APPENDIX C

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

Executive Lead - Chief Operating Officer						
ABM 14-15-003	**Disability Discrimination Estates Compliance**			**Report Issued March 2015**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
4	Costs to achieve compliance with DDA identified in Estates Facilities Performance Management System (EFPMS) data could not be reconciled to previously commissioned disabled persons access reports. Procedures will be established to demonstrate the derivation of EFPMS declared compliance costs (including reconciliation to surveys)	**M**	Agreed - However, the DDA act requires the Health Board to make services available to all patients, visitors and staff. Therefore in some cases there is no need to take action until a concern is raised over the accessibility to the service provided. Whilst it is important for the Health Board to address the fundamental accessibility issues such as disabled access through doors, hearing loops etc. More specific actions are only required if the Health Board cannot provide those services within its existing estate.	31/08/2018	**December 2021** Following meetings with the Chief Executive and Director of Strategy in August 2021, it was agreed that the Health Board will go to tender for the provision of the Six Facet Survey including DDA review. The contract for this work has been awarded to a company on the NHS Shared Business Services framework, and initial meetings have taken place. It is anticipated that the work will be completed by 31st March 2022. This work will quantify the value of the health board's maximum exposure under DDA in terms of repairs and new provisions.	01/04/2022

Executive Lead - Chief Operating Officer						
ABM 1617-009	**Backlog Maintenance**		**Report Issued October 2017**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management has stated that association with the ARCH collaboration is seen as a mechanism to address the longer strategy for Estates. However, there is no narrative information to support the detail of the longer term strategy / direction of the UHB; and is subject to the success of the collaboration which has yet to be tangibly demonstrated. Management will draft and issue an Estates Strategy which specifically identifies the longer term direction of the UHB, how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed i.e. targets for reducing significant backlog and how it is to be achieved in terms of capital delivery plans	**H**	The directorate, as part of the Arch project, is developing an overarching strategic plan for its estate. This will be based upon the six-facet survey that the Health Board is seeking to commission this financial year. The Health Board is developing specification for the completion of a six-facet survey, which will allow the Health Board to take an informed review of the estate under its control. The Health Board had approached Welsh Government for central funding for the provision of a six-facet survey as this had been centrally funded for another Health Board. However, the Health Board has not had confirmation of this funding and therefore is seeking to start the process utilising existing discretionary capital.	31/12/2018	**December 2021** Following meetings with the Chief Executive and Director of Strategy in August 2021, it was agreed that the Health Board will go to tender for the provision of the Six Facet Survey including DDA review. The contract for this work has been awarded to a company on the NHS Shared Business Services framework, and initial meetings have taken place. It is anticipated that the work will be completed by 31st March 2022. The health board has engaged consultants to support to support the development of the estate strategy in line with the clinical service strategy. A meeting to agree the project plan has been scheduled for early January 2022. It is envisaged that the estates strategy will be produced by 31st March 2022, which will address the management of the estate, including backlog maintenance.	01/04/2022
4	With regard to the maintaining of the detail on OAKLEAF, it has been observed that the updates are not appropriately delegated. The Assistant Director of Strategy (Estates) currently updates and maintains the system on an annual basis, rather than the system being updated from an operational basis with greater frequency. OAKLEAF categorises all assets by condition and risk, an exercise which will be performed on an annual basis. However, it was not evident that this information was extracted from the system to assist in the categorisation of work when bidding for capital funding; rather reliance placed on accumulated knowledge used to populate the departmental risk register The ownership of managing the OAKLEAF system will be reviewed to ensure timely, operational information is reflected	**M**	The Assistant Director of Strategy (Estates) formally coordinated the OAKLEAF return completion. In June 2017 he updated the database and advised each of the Estates Managers that they were now responsible for maintaining the information within the OAKLEAF system. Capital bids can only be made if the item is listed within the backlog maintenance system (excluding statutory work). Each estates department has a performance review every 6 to 8 weeks. It is now intended that this review will include backlog as an agenda item.	01/12/2018	**August 2021** The department transferred its significant and high risks from the Oakleaf system into the DATIX system. Governance undertaking a review of the risk register in September, following review the risk register will be presented at scrutiny panel in October. Evidence from senior team meetings will be forwarded to Internal Audit to evidence that the process is in place.	None Entered

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
7	The last recognised date for the completion of a condition survey is circa 2005. Consequently, backlog maintenance costs are not properly stated. The UHB is in the process of developing a specification for the requirement of completion of a full condition survey on a room by room basis. The development of the specification will be finalised as soon as possible to facilitate the provision of a current 'market' backlog maintenance cost. This information will further assist in identifying the significant capital projects required to ensure the UHB sites are 'fit for purpose'	**M**	The Health Board is seeking to commission a six-facet survey this financial year. The Health Board is developing a specification for the completion of the survey, which will allow the Health Board to take an informed view of the estate under its control. The Health Board had approached the Welsh Government for central funding, for the provision of the survey, as it had been centrally funded for another Health Board. However, the Health Board has not had confirmation of this funding and, therefore, is seeking to start the process utilising existing discretionary capital.	01/10/2018	**December 2021** Following meetings with the Chief Executive and Director of Strategy in August 2021, it was agreed that the Health Board will go to tender for the provision of the Six Facet Survey including DDA review. The contract for this work has been awarded to a company on the NHS Shared Business Services framework, and initial meetings have taken place. It is anticipated that the work will be completed by 31st March 2022.	01/04/2022

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

Executive Lead - 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 over arching policy/procedure will be developed for the management of all external regulator / inspection reports that will bring together the various processes currently operating for dealing with HIW, CHC, HSE and other, to ensure that any action required is appropriately managed and the HB is assured that all actions are complete and any lessons to be learned are disseminated in a timely and robust way.	31/01/2020	**December 2021** This work is being taken forward by the Interim Director of Corporate Governance in conjunction with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Director of Strategy, and links with quality governance and strategy work which is currently being taken forward as part of the Board Effectiveness Assessment Action Plan. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan	31/05/2022
2	The CHC reports were not being discussed at committee level. We would recommend reports on the "external papers" that go to the Quality and Safety Committee include those CHC reports that were issued in the period.	**M**	Reports on the "external papers" that go to the Quality and Safety Committee will include those CHC reports that were issued in the period. The Assistant Director of Strategy & Partnerships will provide the necessary details to the Head of Patient Experience, Risk & Litigation to incorporate in Committee reports.	30/10/2019	None Provided	None Provided
4	Neither the Board nor any of its Committees have received assurance that issues arising from CHC reports have been actioned. However, it is noted that the COO and other Directors have regular Liaison meetings with the CHC to provide assurance that their reports are being appropriately managed. The Director of Nursing and Patient Experience should ensure that CHC reporting follows the same approach as HIW reports and appropriate information and assurance is given to the Quality & Safety Committee.	**M**	The Director of Strategy will ensure that CHC reporting follows the same approach as HIW reports and appropriate information and assurance is given to the Quality & Safety Committee.	30/10/2019	None Provided	None Provided
5	During our observation visit, we found areas that had recurring issues. Management should consider how they address issues of custom and practice that is resulting in repeat non-compliance with policies and procedures.	**M**	The policy (ref action 1 above) will set out a process for managing repeat non-compliance with policies and procedures to identify the issues and actions required by Units / specialist corporate staff / groups / committees.	31/01/2020	**December 2021** This work is being taken forward by the Interim Director of Corporate Governance in conjunction with the Interim Executive Director of Nursing & Patient Experience, Executive Medical Director and Director of Strategy, and links with quality governance and strategy work which is currently being taken forward as part of the Board Effectiveness Assessment Action Plan. Noting the above, date extended to 31/05/2022 to align with timescales within the Board Effectiveness Assessment Action Plan	31/05/2022

Executive Lead - Chief Operating Officer						
ABM 1920-007	**Capital Systems Financial Safeguarding**			**Report Issued November 2019**	**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2	Failure to comply with SO's/SFI's and Local Framework requirements in respect of: – Failure to use formal contracts (as opposed to simple orders) for procurements in excess of £25,000 [this is regardless of whether they are on a framework or not] – Failure to undertake financial vetting for new contracts/procurements in excess of £25,000 – Failure to apply Standards of Business Conduct requirements in respect of the completion of Declarations of Interest Local Framework Procedures and SFI/SOs should be reviewed, and updated where appropriate, to reflect the Estates Department's requirements.	**M**	Discussions will be initiated with the Director of Corporate Governance and the Assistant Director of Strategy – Capital to ensure that all procedural requirements are fit for purpose (e.g. SO/SFI and Local Framework Protocols).	01/01/2020	**December 2021** Estates management are now working with Capital colleagues in order to ensure that all procurements over £25,000 have appropriate contractual arrangements in place. SFI's have been reviewed and updated since the audit was undertaken, and no longer contain the references to financial vetting quoted within the report. The Health board's position with regard to financial vetting is currently being reviewed by Finance colleagues, with a view to clarifying requirements and processes within both the Capital and Estates Teams. The proposed utilisation of contractor assurance systems will also be considered as part of this review. It is anticipated that this work will be completed by the end of January 2022. The department now do an annual declaration of interest review with staff asked to confirm that they are not aware of any conflicts of interest. The procedure also requires staff to advise managers if they become aware of a conflict of interest as soon as it occurs. A copy of the recently revised Standards of Business Conduct will be circulated to all relevant staff, with particular reference made to the need to ensure that declarations of interest pro-forma are completed for ALL relevant procurement processes.	31/01/2022
3	Estates procurement activity was reviewed for the period April 2018 to July 2019, including an examination of all relevant Estates cost centres to determine patterns of unusual activity. This identified a significant number of individual orders below £5,000 in value placed with certain contractors. These were reviewed in more detail and discussed with Estates managers, and it was confirmed that: – The above relate primarily to maintenance/repairs – No formal competitive exercises had been undertaken to confirm that these contractors provided best value; – No competency vetting (including, e.g. appropriate industry accreditation checks, health and safety policies etc.) could be demonstrated – Mgmt. advised that the refrigeration contractor's qualifications should be held within an online portal, however evidence was not provided. – Declarations of interest proforma had not been completed (see also the Capital Systems report 2018/19). The Estates department utilises maintenance contracts	**H**	Agreed. Appropriate procurement controls will be developed for utilisation within the estates department. These will specifically consider repeat/multiple orders with key contractors/suppliers.	31/12/2019	**December 2021** A review of maintenance requirements and spends has been completed by the department. As a result, contracts are currently in the process of being put in place for the following, which represent the highest areas of maintenance spend within the health board: • Water Management Risk Assessments (Legionella Testing) – Contract awarded • Refrigeration Maintenance – Specification with NWSSP Procurement Services • Boiler Maintenance – Specification with NWSSP Procurement Services • High Voltage Maintenance – Contract Awarded It is anticipated that contracts for boiler and refrigeration maintenance will be in place by 1st April 2022 Generally, orders under £5k are placed with companies who have already demonstrated that they provide best value during previous larger competitive processes. The Assistant Director of Operations (Estates) will now write to all Estates Managers reinforcing this practice. In addition, the department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include reviewing contracts in place, and working with Procurement colleagues to ensure that we have robust systems in place. The department are adopting the CHAS contractor assurance system which will	30/04/2022

	to manage longer-term requirements for the provision of maintenance and inspection/testing services for estates infrastructure/ equipment, and in some instances the associated breakdown and repair works. Effective from January 2018 the local NWSSP Procurement Services Maintenance team manages a number of these maintenance contracts. However, it was evident from the above, that not all maintenance areas are covered by appropriate contract arrangements. Note: see also Water Management, COSHH, Backlog Maintenance, Capital systems (2018/19) reports previously issued re: maintenance contracts etc. Appropriate procurement controls should be implemented for contractors employed below current quotation thresholds				provide assurance around a prospective contractor's: – Health & safety policies – Staff training records – Insurances – Financial details The department are also currently going through a competitive process to engage a second assurance company whose services will supplement/complement the above. It is envisaged that these systems will be implemented from April 2022. The department now do an annual declaration of interest review with staff asked to confirm that they are not aware of any conflicts of interest. The procedure also requires staff to advise managers if they become aware of a conflict of interest as soon as it occurs. A copy of the recently revised Standards of Business Conduct will be circulated to all relevant staff, with particular reference made to the need to ensure that declarations of interest pro-forma are completed for ALL relevant procurement processes."	
4(a)	Lack of appropriate procurement controls for cumulative spends in excess of £5,000 relating to maintenance contracts (see 3 above) An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented.	**M**	Accepted. A review of all maintenance contract requirements across the estate will be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee for consideration and action as appropriate.	01/01/2020	**December 2021** A review of maintenance requirements and spends has been completed by the department. As a result, contracts are currently in the process of being put in place for the following, which represent the highest areas of maintenance spend within the health board: • Water Management Risk Assessments (Legionella Testing) – Contract awarded • Refrigeration Maintenance – Specification with NWSSP Procurement Services • Boiler Maintenance – Specification with NWSSP Procurement Services • High Voltage Maintenance – Contract Awarded It is anticipated that contracts for boiler and refrigeration maintenance will be in place by 1st April 2022 In addition, the department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include reviewing contracts in place, and working with Procurement colleagues to ensure that we have robust systems in place.	30/04/2022
8	We sought to confirm that financial vetting had been undertaken where appropriate (i.e. for contractual arrangements over £25k in value). Financial vetting had not been undertaken at any of the 8 procurement exercises reviewed over the £25k threshold requirement. Financial vetting should be undertaken prior to entering into any contractual arrangement above £25k in value (in accordance with Standing Financial Instructions). Estates should liaise with Finance and Capital Planning to establish requirements for financial vetting at the Local Framework.	**M**	Agreed. Advice will be sought from UHB Finance and Capital Planning, together with NWSSP Procurement Services colleagues to determine an appropriate way forward.	01/01/2020	SFI's have been reviewed and updated since the audit was undertaken, and no longer contain the references to financial vetting quoted within the report. The Health board position with regard to financial vetting is currently being reviewed by Finance colleagues, with a view to clarifying requirements and processes within both the Capital and Estates Teams. The proposed utilisation of contractor assurance systems will also be considered as part of this review. It is anticipated that this work will be completed by the end of January 2022.	31/01/2022

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
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	The department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include the production of formal procedures for the management of estates stores. This will include the review and implementation of best practice in this area. The department are also in discussions with NWSSP Procurement and health board Finance colleagues to re-instigate independent end-of-year stocktakes. It is anticipated that a stocktake will be undertaken by the end of April 2022. Based on the above, the deadline date has been extended to 30/09/2022 in order to take account of the recruitment process and a period of local induction and familiarisation for the appointed Procurement Officer	30/09/2022
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	The department are currently in the process of recruiting a Procurement Officer, whose responsibilities will include the production of formal procedures for the management of estates stores. This will include the review and implementation of best practice in this area. The department are also in discussions with NWSSP Procurement and health board Finance colleagues to re-instigate independent end-of-year stocktakes. It is anticipated that a stocktake will be undertaken by the end of April 2022. Based on the above, the deadline date has been extended to 30/09/2022 in order to take account of the recruitment process and a period of local induction and familiarisation for the appointed Procurement Officer	30/09/2022

Executive Lead - Chief Operating Officer						
SBU 2021-025		**Infection Control - Cleaning**		**Report Issued January 2021**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	There is no over-arching policy or strategy in place setting out roles, responsibilities and lines of accountability for cleanliness Roles, responsibilities and lines of accountability for cleanliness, should be described within a formal, documented policy for consideration at the Infection Control Committee. (There are examples at other health boards that could provide a basis for development.)	**M**	Agreed – current cleaning strategy and general cleaning plan to be prepared. Papers will be taken to Infection Control Committee with the aim of agreement in April 2021 – though this will depend on the input and views of other services. Progress (including any changes to timescales) will be reported to ICC.	30/04/2021	**December 2021** A document was prepared and shared with the Infection Control Committee on the 8/02/21. Comments were requested and have been received. A revised version will be presented to the next Committee meeting on 26/01/2022	26/01/2022
3	Domestic services 'work schedules' provide guidance on the frequencies of cleaning expected in different areas. Our review has shown that for some areas frequencies did not align with the Cleaning Standards. Out of 28 areas reviewed, four did not match for 'full' cleans and seven did not match for 'check' cleans. At another organisation, where an over-arching cleaning policy has been adopted, minimum cleaning frequencies (and those functions responsible for the elements listed) have been appended giving the expectations greater visibility for all functions responsible and for clear oversight. A) Work schedules should be reviewed to ensure alignment with cleaning frequencies of elements as outlined within Appendix 2 of the Cleaning Standards (2009). B) Frequencies should be appended to the policy document previously recommended for consideration at Infection Control Committee	**M**	A) Agreed - Project and performance manager to update work schedules. B) Agreed - Head of Support Services to include this information in cleaning strategy	20/02/2021	**December 2021** The document was tabled at Infection Control Committee (ICC). Unfortunately due to an oversight it was not formally approved. It was discussed again at the last ICC, and it was agreed it would be tabled again at the next meeting so that it could be formally adopted. The meeting was due to take place on 14/12/2021, however has now been postponed until 26/01/2022	26/01/2022

Executive Lead - Chief Operating Officer						
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	**M**	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).		**December 2021** The department are adopting the CHAS contractor assurance system which will provide assurance around a prospective contractor's: – Health & safety policies – Staff training records – Insurances – Financial details The department are also currently going through a competitive process to engage a second assurance company whose services will supplement/complement the above. It is envisaged that these systems will be implemented from April 2022. This will allow us to ensure that any contractors appointed have appropriate documentation in place. Where companies do not have accreditation, they will be specifically asked for documentation prior to award.	01/04/2022
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.		**December 2021** The Department are currently reviewing the Control of Contractors Policy, which will include the requirement for contractors to provide information on their insurance where appropriate.	31/01/2022
4	Management advised that there were plans to introduce a more formal competency procedure within Estates. A spreadsheet template had been created, with pre-determined questions to ensure that contractor information in key areas such as H&S policies, competencies, cub-contractor arrangements, risk assessments, insurances etc. has been checked. However, this was not in use at the time of fieldwork. Estates should finalise and apply the new contractor evaluation spreadsheet at all appropriate new appointments	**M**	Agreed. The evaluation spreadsheet will be introduced for use in Financial Year 20/21.	31/07/2021	**December 2021** The introduction of the spreadsheet has been delayed due to COVID pressures, but will now be in place by the end of January 2022. Going forward, the health board are looking to adopt the use of external assurance processes for 2022/23.	31/01/2022

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
5(a)	The UHB's last in-house audit of induction compliance undertaken at the time of audit fieldwork (dated March 2018) (see also finding 8), which identified that on average 36% of contractors/operatives (at the Morriston & Singleton sites), who had signed in to work on site during March 2018 had not received an induction. Whilst management advised that improvements had been made following those results, a follow-up audit had not been undertaken by the UHB at the time of this review, to determine current compliance rates. Subsequent to the conclusion of the audit fieldwork (January 2020), a new in-house audit of induction compliance rates was undertaken by the Estates team. This audit found reduced compliance from that previously reported. Contractors/operatives should not be allowed to commence work on site without having received an induction.	**H**	Agreed. Estates Managers will be reminded of the need to ensure all contractors have received appropriate induction.	21/04/2021	**December 2021** Estates managers have been reminded of the need to ensure that all contractors have received appropriate induction. The health board are currently looking to adopt a 'swipe card' system as part of their assurance processes, which will identify on arrival any contractor who has not undergone formal induction, and send an automatic alert to estates staff who can then take the necessary action. It is anticipated that this system will be in place by April 2022.	30/04/2022
6	One instance was highlighted where a contractor had not provided a Risk Assessment/Method Statement. This is contrary to the Management of Health & Safety at work Regulations (1999) and UHB requirements. Jobs should not be permitted to commence unless a Risk Assessment and Method Statement has been provided by the contractor	**M**	Agreed. Whilst for some tasks this is required, we need to review how this will be policed as a number of firms will just provide a generic Risk Assessment, as they are the same each time work is undertaken. This should be quantified in line with risk, as generic Risk Assessment for laying flooring or fitting a sign will be the same due to the level of risk. Management will identify tasks which require a Risk Assessment and Method Statement to be reviewed.	21/04/2021	**December 2021** The Assistant Director of Operations (Estates) will again write to all Estates Managers reminding of the need to ensure that RAMS are provided prior to the commencement of all jobs, and reviewed appropriately.	31/12/2021

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

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

Executive Lead – 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**
1	The Senior Information Risk Officer (SIRO) produces an annual report which includes reporting on compliance for IM&T across the health board and includes items related to IG, data and cyber security and as such identifies most of the key areas of required legislative compliance.This process is incomplete however as there is no consideration of the Payment Card Industry Data Security Standard (PCI/DSS) and there is no full register or record of the existing compliance requirements or the consequences of non-compliance within Digital.In addition, there is no process to fully assess the status of compliance and report upwards to committee for all items such as PCI/DSS. Consequently, the committee may not be fully aware of the assurance it needs to seek over compliance with external requirements, or indeed how well the health board is complying in its entirety. A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.	**L**	A review of appropriate compliance requirements will be undertaken (June 21) and a process for reporting to Audit Committee established (Sept 21)	31/08/2021	**December 2021 Update** A comprehensive register of compliance requirements for IM&T legislation has been difficult to obtain. A request to Heads of IT across NHS Wales has been issued and the HB are awaiting a response	None Entered
5	There are some departments that manage their own systems and these do not fully fit within the digital structure. Whilst there is an expectation that they will comply with the digital way of working, and there are structures in place to share information and requirements, the mechanisms for assurance are not fully formalised, particularly for items such as change control where there is no organisational policy or procedure. Departmentally managed systems should comply with good practice for the management of digital. Digital services should produce good practice guidance documentation for the health board overall, with all departments required to comply for areas such as change control.	**L**	Digital Services will develop a change control guidance document to share with the relevant devolved Digital Services.	30/11/2021	**December 2021 Update** Change control guidance document being drafted and will be presented at the next DSMG to be signed off in January.	None Entered
10	There is no full, formal documented continuity policy or statement for digital services that sets out the risks, measures taken, residual risk linked to a time based impact assessment for the organisation, the actions that digital will take and the RTO / RPO for each of the IT systems used within the health board. As such not all executives and stakeholders may be aware of the full continuity position and risk. System support priority is agreed with stakeholders on system implementation and the option to improve support is provided with associated costs. However, as the RTO/RPO are not fully defined then stakeholders may not	**L**	Digital Services will summarise the information held within the Service Catalogue into a Digital Services Business Continuity Statement to be shared with the SDUs.	30/11/2021	**December 2021 Update** RTO/RPO being developed and will be signed off by DSMG in January	None Entered

	be fully aware of the residual risk to their service. A full business continuity policy or statement for digital should be developed that sets out: • Risks to service • Mitigations in place • The residual position • The effective RTO/RPO for each service level This should be agreed by the health board services, with options to improve positions if required.					

Executive Lead – Director of Finance						
SBU 1920-016		**Procurement No PO – No Pay**		**Report Issued December 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	The Service Level Agreement between SBU and NWSSP for the provision of procurement services was inconsistent with those relating to other NWSSP function, and not as clear on the respective roles & responsibilities of each. We would recommend that the Health Board liaise with colleagues in the NWSSP to enhance the clarity of its SLA to ensure roles & responsibilities are clear.	**M**	It is noted that the SLA for the provision of Procurement Services by NWSSP to SBU requires more clarity with regard to respective roles and responsibilities of each organisation. The relationship between both parties has developed significantly since the introduction of a shared service model but this has not been reflected formally through the SLA. The SBU Head of Accounting and the NWSSP SBU Head of Procurement will meet in January 2020 to discuss and agree the respective roles and responsibilities for each organisation. This will be reviewed and approved by the SBU Director of Finance and the NWSSP Director of Procurement Services with an updated agreement in situ by the end of March 2020	31/03/2020	**December 2021 Update** This action has been superseded by a review of all SLA's as part of the deployment of the National Operating Model (NOM) for procurement, which is expected to be completed by April 2022. The NOM for procurement will be presented to Health Boards in February 22. Deadline extended to 30/04/2022 based on the above	30/04/2022

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.	**High**	Agreed. A policy/guidance will be composed.	01/09/2018	**December 2021** A guidance document has been drafted and is currently under final review. It is anticipated that this will be issued on or before 01/02/2022. Given the specific issue highlighted within this audit, W&OD will work with management to ensure its implementation within Support Services. Revised Deadline Date – 01/02/2022	01/02/2022
ABM 1819-042	**Junior Doctors Bandings Follow Up**		**Report Issued April 2019**		**Reasonable Assurance**	
1	On the recommendation of a previous audit review, Medical HR composed a draft document giving guidance on Junior Doctors Hours. The guidance outlined: - The requirements of junior doctors in terms of WTD compliance and Natural Breaks. - The need for operational service support for the monitoring process. The document was presented to the Local Negotiating Committee (LNC) where, we were informed, there was disagreement to some of the content (exception forms) by some attendees, so the guidance was not progressed any further at that time. It was also noted that a guidance document for handover procedures was also drafted, but also progressed no further. There was no progress on a policy/guidance on the use of hospital pager bleeps. We would recommend that the Medical Director, with the support of the Director of Workforce & OD, consider review of draft policies and procedures and progress their development and formal adoption.	**M**	This action is agreed by management. It should be noted there has been extensive resistance from the LNC to the adoption of the guidance and in particular the use of the exception form. We need to liaise with the newly constituted LNC for Swansea Bay UHB and junior doctors reps but after this, irrespective of views expressed, the documentation will be implemented.	30/06/2019	**November 2021** Action yet to be progressed due to workforce pressures and other priorities. Aim is that matters progress Q1/2 2022/23. It should be noted Wales is currently exploring a new junior doctor contract and if adopted this will remove the need to monitor under the New Deal arrangements	30/06/2022

Executive Lead – Director of Workforce & Organisational Development						
ABM 1819-043		**Staff Performance Management and Appraisals**		**Report Issued April 2019**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	The Workforce risk register recognises that maintaining current levels of PADR compliance will remain a challenge until structures are stabilised and the roll out of ESR self and supervisor self-service are complete. Whilst there has been Board level discussion of using ESR more effectively within the Health Board, timescales for implementing supervisor self-service have not been set out yet. Whilst resource is focused on the Bridgend transition arrangements at the end of March 2019, we would recommend that responsibilities and the future ownership of ESR be agreed at Executive level and that the Lead Executive agrees Supervisor Self Service rollout plans and timescales.	**High**	As part of the review of corporate executive responsibilities, it has been agreed that responsibility for ESR will transfer from the Director of Finance to the Director of Workforce and OD from April 2019. In preparation for the development of a full functionality deployment plan, the national ESR team have already conducted a site visit (November 2018) to assess preparedness and support the development of a full functionality roll out plan. A timetable and roll out plan for the deployment ESR self-service and other un-utilised ESR functionality cannot be developed without the identification and deployment of additional resource to undertake the significant digital transformation programme. ABMU is a number of years behind other organisations in Wales in respect of the utilisation of ESR and the resourcing of the ESR team will need to be enhanced to take the required deployment forward. The pace of the deployment of ESR functionality across the Health Board will be dependent on the resource investment agreed to support this programme of work. Until this issue is resolved the timescales for full deployment cannot be agreed. However, capacity issues are subject to discussion at Executive Director level currently and it is intended to provide the Workforce & OD Committee with the vision and route map for use of the system by the end of June.	01/06/2019	**November 2021** Proposals for the transfer of ESR and the rollout of ESS, SSS, and MSS have been drafted and will be presented to executives for review before the end of the calendar year.	31/12/2021

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

Executive Lead – Director of Workforce & Organisational Development						
SBU 1920-032			**WOD Directorate**	**Report Issued August 2020**		**Reasonable Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	We were provided with details of WOD directorate staff PADR status. Performance to October 2019 indicated the directorate was 14% below the Health Board average of 67%. Analysis against directorate staff individual status highlighted that the majority listed as expired were overdue by only a few months - 85% of staff were either in date or with 3 months of expiry. Whilst management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit). We recommend management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit).	**H**	It is noted that the Trade Union Officers PADR is not completed by the WOD function. Following the audit targeted work began to ensure all WOD PADRs were completed. This meant that compliance rose to 73% in January 2020. Due to the COVID-19 pandemic it is recognised that the WOD PADR compliance has fallen to 55%. The funding to ensure that WOD are able to continue to function which was agreed early 2020 has been on hold meaning that gaps remain in management structure. Due to the uncertainty of the situation, the redeployment of people and reassignment of tasks PADRs may not take place at due dates. Management can reassure that discussions around wellbeing and tasks are continuing. The completion of PADRs will be dependant on no second wave of the pandemic, a return to a more normal way of working and recruitment into posts.	01/03/2021	**November 2021** Plan to complete PADR underway however due to the various changes in senior personnel this has impacted progress.	None Entered

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

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1516-008		Health & Safety Primary Care Estates		Report Issued March 2017		Reasonable Assurance
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
1	Other than defining the lead for Estates input, the Health & Safety Policy does not reflect the key Estates contribution to the management of Health & Safety. The Policy lacks clarity on the accountability, responsibilities, reporting lines and interaction with the Health & Safety Manager. The Health & Safety policy will be updated to clearly define the role of the Estates function (as relating to the Health & Safety Manager) – detailing any accountability, responsibilities, reporting requirements etc.	**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.	31/07/2018	**Undated** This will be discussed at the next H&S Committee to ensure there is a balanced account of the relationship with estates when compared to all other departments linked with. **February 2019** Policy will be reviewed to be fit for when New Health Board is implemented. Policy will be developed by the operational Health & Safety Committee, with input by Estates, with final approval by ABMU Health board Committee. Revised deadline date of October 2019 **Undated** Please extend until 31 March 2020 **Undated** Due to COVID Please extend until December 2020	31/12/2020

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1819-009	**Water Safety 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	**August 2019** SLA has been put in place for water testing in SBUHB with the public Health however they are unable to do legionella testing at the scale and level required. Contract currently being discussed with a view to be agreed by December 2019. **Undated** Water safety plan now states that one area should be tested once a month - Testing is taking place - formal contract not currently in place **June 2021 (Follow Up Report)** Partially Implemented An original deadline of July 2019 was agreed for this recommendation. The follow up audit (June 2020) determined that no progress had been made and a revised deadline of September 2020 set. At the time of the audit, a draft tender specification for water testing had been developed, but not finalised and agreed. In the meantime, some water testing has still been undertaken, with the limited resource available (both within the UHB and at the testing laboratory); and focused on high risk areas (e.g. augmented care units). It is acknowledged that wider testing is not mandatory but is a goal for the UHB. It is recognised that the COVID pandemic has impacted both laboratory service delivery and availability of resources within Estates*	30/09/2020

***Updates provided in respect of outstanding actions relating to other NWSSP Audit & Assurance Reports indicate that a contract for Water Management Risk Assessments (Legionella Testing) has been awarded, however no such update has been entered in respect of this recommendation.**

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

Executive Lead – Executive Director of Nursing & Patient Experience						
ABM 1920-006		**Health & Safety**		**Report Issued March 2020**		**Limited Assurance**
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3i	The HSOG terms of reference indicate that it will receive reports for information and advise the HSC on a number of subjects, including KPIs. It has not received any papers on KPIs to date. We would recommend that a suite of KPIs be developed at HSOG and used for monitoring and reporting to HSC.	**M**	HSOG are reviewing the outcomes covering the various subjects and from this develop KPI's for the group, i.e. Actions from the various surveys'/audits/inspections/COSHH etc. - examples of KPI's: H&S subjects - Fire RA completion - Asbestos Assessments - Water assessments	31/08/2020	**Undated** Draft KPI's submitted to the H&S Ops Group in May 2021 and the H&S committee in July 2021, with the HB adopting these going forward and will form part of the key issues report from H&S Ops to H&S committee in Q3 2021/22. Based on the above, deadline has been extended to 31/12/2021	31/12/2021
3ii	Within Estates Services and elsewhere there are a number of Health & Safety related management groups (such as Medical Gases, Fire Safety, Water Safety, Safer Sharps). Whilst some reporting is evident via the Estates report, the operational and reporting expectations of the specialist groups have not been set out with the same clarity as those for Unit groups. We would recommend that Management review the reporting expectations from the specialist groups to ensure that their objectives, work plans and reporting arrangements support the work of the Health & Safety Operational group and the assurances to the HSC in turn. Additionally, as has been adopted by Unit H&S groups, we would recommend that calendar arrangements be reviewed to assist in action completion. Scheduled reporting from the groups should then be included within the HSOG Forward Work Plan.	**M**	A review of the 14 sub groups has taken place and it is the intention of the HB to introduce an overarching group - Water Environment & Buildings (WEB), this will concentrate on the compliances in each of the areas, all of which will have KPI's and appropriate action plans. A HB dashboard will be produced to provide an overview of compliance.	31/08/2020	**Undated** Due to the on-going challenges with COVID-19 and the enhanced programme to meet the operational backlog of patients this has been deferred to 2022/23 financial year. Based on the above, deadline has been extended to 30/04/2022 for further update	30/04/2022
4	Risks and concerns as reported through HSOG within the Estates report have lacked clearer detail when transferred to the HSOG key issues report provided to the HSC. We would recommend the Key Issues report provided to the HSC be enhanced to capture clearer updates across the specialist areas which currently feature within the Estates report.	**M**	This will be picked up with the introduction of the WEB group	31/08/2020	**Undated** Due to challenges of COVID - 19 this has been postponed to end of Q1 2021/22. **Undated** This will be picked up in the key issues report from September 2021	30/09/2021

Executive Lead – Executive Director of Nursing & Patient Experience						
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	**Undated** Unable to access the website, contacted IT for support and currently awaiting response. New completed date 31st March 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. **Undated** No further update at this stage	31/03/2021
7(i)	Our previous report highlighted that of the 78 actions contained within the 2019/20 Improvement Plan only 17 were listed as complete, and that as part of closure of 2019/20 and as part of developing longer term strategies, the status of those actions remaining outstanding should be reported. The pandemic has had an impact both on the resource with which to address plans early in the year, and on the need to refresh the content of plans. It is apparent from our review of papers that there has been ongoing discussion on the development of the Strategic Action Plan for 2020/21 which has been received at HSC meetings in June, September and December 2020. Meeting notes of both the HSC and the Health & Safety Operational Group do not record effectively how the original 2019/20 improvement plan was closed. We note though that it is intended that an operational plan to support the strategic plan will be developed to support the SAP. We recognise that priorities have changed this year and new approaches and fresh plans may be appropriate. A plan has been presented to HSOG setting out how the health & safety function will support wider services. It has been too early to demonstrate the effectiveness of monitoring of progress against plans, noting that the development of the SAP has been ongoing during 2020/21 – so the principle of our previous recommendation remains to be addressed. We have none the less updated the recommendation as detailed below. Additionally, we would note that the term ‘action plan’ is often used interchangeably in papers and agendas making the distinction unclear and the content of minutes of discussions and decisions at the HSOG does not assist clarity. This has been reflected in the revised recommendation for point 7(ii).	**H**	Due to the on-going challenges with COVID-19 and priorities being focussed in other areas and the realisation of the SAP original dates being over optimistic, the SAP has been updated and presented to the HSC in December 2020, it was agreed that the plan will be for 2021/22 financial year. This will be relayed to the HSOG in the meeting scheduled 03/02/21. The SAP will be monitored through the HSOG and updates provided to the HSC for scrutiny	31/3/2021	**August 2021** The plan has had to be revised to accommodate the COVID-19 challenges and will be fully reviewed in Q4 (2021/22), this will enable realistic dates to be identified and for the revised SAP to go back through the H&S Ops and H&S Committee for approval	31/03/2022

	From December 2020, update reports to the HSC on the Health & Safety Strategic Action Plan should include a clear indication of progress against actions, with a summary position to aid oversight. The reports should include information on delay against original timescales and/or record where there are changes to original target dates clearly.					
7(ii)	Review of agendas and minutes confirmed that the Health & Safety Strategic Action Plan 2020/21 has been included within HSOG agendas at a number of meetings throughout 2020 as it was developed and timescales amended in light of the impact of the COVID-19 pandemic though it is too early to demonstrate review of progress. As noted at 7(i) above, discussion of the 2019/20 improvement plan was not clear. We note that whilst the Strategic Action Plan was not presented to the HSOG in November, the group received a 'Health and Safety Plan 2020-21' outlining the areas the corporate H&S team would prioritise for 2020-21. Consistent terminology should be used when referring to the Strategic Action Plan and any supporting plans for clarity, and that progress against each be reported clearly at HSOG meetings.	**M**	The HB take on board the points raised and the confusion this may cause and moving forward there will be the SAP that will outline the strategic view and the HSP (HSWP) that will have a more detailed operational plan to assist in implementing the SAP, both will be reviewed by the HSOG with updates provided to the HSC.	30/06/2021	August 2021 The HSW plan will be revised based on the updated SAP outlined in (7i), with the revised ESWP to go back through the H&S Ops and H&S committee for approval*	None Entered

***Based on the update provided, the Head of Compliance will now extend the action deadline date to 31/03/2022 in order to align with recommendation 7(i)**

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
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	Service Group Nurse directors will re-issue the information governance policy outlining what patient identifiable information can be displayed publicly.	31/03/2021	**Undated** A Head of Nursing (Patient Flow) has only very recently taken up post and will we working with Service Group directors to address this issue. Please extend until May 2021. Work ongoing	31/05/2021
		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	**Undated** A Head of Nursing (Patient Flow)has only very recently taken up post and will we working on this . Please extend until May 2021 **Undated** Work is currently ongoing with this action	31/05/2021

ABM 2021-015	Adjusting Services Quality Impact Assessment	Report Issued April 2021	Reasonable Assurance

Rec Ref	Findings & Recommendation	Priority	Original Response / Agreed Action	Original Agreed Deadline	Most Recent Update/Comment	Revised Deadline
6	The process in place early in the year indicated that it was the role of the Reset & Recovery Coordination Group (RRCG) to identify any schemes proceeding at risk that required reporting to the QSC. The RRCG no longer exists – consideration is being given to directing QIAs to the Silver Command group of the COVID-19 pandemic response. As groups involved in this process change, the process document should be revised to indicate any committee reporting requirements and which group or individual is responsible for deciding what to report.	L	Accept recommendation, QIA Scrutiny Panel ToR to be updated that QIAs will go to Silver Operational Command re: reintroduction/adjustment of services. As operational requirements return to normal, post COVID-19, development of proposal to Quality and Safety Committee as to how QIA will integrate into business planning of organisation.	30/06/2021	**Undated** Partially completed. QIAs are now being approved by the Silver Operational Command. **Undated** Further work ongoing - Proposal being developed with Q&S Committee as to how QIA will integrate into business planning of organisation. This will on the Agenda and discussed at the November meeting of the Quality Safety Governance Committee ND 20/10/21 **December 2021** Unfortunately was not discussed at November meeting but will be discussed at the next Q&S meeting on the 21st December and the action will then be able to be closed Deadline amended to 31/12/21	31/12/2021

Executive Lead – Executive Director of Nursing & Patient Experience						
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 Government. Site level reports undertaken by management in November 2020 detailed the following with regard the sampled sites: **Hospital Site** / **% compliance with Firecode** / **Projected compliance date** / **Cost to achieve compliance** Singleton / 70% / 2025 / £5m Morriston / 75% / 2021 / £5m Cefn Coed / 75% / 2022 / £0.3m 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	Bids completed by Capital/Estates(Health & Safety submitted to NWSSP-SES and confirmation of agreed funding. Waiting for confirmation of receipt of funds prior to commencing works. Bid confirmation - There is a requirement to build a 5 year strategy covering fire compliance. Requirement to undertake 6 facet survey to identify long term strategy	None Entered
7	Management are required to complete All Wales returns in respect of: • fire incidents; • fire risk assessment; and • fire audit. However, management advised that system interface issues presently require re-entry of data between systems, and that there is an inability to match data between systems e.g. a ward refurbishment recorded at Estates works may not correspond to fire risk actions. This has exacerbated central resource issues, and impeded effective information flows. Management should ensure effective information systems to facilitate appropriate fire safety assurances.	**M**	Agreed. The All Wales fire safety risk system is not compatible with other systems as it is a standalone software system. With the new agenda for the Health & Safety Fire Safety group, there is a section that will capture the actions identified in the FRA and will be reviewed to ensure actions are either completed or have a scheduled programme to be completed. Historical actions will be reviewed separately not to delay the implementation of the new system. (The new agenda will cover the reviews from May onwards)	31/05/2021	**Undated** Partial review of risk assessment areas has been undertaken. Further review will be completed while completing the overdue risk assessments. NWSSP -SES system does not link to other software and a two-tier system needs to be introduced or preferably, NWSSP -SES upgrade current system to enable accurate recording of FRA action status that captures work completed. Hywel Dda have just introduced a separate system to capture FRA and actions that are linked to estate works. There is a set up and ongoing revenue costs to this and would suggest the NWSSP take this forward on an All Wales basis. **Undated** An all Wales fire safety group has been set up and one of the actions is to review and develop an appropriate system to capture the appropriate information. Please extend to 31st March 2022	31/03/2022

10	The existing action plans contained over 5,000 outstanding actions to be addressed by the UHB. The Head of Health & Safety reported to the March 2020 Board that there were “insufficient resources in Health & Safety to totally review all 5,000 actions on the risk register”. The audit observed, via the testing of risk assessments and local monitoring/ reporting, key weaknesses such as: – Drawings – the sample at the audit did not comply with WHTM or Firecode requirements in respect of the detail contained within drawings. The drawings were also unavailable at reception for the Fire Authority as required; – Fire Doors and Compartmentation – the audit observed widespread issues relating respectively to deterioration and penetration; and – Site specific maintenance The November 2020 management audits also identified that for both Morriston & Singleton - “The site should have a full set of fire drawings indicating compartmentation, sub-compartmentation & hazard room enclosures. Full compartmentation survey required for this site.” Appropriate arrangements should be put in place to implement the prioritised action plans.	**H**	Agreed. Currently both the ward manager and operations manager get a copy of risk assessment actions, to ensure that the practical actions are undertaken, alongside the Estates actions. SBUHB are currently working with NWSSP-SES authorised engineer for fire to identify compartmentation lines to update fire drawings to identify compartmentation, sub-compartmentation & hazard rooms. Due to the pandemic site surveys have not been possible and will be reintroduced when safe to do so.	31/08/2021	**Undated** This will be monitored by the FSG with appropriate reports submitted to H&S Ops group and H&S committee. **Undated** Fire compartmentation lines identified for NPTH – Singleton and 70% completion of Morriston hospital	None Entered
12	In accordance with the Fire Safety Policy, there are enhanced fire responsibilities for key staff groups e.g. fire wardens, ward managers etc. Data for enhanced training, notably Fire Wardens was not identified across the UHB. However, management were able to evidence that the overall figure trained as of February 2021 was 75% (benchmarking below other health bodies that have recently been audited). However, there was also need to ensure adequate numbers of Fire Wardens / those with enhanced duties are trained (noting their key roles in outbreak and feedback). Noting the local and dynamic nature of training compliance, this is best monitored at a local level, with summaries to corporate management. This would also free limited central resource. Annual audits undertaken by central management (as required by WHTM 05), can focus on ensuring effective operation of such local controls. Fire safety training in the UHB should be prioritised for all staff.	**M**	Agreed. All face 2 face training was put on hold initially in wave 1 of the pandemic and has continued due to operational pressures to deal with COVID-19. All new starters have been provided fires safety training as part of the HB pathway for new and redeployed staff in response to the pandemic. Where staff have been able, they have undertaken on-line fire safety training with compliance of 75% at the end February 2021. As part of the transition to business as usual, there will be a focus on training (on-line) initially and then a combination of face 2 face and on-line learning.	31/05/2021	**Undated** Fire safety training is primarily completed on line, with additional face-to-face training on hold due to COVID-19. Plans are in place to recommence face to face once practicable to do so with COVID-19 restrictions. **May 2021** No changes at present and will probably be reviewed in readiness for the new financial year (2022/23) (MP 11/8/21)	30/03/2022
13	In accordance with the Fire Safety Policy, there are enhanced fire responsibilities for key staff groups e.g. fire wardens, ward managers etc. Data for enhanced training, notably Fire Wardens was not identified across the UHB. However, management were able to evidence that the overall figure trained as of February 2021 was 75% (benchmarking below other health bodies that have recently been audited). However, there was also need to ensure adequate numbers	**H**	Agreed. As with the points raised response to recommendation 12, face 2 face training has not been possible, with limited fire warden training provided. As part of the transition to business as usual this will be one of the priority areas and all Service Groups have been asked to provide an updated list of fire wardens for each of the areas. In addition to the challenges of providing face 2 face	31/10/2021	**Undated** Roles and responsibilities captured in HB Fire Safety Policy, some additional committee interrelationships added. Local procedures being reviewed to ensure roles & responsibilities are captured. Fire Wardens being identified with training ready to roll out.	None Entered

	of Fire Wardens / those with enhanced duties are trained (noting their key roles in outbreak and feedback). Noting the local and dynamic nature of training compliance, this is best monitored at a local level, with summaries to corporate management. This would also free limited central resource. Annual audits undertaken by central management (as required by WHTM 05), can focus on ensuring effective operation of such local controls. The adequacy of fire warden provision across the UHB should be affirmed – ensuring that appropriate training is provided (this should include all roles with enhanced fire responsibilities).		training, fire safety resources have been directed to address the overdue risk assessments, so with positive progress with FRA the aim is to commence with training later this year (September/October). Fire wardens in situ have had training and if there are any challenges identified, support is available and provided by the Heath & Safety team. Any new fire wardens will be targeted as a priority to train. This will also be picked up in the Health & Safety Fire Safety group from May 2021 to ensure local monitoring is taking place and reported through the health and safety governance structure.			

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 1718-011	**Control of Substances Hazardous to Health (COSHH)**		**Report Issued February 2019**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
6	There is particular need to locally test the built environment e.g. • ventilation functioning - number of air changes etc • storage - adequacy for hazardous substances • lay-out – length of carry, obstacles, trip hazards between storage and use. Management advised that these more technical reviews were undertaken only on request. Excepting an "All Wales Sterile Service Survey" undertaken by NWSSP: Specialist Estates Services, we did not identify reporting in relation to the built environment. **<u>Equipment</u>** Local calibration records were found in relation to monitoring equipment. However, a mechanism was not identified by which the Health and Safety managers / Committee could be assured that all relevant equipment had been checked. Periodic reports will demonstrate appropriate coverage including testing of the built environment and monitoring equipment.	**M**	Agreed	31/05/2019	**Estates Assurance Follow Up – Outstanding** Management advised that equipment such as ventilation and other technical equipment are covered under Planned, Preventative Maintenance Schedules, which are undertaken in accordance with the technical guidance. It was advised there are also service contracts in place for other equipment. Other issues referenced in the original report (storage, lay-out etc) would be considered at departmental risk assessments. Recognising the above arrangements, the recommendation required the central reporting of assurance in this area, to confirm that the H&S Operational Group are satisfied with the existing processes. **August 2021** No further updates at this time.	31/07/2021

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	30/04/2022

Executive Lead – Executive Director of Nursing & Patient Experience						
SBU 2021-008		**Water Safety**	**Report Issued June 2021**		**Limited Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
8(a)	The Water Safety Plan documents the training requirements for key officers, including the requirement for training to be refreshed at least every three years. Training was in date for the current Responsible Persons and Authorised Persons. However, training for Competent Persons (Estates Officers) was out of date with the last training recorded as February 2017. Management advised that the provision of the required face-to-face training had not been possible due to COVID restrictions. # It is acknowledged that some Authorised Persons training has now been arranged (noting this takes place offsite); but securing on-site training (for Competent Persons) remains difficult. It was noted that whilst a training matrix for Estates officers was held for those working at the Singleton estate, the same was not evidenced for the Morriston estate. Training should be updated for relevant staff as soon as possible, COVID restrictions permitting	**M**	Agreed. Training will be updated as soon as possible.	31/07/2021	**August 2021** The health board are trying to commission additional training. However due to COVID there are availability issues. However, that these OAPs are having training updated in accordance with the WHTM's opener.	31/03/2022
9(b)	Water-related risks are recorded by Estates management in the Datix risk management system in line with the wider corporate risk management procedure, escalating to the Corporate Risk Register should the score be sufficiently high. There were no corporate-level water risks reported at the time of the audit. The Water Safety Management Committee's terms of reference state that it should: – Provide a forum in which high level Water System monitoring outcomes and risks can be reported to, evaluated, so that appropriate reduction or elimination action is agreed; and – Consider identified risks, set priorities and produce action plans for each site. Whilst a number of appropriate risks were seen to be discussed at the Water Safety Management Committee, the risk register itself (as recorded in Datix) was not shared. On review of the current Datix recorded water-related risks, it was noted that some high-risk issues discussed at the Water Safety Management Committee had not been recorded (e.g. the absence of up to date risk assessments), whilst other risks, recorded in Datix, had not been discussed	**M**	Agreed. As explained at the time of the Audit, the Estates element of DATIX has not yet gone "live". The Governance Department are arranging for a review of the Estates Risks and have also been working with the Department to allow us to put Health Board wide risks into the database. The reason that the risk assessment having just gone out of date is not entered, is because we were having to enter it for individual buildings. We are currently in discussions with Governance about giving us the capability to enter this information across the Estate rather than by building. The Health Board is in the process of awarding the risk assessment contract.	31/07/2021	**August 2021** The Governance department are reviewing the estates risk register in September with the Estates team, which will also consider how the risks are allocated across the health board. This will then be presented to the October scrutiny panel suggested new date. First of November	01/11/2021

	at the same (e.g. ‘provision of resilience for the [Morriston] site’. Management should resolve the current Datix usability issues to ensure water-related Estates risks can be accurately captured, monitored and reported.					

Executive Lead – Director of 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	**October 2018** The business case for regular data cleansing to avoid future discrepancies will be progressed once a workshop has been held between leads in Child health system and primary care to understand the issues and quantify size of issue and cost of a data cleansing exercise. Progress on date and venue to be expected by November SIG. A previous business case/paper has been prepared by the child health directorate, highlighting data quality issues following the 2013 measles outbreak. Escalation to Q&S forum requested at SIG for chair of SIG to raise concern that poor data quality is a risk impacting on population health requesting, their support for resources to do the data cleansing. **December 2019** Additional admin resource is still required to undertake this work. SBAR has not been progressed.	31/12/2019

Executive Lead – Director of Strategy						
SBU 1819-038	**Strategy & Planning Directorate**		**Report Issued October 2018**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
2(i)	Most staff had objectives set for 2017/18. However, the objectives provided for Estates supporting managers related to delivery in 2015 & 2016. Additionally, whilst Capital Planning staff had objectives which included delivery in 2017/18, for some (including the Assistant Director) there were also objectives with delivery dates in preceding years - suggesting objectives had not been refreshed annually. We would recommend that Capital Planning & Estates refresh objectives annually, setting new targets for the year(s) ahead.	**M**	PADRs will be held with all staff to set objectives and targets	21/12/2018	**July 2019** PADRs are reviewed via Estates Board, objectives have been set on a reactive basis to date. Moving forward objectives will be set at the start of financial year to align with budget allocations.	21/12/2018
SBU 2122-012	**Annual Planning Approach**		**Report Issued October 2021**		**Reasonable Assurance**	
Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response / Agreed Action**	**Original Agreed Deadline**	**Most Recent Update/Comment**	**Revised Deadline**
3.1	The Executive Steering Groups terms of reference include clarity of purpose and detail is included relating to its role in plan development. However, it appears that it has not been refreshed for some time with a number of individuals listed within the membership having left the health board or taken on different roles. Membership also included the Director of Nursing & Patient Experience and Director of Public Health but we could not see evidence that this remained the case currently. Other aspects including key stakeholders would also benefit from refreshment. We recommend terms of reference for the Executive Steering Group be refreshed to reflect current membership and stakeholders. Consideration should be given to inclusion of senior quality & safety representation.	**L**	Executive Steering Group Terms of Reference will be refreshed.	04/10/2021	**Undated** Updated Terms of Reference to be discussed at the Executive Steering Group (ESG) being held on 6th January 2022. The ESG meetings held in November and December 2021 were solely used for the review of R&S priorities.	06/01/2022

Executive Lead – Director of Strategy						
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**
10	The Standards of Business Conduct policy (Appendix 7) requires a declaration of interest proforma to be completed at all procurement exercises over £5k in value. Where NWSSP Procurement Services manage the procurement exercise, they are responsible for the issuing and completion of the DoI forms, for all relevant staff involved in the procurement (including the procurement officer, Health Board client/end user and Estates/Capital Planning as appropriate). Internal procurement exercises are also separately progressed by UHB Estates staff (the audit was unable to quantify number/value of the exercises). DOI forms were not routinely completed (by Estates or other UHB staff) at these internally managed procurement exercises. The DOI proforma should be completed at all procurement exercises (including Estates, client, end users as appropriate) in accordance with Appendix 7 of the Standards of Business Conduct policy.	**M**	Agreed	30/04/2019	**July 2019** This will be actioned via Estates Board to all Senior Staff - Procurement colleagues will be required to provide training (over £5k). Added to Estates Board Agenda for discussion. **December 2019** Assistant Director of Operations (Estates) will be writing to all staff that have raised orders in January to ask them for declaration on any known interests. Meeting Scheduled 15th January 2020 for discussion. [1]	31/05/2021
14	Management were able to explain how the capital allocations from the 2018/19 discretionary programme were determined, based on risk, however no audit trail was available to verify the use of OAKLEAF to drive this process. It was also noted that the Estates Operating Procedures were out of date, and the funding allocation procedure described by management was not formally documented. Estates Operating Procedures should be updated, to set out the required processes associated with the recording of identified risks, and in the risk prioritised allocation of discretionary capital.	**M**	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	30/09/2019	**December 2019** High & Significant risks for the two main sites have been entered onto DATIX. The risk team have been working with us to develop the ability to record two separate risks. Meetings are planned for January 2020 to review risks before making them live on Datix. **January 2020** Meeting took place. Work is ongoing. It is planned to have transfer complete of High and Significant risks by May. **Capital Assurance Follow-Up (SSU-SBUHB-2021-004) – Outstanding** Un update has not been provided by Management on this issue. Revised Timescale – 31/08/2021	31/08/2021
16	A significant number of estate-related risks were captured on Unit risk registers across the Health Board. Unit risk registers (as held in the DATIX risk management system) were reviewed during the audit, and circa 100 risks were identified which had been categorised as relating to “Environment, Estates and Infrastructure.” There is currently no formal process by which Estates were involved in the assessment or review of such risks held within the DATIX system. The only means by which the	**M**	Agreed. The Department are starting discussions on how to transfer its Risk Register onto DATIX. Once this is achieved, the Department will be able to capture all risk associated with the Estate from all of the Service Directorates. The OAKLEAF system will then be used only to hold its Condition Appraisal information, with DATIX being the Department’s Risk Register.	30/09/2019	**July 2019** By moving to the DATIX system, Estates will be able to see all Estates assigned risks, ensuring fully captured and will avoid duplication. **December 2019** Once the meeting has taken place in January to review risks on DATIX the database will go live. We are already linking with the Unit Risk Management Team to ensure all risks are captured	31/05/2021

	department would be aware of these risks, was if the Unit notified Estates of an issue which may require repair/resolution. There is a risk, therefore, that the OAKLEAF system may not adequately reflect the full range of estate risks identified across the UHB (particularly noting concerns that the OAKLEAF system may in general not be sufficiently up to date, given the lack of recent Health Board-wide estate survey: as highlighted at the 2016/17 Backlog Maintenance audit). Estates should review the estate-related risks captured at Unit risk registers, and ensure these are reflected in OAKLEAF, where appropriate.					
17	It was observed that "assurance reports" provided by the Assistant Director of Operations (Estates) to the Director of Strategy and (verbally) to the Health & Safety Committee were somewhat disparate, and did not reference the Estates risk register, or the respective risk ranking of each of the compliance areas. Reporting of the key estates compliance issues to the responsible Director and elsewhere should include linkage to the risk register and the risk-ranked prioritisation of the issue/s being reported.	**M**	Agreed. Management will review the format of the report to include a risk rating for each of the issues being highlighted, with a view to prioritising these issues within the report.	31/05/2019	**July 20219** A coordinated report without risks has been presented to H&S Group. Also presented a report to main H&S Committee on Estates Risks. A new report will be developed for September's Committee using Risk ratings. It was agreed this format will be used going forward. **January 2020** Reports have been presented at H&S Committee on Estates issues. The new WEB meeting will further enhance this operational H&S group.	31/05/2021

[1] **Updates provided in respect of outstanding actions relating to other NWSSP Audit & Assurance Reports indicate that the department now do an annual declaration of interest review with staff asked to confirm that they are not aware of any conflicts of interest, and that a copy of the recently revised Standards of Business Conduct will be circulated to all relevant staff, with particular reference made to the need to ensure that declarations of interest pro-forma are completed for ALL relevant procurement processes. However no such update has been entered in respect of this recommendation.**

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

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

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

7	The Project Execution Plan states that the Project Board is the body "responsible for the overall direction and management of the project through to completion." While project changes were authorised via correspondence between the Project Director and the Senior Responsible Officer, the Project Board had no defined role scrutiny or challenge of project changes. Testing was undertaken as follows: **Authorisation** While approval by the Senior Responsible Officer was obtained for one recent Compensation Event, Project Board approval was not evidenced. Neither the Senior Responsible Officer, nor the Project Board had a defined role in approving Compensation Events at the Project Execution Plan (the Project Board being the accountable body for project control). Signed approval at the Supply Chain Partner Compensation Events was only provided by the external Cost Adviser. This was contrary to the requirements of the Project Execution Plan, which requires Health Board approval. In all 9 cases sampled, Compensation Events were well substantiated by calculations of time and resource. (Observations relating to the need to align resource charged to project tasks has made at MA 6). For the 6 sampled changes in respect of the advisers, they were signed by both the requesting adviser and the Health Board Capital Planning lead in accordance with his delegated limits (£25,000 as specified at the Project Execution Plan).	**M**	**7.1** Agreed. We will update the role of the Project Board in respect of approval of Compensation Events. **7.2** Agreed. We will ensure that both Compensation Events and Requests for Information are monitored for timely approval.	31/10/2021 31/10/2021	None Entered None Entered	None Entered None Entered

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

	Timeliness The Project Execution Plan reflects the contract in requiring agreement within stipulated time frames (response to Compensation Event requests within two weeks). This is required to avoid agreement by default due to breach of these time limits. All three Supply Chain Partner Compensation Events were agreed within the required time frames, but similar monitoring was not found for agreement of adviser Compensation Events. Only four of the six adviser Compensation Events to date were provided (hence sample size. Of the remaining two (which could not therefore be sampled), one was raised two months earlier, and the date the other was raised was not recorded. There was a need therefore to monitor timely approval, additional to appropriate authorisation. There was also a need to monitor timely response for Requests for Information (RFI) from the Supply Chain Partner, to avoid compensation claim for delay. **7.1** The Project Execution Plan should define the role of the Project Board in scrutiny and approval of project changes. **7.2** Timely agreement of Compensation Events and Requests for Information should be monitored and reported.					

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

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

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

	As part of the refreshed governance structure initiated from September 2021 onwards, a new Decisions Log has been implemented. This will be supported by the minutes of formal Steering Group meetings held going forward. The Decisions Log should be backdated to provide a clear audit trail of decision points in the direction of the revenue solution, including where formal instruction was given to pursue a particular option.					
7.1	The project risk management procedure was clearly defined in the Project Initiation Document, with a new risk register recently prepared to align with the refreshed governance arrangements and to reflect the current stage of the project. Whilst a range of risks had been appropriately identified and recorded at the time of review, the Project Manager recognised that further development was required, both through the involvement of the Steering Group and the supporting work streams (for example, recruitment and blood bank risks have been highlighted as areas requiring more detailed consideration). It is also noted that the revenue funding requirement for the project remained to be confirmed. This and other risks, such as procurement matters, were not captured on the risk register reviewed. The further development of the risk register will support existing reporting processes to the Steering Group and Planned Care Delivery Board, and ensure members can provide scrutiny and direction as to the management of the key risks affecting the project. The risk register should continue to be developed to ensure all relevant risks are captured.	**M**	Agreed. Going forward, the risk register will support existing reporting processes and will ensure that all relevant risks are captured so that members can provide scrutiny and direction as to the management of the key risks affecting the project.	30/11/2021	None Entered	None Entered
9.1	Once formal approval has been granted for the preferred way forward, any subsequent changes to the approved option need to be carefully managed, via a formal process of assessment and approval (in line with the UHB and project delegated authorities relevant to the quantum of the change in question). The ability to effectively control project changes will depend on the clarity with which the agreed project scope, design, objectives and benefits have been defined. However, the Project Initiation Document did not define a change management procedure to be applied. The Project Initiation Document should define the change management procedure to be applied at the project.	**L**	Agreed. The Project Initiation Document will be amended to define the change management procedure that will be applied at this project.	30/11/2021	None Entered	None Entered

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