR, but we were informed that due to the large agenda there can be challenges in keeping the meeting within its timings whilst allowing contributors adequate scope to present reports and highlight key issues. A number of other objectives including monitoring of licensing standards, agreement of Patient Experience Plan and review implications of confidential enquiry reports could also be considered if still appropriate as objectives for the group. The QSPF includes that the QSGG 'acts as the first layer of corporate oversight, which exists to provide appropriate oversight to the devolved Service Delivery Units own quality and safety meetings, together with other formed groups and sub committees.' The current exception report in use provides coverage of performance but does not prompt information on the operation of service group quality and safety groups. We recommend that the exception report include reporting on service group quality and safety group operation. The QSGG attendance tracker could be shared to support good practice in this area	**M**	Agreed - The exception report from Q&SGG to Q&S Committee will be reviewed following the Q&S workshops and a revised reporting template agreed by the Q&S Committee	01/06/2022	**June 2022:** Revised exception report being developed. Sub groups set up and inaugural meetings starting w/c 13/6 and reporting templates to be developed by these groups	30/06/2022

4.1	Review of service group terms of reference identified variation of content related to group's purposes. Only one contained a reference to the Quality & Safety Process Framework, with others referencing the health board's expired Quality Strategy 2014-18. Each contained a requirement for annual review of their terms of reference and self-assessment but the methodology and any further reporting of these are not outlined Following any review of the health board's Quality and Safety Process Framework and Quality and Safety Governance Group terms of reference, there should be consideration of any key content to be adopted within quality and safety groups throughout the organisation to promote consistency and alignment of objectives.	**M**	Agreed - These "golden threads" will be reviewed and confirmed following the Quality and Safety away sessions being held in Feb/March 2022. They will include a focus on the quality priorities, key requirements of the annual plan, service specific indicators, national quality frameworks, NICE compliance, as well as local risks, harms, outcomes.	01/07/2022	Inaugural meeting of QSPSG held. TORs to be agreed following this	
4.2	Review of service group terms of reference identified variation of content related to group's purposes. Only one contained a reference to the Quality & Safety Process Framework, with others referencing the health board's expired Quality Strategy 2014-18. Each contained a requirement for annual review of their terms of reference and self-assessment but the methodology and any further reporting of these are not outlined In undertaking the above, the health board should consider if specific requirements are needed to support quality and safety group's self-assessments and if these should be periodically reviewed. The maturity matrix included within the health board's quality governance review may provide reference point for this.	**M**	Agreed – These will be considered, as well as the use of the maturity matrix, along with the outcomes of the Quality and Safety away sessions and the expectations contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020.	01/07/2022	To be taken forward following review of QSGG.	

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2122-023		**Mental Health Legislative Compliance**		**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	Reports presented to the MHL Committee provide a broad coverage of compliance against legislation. We recognise that some sections within legislation do not place statutory duties on health boards and that reporting is undertaken by exception, however assurance on the completeness of compliance cannot be demonstrated in the absence of a compliance map. We recommend that an exercise is undertaken to map the legislation and/or the Codes of Practice to the arrangements the health board has in place, in order to provide assurance on compliance against legislation, that arrangements are monitored and that there are no omissions.	**M**	An exercise will be undertaken to match the legislation and/or the Code of Practice to the regular reports made to the Mental Health Legislative Committee.	30/04/2022	**August 2022:** Re the compliance map - This is still work in train (scoping how this can be done), and is quite complex in terms of cross referencing, and understanding which parts of the legislation need to be reported against. The plan is for the compliance map to enable the code/legislation to provide the key headings under which future reports will be developed. This is complicated further by the developing work around LPS, and the future need for this to be incorporated into future reporting requirements. Suggest GH and HL meet up to scope where we are – esp. around the legal position and as such may also need input from Shared/Legal Services. MH Leg Committee updated of the plan and a progress update will be provided to the October 2022 Committee It is a medium priority, so would ask that the due date in the plan be changed to October 2022	31/10/2022
2.2	As reported to the MHL Committee, there have been 3 invalid detentions identified by the MHA Team in the first half of this financial year. We note that there is no formal MHA training provided to staff within the MHLD service group on a cyclical basis but that guidance in relation to form completion is available within patient dashboards. A review of service group performance reports taken to Safeguarding Committee has shown inconsistent levels of reporting of MCA and DoLS training and that in some instances, compliance is measured against all staff while some training is specific to certain staff levels. There was one report that did not record compliance against MCA and DoLS training. We recognise that this finding has wider implications across the health board and is not specific to MCA and DoLS Consideration should be given to undertake service group training needs analysis to establish which staff levels require which level of training, in order to effectively manage compliance across the health board.	**H**	The Learning & Development team will put processes in place to ensure that the training available is targeted at the correct staff groups.	30/04/2022	**October 2022:** Work is currently being undertaken with L&D colleagues in order to develop and undertake training needs assessment.	30/11/2022

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	**Vaccinations & Immunisation Follow Up (SBU-2021-014) – Partially Implemented** We note that additional resources were not secured immediately following the last audit to assist in clearing the data input backlog and additional on-going data cleansing. An SBAR paper had been completed but it is not clear following changes in key management positions that the paper progressed any further towards a decision. Discussions with the Service Group Manager, Children's Service Group and the ChIG Chair informed us that there had been some recent ad-hoc validation of GP and Child Health records to support data quality but that it was not yet and embedded process. We note that the draft ChIG 2020 Plan includes the intention to undertake quarterly data cleansing exercises between GP and Child Health records assisted by Health Visitors. The recommendation should remain open until the ChIG plan is approved and the routine data quality cleansing process is confirmed as implemented at SIG	30/06/2022

Executive 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**
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.	On Completion of Each Scheme	**Follow-up: Capital Assurance (SSU-SBUHB-2122-002) – Outstanding** Review of the latest version of the project risk register noted no costings. As a minimum, noting the current stage of the project, costs associated with the design, site/construction risks etc. to be included. As noted by the appointed Cost Adviser, a comprehensive Risk Register was developed for the project from completion of the RIBA Stage 2 report, which set out the scope of the project. The risk register reflected the anticipated risks thereon, has been reviewed by all parties and updated at regular intervals, and has been used in design development to mitigate risks and consequent costs. A financial evaluation of the risks will be included in the BJC submission, which will allocate the risks to the party best suited to manage them. The regular review of the risk register will continue throughout the construction period, assessing all risks not just those for which the Health Boards is responsible. The financial risks for which the Health Board is responsible will continue to be evaluated as construction work progresses. As a risk is partially or completely mitigated/closed out this will be reflected in the changing value included in the risk register. The value of a risk may increase as well as decrease and this will equally be shown. The residual risk values will be considered within each monthly cost report and will consider the out-turn cost for the project and not just the construction costs. The consideration of risk values within the cost report will ensure that the forecast out-turn cost is accurately reported, be it an under or over-spend. The risk contingency will not be used just to balance the forecast out-turn cost to the funding approval as this would potentially report a misleading financial position. A revised deadline date of 30/09/2022 has been agreed as part of the follow-up review. **October 2022:** A copy of the most up to date CE Register is required for review by NWSSP A&A colleagues before this action can be closed.	31/10/2022

8	The PPE should be guided by a pre-determined structure, in this instance as specified in the Local Framework Requirements (and requirements outlined at the BJC as appropriate), supported by quantitative data, to ensure all relevant points are covered. The UHB did not apply the post project evaluation procedure determined within the approved BJC1. The BJC1 works were let via the UHB's Local Framework. The Local Framework Operating Procedures state: "***Critical Success Factors (CSF) should be identified at project outset and reviewed in the Lessons learned meeting to evaluate project performance. These CSF's should include:*** – ***Time*** – ***Cost*** – ***Quality*** – ***H&S*** – ***Compensation events*** – ***KPIs*** – ***Functionality*** – ***User satisfaction***." The completed lessons learnt exercise was assessed against the above requirements. A number of the above items were discussed during the meeting, with action points identified to ensure that lessons were identified and could be applied at other projects. However, a number of the above key areas were not considered i.e. – Time and cost performance of the individual schemes – compensation events – KPI data (see also recommendation 2) – the procurement approach (including value for money) No quantitative data was assessed during the exercise. Post project evaluation / lessons learned exercises should be guided by a predetermined set of areas for discussion, to ensure all relevant aspects of project delivery are given due consideration, in line with relevant guidance and best practice. Analysis should be supported by quantitative data, including the time and cost performance at individual schemes / contracts, and KPI data in relation to contractor and adviser performance (D).	**M**	Agreed. It is accepted that the scope of the Lessons Learnt exercise could have been more extensive however it is noted that the cost performance was extensively monitored and assessed throughout the course of the project. Noting the change to D4L for BJC2, the full PPE process will be applied as required by the Framework.	At the BJC2 Lessons Learnt Exercise	**October 2022):** Following discussions with NWSSP A&A colleagues, it has been agreed that recommendation to remain 'in progress' on the Tracker until the lessons learnt exercise is undertaken at the completion of the project. Noting the foregoing, deadline extended to 31/03/2023 for further update.	31/03/2023

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**
10.1 (a)	Advisers have been appointed from the UHB's Local Framework, to provide architectural, cost and mechanical and electrical advisory services to the project to date. Contracts were in place at the time of review, covering work on both the SOC and revenue solution, and had been appropriately completed and executed. However, the following issues were noted: • The Architect contract ('temporary bridging solution') was capped at £10,000, but payments to date totalled £23,584, exceeding the delegated authority provided by the contract signatories; and • All contracts had been executed after adviser duties commenced; with delays ranging from only one week to seven months (from the date first payment was made). Sufficient contractual cover should be in place to cover the value of works instructed.	**M**	Agreed. Within the Capital Planning Department, we strive to ensure that contracts are in place in a timely manner, as demonstrated within this instance. The contractors that we work with are selected from an existing framework which has already undergone competitive compliant procurement exercises that ensures that the Health Board is receiving Value for Money. We place a cap on the contracts to ensure that we are not financially exposed. We accept and agree with your comments. With regards to this particular instance as we have already iterated the project is evolving and progressing at pace and as a result the costs had escalated quickly. We are aware of it and will look to revise the contract to reflect these changes.	30/11/2021	**October 2022:** Work is currently being undertaken to map the invoices to the contract. It is suggested that conversations are held with Procurement to vary the contract / raise a new contract in accordance with the Procurement Regulations i.e., under the Public Contract Regulations (2015) Regulation 72: a variation to the contract may be granted where a need for additional deliverables is required due to unforeseen circumstances. In these circumstances, the maximum contract variation is limited to 50% of the overall contracted value. Further, review of the spreadsheets maintained, recording the cumulative expenditure should be undertaken to ensure it is clearly flagged [for PM action] when invoices exceed / close to exceeding the confirmed contract value.	30/11/2022

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**
1.1	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The health board should ensure that there is an appropriate SLA or service specification in place for the commissioning arrangement between the health board and CTMUHB that covers all key areas of the CAMHS commissioned.	**H**	As stated, the Health Board had already identified that developing a service specification for CAMHS would be included in the 2021-22 work programme. However the postholder supporting this work transferred to a new role in July 2021, and the backfill post was appointed to, but the candidate then withdrew, there has been no cover for this role since this time. This post is currently out to advert but it is unlikely that it will be filled until early 2022 which impacts on the target date for this. There will also need to be careful consideration for the Health Board of the financial implications of implementing a service specification to meet all national requirements which will need to be prioritised as part of the Annual Plan and resourcing requirements agreed for 2023-24 onwards.	30/04/2022	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting.	31/10/2022
1.2	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The SLA/service specification should include, but not be limited to, a description of the services to be provided and their expected service levels, metrics (both performance and quality) by which the service is measured, the duties and responsibilities of each party, the remedies or penalties for breach, and a protocol for adding and removing metrics.	**H**	These elements will be included in the service specification as it is developed.	30/04/2022	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. A workshop has been held to develop further the outcome measures and additional measures will be reported from Q4. Detail in the specification enhanced in the short-term working towards more robust position in Q4.	31/03/2023
3.1	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 should identify appropriate quality measures to assess the service and outcomes for its patients.	**H**	The Children's Commissioner's report and other sources of feedback from CYP have demonstrated that speed of access to the right support is the number one concern for young people. Therefore the focus for the Health Board has been on improving access times and improving the range of services available to meet individual's needs better, both of which clearly are key quality measures for this service. Beyond this, BaYouth have been involved in developing and agreeing the priorities for action within the multiagency Delivery Plan, to ensure these address the issues children and young people are facing. The Health Board will identify through the service specification work outlined in 1.1 above further quality measures and outcomes for patients. The Quality & Safety Committee receives regular reports on performance of CAMHS services, and has not sought any additional quality measures.	31/07/2022	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. A workshop has been held to develop further the outcome measures and additional measures will be reported from Q4. Detail in the specification enhanced in the short-term working towards more robust position in Q4.	31/03/2023

Executive Lead – Director of Strategy						
SBU–2223-007	**Singleton Hospital Cladding Replacement**		**Report Issued August 2022**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
5.1	The latest façade cost report (no. 15, issued June 2022) presented a total anticipated underspend of £163,359 against the approved funding envelope, with a balance of UHB contingency of £278,606. The risk register (revision 29) separately recorded risks valued at £356,256, therefore exceeding remaining contingency. The risk of insufficient funds to deliver the project to completion has been discussed at Project Board, and flagged at the Welsh Government Project Progress Reports. However, as above this is not currently reflected in the cost reporting, which presents an anticipated underspend. Cost reports should incorporate the value of costed risks against available contingency when considering the forecast over/ underspend position.	**M**	Agreed. The forecast position will be incorporated into the cost reports from now on. The UHB will endeavour to reclaim the Expert Witness and Covid-19 costs at completion, and if successful, the scheme is currently affordable. SES attend Project Board, and are aware of the current situation, but have said that all contingencies and any gain share has to be accounted for before any funding is allocated.	30/09/2022	**October 2022:** Project Board papers/minutes to be provided to NWSSP Audit & Assurance for review prior to the closure of this action. Deadline Extended to 31/10/2022 in order to facilitate the foregoing	31/10/2022
6.1	Whilst the prior Cladding audit report (issued October 2021) noted that management had scheduled a lessons-learnt exercise after completion of the first ward, we are advised that this did not take place. With the project now at the half-way point, management agreed that this exercise would remain beneficial to inform delivery of the remaining programme. A mid-point lessons learnt review should be undertaken.	**M**	Agreed. A session has been scheduled with relevant internal and external parties in September 2022.	30/09/222	**October 2022:** Completion of this action to be deferred due to availability of personnel at Kier. Deadline extended to 31/01/2023 in line with the foregoing	31/01/2023
6.2	Whilst recognising that quality issues have been clearly documented in e.g. project reports and Project Board / Team minutes, a lessons learnt log was not in operation to centrally capture the full range of issues identified (which may include both technical and operational matters). Lessons learnt (both technical and operational) should be captured in a central log.	**L**	Agreed. Follow up discussions to be had with the Project Manager to review lessons learned. Once these have been identified, they will be captured in a central log.	30/09/2022	**October 2022:** Completion of this action to be deferred due to availability of personnel at Kier. Deadline extended to 31/01/2023 in line with the foregoing	31/01/2023

Executive Lead – Executive Medical Director						
SBU 2122-017			**NICE Guidance**	**Report Issued May 2022**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2.2	During the audit, we selected a random sample of NICE Guidance publications to determine how they had been considered at service group level in line with the SOP. We requested evidence to demonstrate how each NICE Guidance publication had been reviewed for implementation and how the responses had been collated for reporting to COEG. However, we received limited responses and evidence to substantiate the process followed. Updates on NICE Guidance should be provided in a timely manner by Service Group Medical Directors or nominated responders.	**H**	The Internal Audit Report and required actions will be shared with the Group members at the next available meeting on 13th May 2022. Service Delivery Group MDs will be reminded of their responsibilities to the Group.	31/05/2022	**October 2022:** Process for receipt and distribution of NICE guidance; as well as process for self-assessment of compliance with guidance agreed. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
2.3	Despite the lack of evidence provided, the Service Group Medical Director (SGMD) for Mental Health and Learning Disabilities advised that NICE Guidance should be added to the Quality and Safety Group agenda for action. Audits against NICE Guidance would be managed by the Clinical Audit subgroup and reported to the Mental Health and Learning Disabilities Quality and Safety Group. Similarly, the SGMD for Neath Port Talbot and Singleton Service Group advised that NICE Guidance and other technology appraisals are disseminated to the relevant divisions and are subject to departmental audits as appropriate. The SGMDs were unable to offer evidence that NICE guidance had been considered by the Service Group and that guidance had been adopted, or that there was a clear rationale for not adopting. However, they planned to have NICE Guidance as a standing agenda item at their Service Group Quality and Safety meeting to monitor going forward. Consideration should be given to include NICE Guidance, and other relevant standards, as a standard agenda item at Service Group Quality and Safety meetings.	**H**	The Internal Audit Report and required actions will be shared with the Group members at the next available meeting on 13th May 2022. Service Delivery Group MDs will be reminded of their responsibilities to the Group. Service Delivery Group MDs will be asked to progress the action point and report progress.	31/05/2022	Compliance with NICE guidance will be discussed at appropriate for a within service groups. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
3.1	The health board has developed a Standard Operating Procedure (SOP) for the 'Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines'. The SOP was approved by COEG in November 2020 and was due for review in November 2021. Review of the SOP has highlighted sections that appear incomplete, including examples where roles and responsibilities were not clearly stated or defined. We also noted several instances where question marks were still	**M**	The SOP for the Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines will be reviewed and updated.	01/07/2022	Revised SOP to be completed by new Chair of COEG. October 2022	31/10/2022

	present in the text of the SOP demonstrating it was incomplete. The SOP for the Development, Dissemination and Review of NICE Guidelines not Specifically Related to Medicines should be reviewed and updated.					
5.1	The health board maintains a 'master spreadsheet' or tracker for monitoring and managing NICE Guidance publications. We consider that the inclusion of the following details at the master spreadsheet would enhance the monitoring arrangements at the health board: 1) Details of the lead individual(s) (nominated responder) responsible for 'championing' the NICE Guidance publication; 2) Confirmation of whether or not the NICE Guidance publication has been adopted and the date this was completed; 3) Justification is documented when it is determined that NICE Guidance will not be adopted; and 4) Measures that have been taken to ensure compliance with the guidance. The health board should consider enhancing the level of detail captured on the tracker to strengthen arrangements to manage and monitor compliance.	**M**	The Health Board will explore what options are available to capture additional detail within the digital AMaT software and will implement where this is possible; if there are constraints to the level of detail that it's possible to capture, these constraints will be reported through COEG and consideration given whether an alternative can be used.	01/10/2022	**October 2022:** Process established for self-assessment. Likely first round of self-assessment in December 2022 for review at COEG and monthly thereafter. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023
5.2	A separate tracker is presented and discussed at the COEG meetings. It is a dynamic document and only contains NICE Guidance that is currently under review and consideration. Once COEG is satisfied, based on responses provided from the Service Groups that guidance has been considered appropriately, the item is removed from the tracker. There is therefore an absence of a mechanism to demonstrate ongoing compliance with the guidance. Since July 2021, updates on NICE Guidance have been provided to the Quality Safety Governance Group, mainly via the 'COEG outstanding responses to national guidance' paper. At the July 2021 QSGG meeting, the percentage of responses received for newly published NICE Guidance was reported at 22.2%, with a small improvement to 27.3% noted in September 2021. This snapshot of 'responses received' is not evident at every COEG and QSGG meeting. However, whilst it is considered a useful tool to highlight the level of engagement within the health board, there is a lack of detail and clarity regarding the content of the responses in order to confirm that the NICE Guidance has been adopted by the health board and is being complied with. The tracker should be presented at COEG to allow senior management to seek assurances that NICE Guidance has been implemented as appropriate. Issues identified should be escalated to QSGG and the Quality and Safety Committee.	**M**	The data available on the AMaT system will be collated as a regular report for COEG.	01/10/2022	**October 2022:** Process established for self-assessment. Likely first round of self-assessment in December 2022 for review at COEG and monthly thereafter. Deadline extended to 31/03/2023 in order to embed revised processes and evidence them in action	31/03/2023

Executive Lead – Executive Medical Director						
SBU 2021-026	**WHO Surgical Safety Checklist Follow Up**		**Report Issued April 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3	During the review, we were provided with an email sent from the Executive Medical Director to the Director of Digital requesting assistance in finding further ways to analyse the TOMS data and exploring the feasibility of providing further data to units. While there was no response recorded to this original request, the Director of Digital described to us the data currently available to units. This did not provide the further analysis required to investigate previous points raised. It was agreed that this action would be taken forward. Management should undertake further analysis and clinical scrutiny of TOMS data in relation to the timing of WHO Checklist completion. It may be useful to focus audits.	**M**	Discussion with Theatre management leads and IT have confirmed that the completion data held in TOMS is designed to be completed retrospectively rather than during the WHO checklist process to ensure staff are focussed on effective communication. This means that any timing data will not reflect actual data collection, making any analysis of this data unreliable. Discussed with Internal Audit and the limitations of TOMS data agreed. No further analysis of TOMS data planned. Compliance will be measured by in theatre audits of practice.	23/04/2021	**August 2022:** Limitations of TOMS data are described in the original management response. EMD has written to Service Group MDs and Clinical Director for Theatres to establish monthly audits of practice to be shared with SGMDs and cascade to Directorates. Improvements to be addressed through SGMDs working directly with Clinical Directors/Clinical Leads for relevant services within their Service Group and progress monitored through Directorate and Service Group Q&S meetings. Deadline: October 2022.	31/10/2022
6	On review of the letter issued by the Executive Medical Director to the Units it notes under action point 4: 'Please ensure that compliance data and observational audit outcomes are included as a standard item on your agenda for your Delivery Unit Quality and Safety meetings. It would also be appropriate for you to ensure that key Directorates within your Units also have audits of WHO Checklist compliance on their own Quality & Safety meeting agendas regularly.' As part of the follow up, we reviewed the Unit Quality & Safety minutes and papers for each of the units to ensure that regular updates on TOMs data and WHO Checklist compliance audits have been issued to the groups for assurance. The following was noted: **Singleton Delivery Unit -** The Unit's Quality & Safety Group papers from March 2020 to December 2020 were supplied for review. On review of the minutes and papers, no review data or WHO Checklist compliance audit outcomes were identified during this period. **Morriston Delivery Unit -** Quality & Safety Unit papers for 2019/20 and 2020/21 were supplied for review. No compliance data or observational audit outcomes were identified within notes of the meetings between October 2019 and November 2020. **Neath Port Talbot Delivery Unit -** As noted in objective 5b, the NPT Unit have issued regular updates on WHO Checklist compliance audits to the Quality, Safety &	**M**	Unit medical directors have been reminded to ensure that the results of LocSSIPs (including the WHO) checks should be included in unit quality and safety meetings. (See recommendation 3 in relation to TOMS data)	30/06/2021	**August 2022:** Executive Medical Director has written to all service groups requesting that TOMS compliance data are standing items on the agenda at Service Group Q&S meetings on a quarterly basis, beginning in September 2022 and that the discussions will be reflected. EMD has ask Service Group MDs to ensure that the same compliance data are discussed at monthly directorate meetings in relevant specialties (SGMDs to communicate to relevant directorates in their service group). Deadline: October 2022.	31/10/2022

	Improvement Group. As indicated in the Executive Medical Director's letter, assurance regarding TOMS compliance data and observational audit outcomes should be reported periodically to service group Quality & Safety groups and discussed at appropriate Directorate meetings.					
7	On completion of the previous review, the Executive Medical Director contacted the Director of Nursing & Patient Experience at the time suggesting that the checklist audit outcomes be issued to the Quality & Safety Forum (now the Quality & Safety Governance Group) on a bi-annual basis. No reports on this were evident in papers of the Quality & Safety Forum / Quality & Safety Governance Group from September 2019 – January 2021. A paper to the QSC in February 2020 set out intended improvements to governance arrangements. These included the establishment of a Clinical Outcomes and Effectiveness Group (COEG), which would be a sub-group of the corporate Quality and Safety Governance Group. The onset of the pandemic has delayed progress on actions intended. In particular, at the outset of the review the Assistant Medical Director informed us that the COEG was still forming and not yet operating fully, so the intended route for assurance to the Quality & Safety Governance Group was not yet in place. We would recommend that a reporting line for corporate assurance on WHO Checklist compliance be implemented.	**H**	Review of LocSSIPs audits will be undertaken at COEG and both Unit/Board Q&S groups. Both groups have been informed of this requirement and have agreed to require reports.	30/06/2021	**August 2022 (RE):** COEG to receive monthly exception reports on actions being taken and improvements in compliance. Deadline October 2022.	31/10/2022