APPENDIX D

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

Executive Lead – Chief Operating Officer				
ABM 1920-038 **Patient Environment** **Report Issued October 2019** **Reasonable Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3	We reviewed the arrangements in place to share CHC issues with other units and was informed that reports would be discussed at NMB meetings and the action log reviewed with the aim that any learning is taken back to the Units. Also, we were made aware that the Corporate Matron was preparing a paper for NMB to discuss options on how learning from CHC will be shared between Units. The process for ensuring wider learning from CHC and HIW reports is not currently documented. Noting work is underway by the Corporate Matron to establish a process for learning lessons across the Health Board, we would recommend that this work be concluded as a matter of priority and include both the CHC and HIW reports. When completed the CHC procedure and the HIW SOP will need to be updated.	All relevant nursing CHC and HIW final reports will be presented to the Nursing and Midwifery Board as part of learning and sharing. (See also R1 above for development of policy/procedure that will include the approach to ensure that lessons learned are disseminated in a timely and robust way)	**December 2021 Update** In line with agreed action, appropriate mechanisms have been established which ensure that all relevant CHC and HIW reports are received by the Nursing & Midwifery Board in order to facilitate learning. This will be linked to the development of the overarching policy/procedure referred to in recommendation 1.

Executive Lead – Chief Operating Officer				
ABM 1920-007 **Capital Systems Financial Safeguarding** **Report Issued November 2019** **Limited Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	5	The audit analysed available procurement records between April 2018 and July 2019, to identify any potential examples of contract splitting. Three such examples were identified:- – Singleton Hospital Ward 12- Flooring: Eleven individual orders (totalling £26,881), were placed with a single flooring contractor between April and June 2019. All eleven orders were valued less than £5,000. No competitive exercise was undertaken and sourcing was not from existing framework arrangements. Management advised that this was associated with emergency work to rectify fire damage in Ward 12 and that full quotation/tender exercises (as required by Standing Financial Instructions) may have slowed progression of the wider project – Singleton Hospital - Chiller hire (June 2018): Two separate orders were placed on the same day i.e. the original order in the sum of £4,588, and a subsequent order in the sum of £2,484 (to extend the hire period) – Morriston Hospital - Theatre work (May 2018): Two orders were placed with the same contractor on the same day – one for materials (£3,632) and one for labour (£2,932). Orders should not be artificially disaggregated into smaller components to avoid the need for obtaining competitive quotations / tenders (in accordance with SO/SFI requirements). Where exceptional situations arise, Estates should consult with NWSSP Procurement Services to determine an appropriate solution. The advice received should be documented and retained.	Accepted. Compliance with SO/SFI requirements will be demonstrated at all future exercises. In the event of exception situations arising, appropriate records will be maintained and reported to the Capital Monitoring Group (as appropriate). We do need to recognise that in certain circumstances we need to waive SO/SFI requirements where we have an emergency and the priority is to reinstate clinical services. The three examples given relate to the Ward 12 Fire and a Theatre failure which meant that we needed services restored as a matter of urgency. The third occasion related to a chiller which was required to keep services operational	**December 2021 Update** All relevant staff/managers have been reminded that orders must not be disaggregated in order to avoid the relevant tender or quotation processes. In emergency situations where an immediate response is required, appropriate procedures have been put in place which include reporting by Estates Managers to the Estates Board and Capital Management Committee. These will not involve the disaggregation of orders or invoices.
	12	Variances in the experience and training afforded to the respective storekeepers at the Moriston and Singleton Hospital sites was noted. It was also indicated that, during periods of absence, members of the Estates Department staff provided cover. However, adequate training in the use of PlanetFM/ Oracle had not been provided. All assigned stores personnel (both permanent and temporary cover) should be afforded appropriate training, in accordance with agreed protocols.	Agreed. Additional training has been identified for key individuals	**December 2021 Update** Relevant staff within the department have received the training required in order for them to carry out the Storekeeper role. This included training on the Oracle and Planet FM systems. The appointee to the new Procurement Officer role will consider any further staff training requirements when in post.

Executive Lead – Chief Operating Officer				
ABM 2021-013 **Primary Care Cluster Plans & Delivery** **Report Issued January 2021** **Reasonable Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	The review of Cluster IMTPs by the Public Health Wales Development & Innovation Hub provided a positive overall position of SBU cluster plans when compared with others in Wales. There were observations which could improve future iterations of plans, including the links between gaps and actions, and the prioritisation of the latter. The Associate Service Director, Primary Community & Therapies confirmed that there was intention to share feedback this had not been formally taken forward at the point of audit. PHW observations should be incorporated within future IMTP development guidance/presentations shared with Cluster members and considered as part of process of review for future plans. (The timing and implementation of this would need to be considered against the requirements of further Welsh Government directions.)	Agreed. The Public Health Wales Observations will be re-circulated to inform the finalisation of the plans and Swansea Bay University Health Board will again a participate in the review with Public Health in 2021 sharing with other Health Boards experience and good practice.	Summative review findings considered for inclusion in 20-21 plans: included reference to patient/cluster participation groups within their action plan/table. Details of cluster membership were scheduled and reviewed through extensive review of cluster TOR in Dec 2020, shared nationally as good practice. PCNA data incorporated into IMTP needs assessment, workforce data included, all clusters contained visions, highlight spend was detailed for cluster WG funds. Extensive revision of cluster proposal documentation to set out SMART outcomes under IMTP delivery. Cluster IMTPs widely considered commentary on prevention activity, noting that local decision making needs to be enabled. Data considered across all areas in informing decision making on activity
	2	Some variation in the format of action logs (or their absence) at cluster meetings meant that actions assigned were not always clearly trackable to completion at meetings. To support clusters in the monitoring and progression of actions we would recommend agreeing with clusters the introduction of action logs and their use for follow up at subsequent meetings.	Agreed	Action logs incorporated across all SBU clusters and included as standard agenda item for every Cluster meeting (x5 each year). Also utilised within Cluster Delivery Groups (sub group to main Cluster meetings) and other cluster performance and implementation mechanisms
	3	We noted that while there was evidence that each cluster sampled discussed a selection of actions within their plans, a mechanism such as the Gantt-style chart introduced in some to provide a summary view of progress across all actions, was not used across all. To assist cluster members and to support future reporting within the health board, we recommend that standardised mechanisms for monitoring the delivery of IMTP actions be introduced across all clusters.	Agreed	Cluster Development Team have provided support in developing performance management skills. Throughout 2021/22 clusters have monitored progress regarding Cluster IMTP via a BRAG assessment. Monitoring of IMTP is a standard agenda item for all Cluster meetings and is main driver of the individual Cluster Delivery Group activity. To support this activity the Clusters have also employed Cluster business managers to maintain positive progress.
	4	Refreshed draft model terms of reference state that the Cluster Lead and Cluster Development Manager will report on the IMTP and delivery of priorities to the PCTS Group board. We note that there is currently no formal reporting which summarises the overall status of delivery of IMTP actions for each cluster for the service group or to inform the health board's wider operational plan reporting requirements We recommend management develop mechanisms to support internal Service Group progress reporting and oversight, and to inform assurance reporting to Board.	Regular reports are made to the Primary and Community Services Board however these can contain a differing focus. A standard approach to cluster monitoring including IMTP progress will be developed and implemented during 2021- 2022.	Following the 2nd wave of COVID 19 and the subsequent national response to same, all Cluster (and contractor) monitoring was directed by Welsh Government to be at a 'light touch'. Clusters have developed and implemented a standard format finance report that is reported to PCT Board every 3/4 months (Jan, March, June, Sept & December 2021) For 2022/23 the Clusters will be reporting progress via revised IMTP structure (ie aligned to SBU GMO approach) and utilising the IMTP BRAG monitoring tool already in place.

Executive Lead – Chief Operating Officer				
ABM 2021-025 **Infection Control Cleaning** **Report Issued January 2021** **Reasonable Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2	Some administrative inconsistencies were identified in manual training records (disparities between summary records and individual training received). We note that Singleton is in the process of transferring manual training records into electronic spreadsheet form. This approach should be taken across all sites and management should ensure that the training record sheet is a complete and up to date record of all training provided. This may assist with monitoring.	Agreed - a common approach to recording and maintaining training records to be developed	**December 2021 Update** Training records have been harmonised across sites, and are regularly updated by departments.
	6	We identified repair actions for Estates identified in a technical audit in one non-clinical, public area (a public toilet and baby changing area at Singleton), which had not been communicated to Estates for action Management should ensure the process for raising issues with Estates and recording the same, are reinforced with staff.	Agreed - Ward and department areas have a procedure in place but a procedure needs to be introduced for "public/general" areas. (This will subsequently be incorporated into the strategy / plans being developed as per R1)	**December 2021 Update** Domestic Managers on each of the sites have now been given responsibility for “public areas”. This revised system is working effectively.
	7	A review of records within the 'Credits for Cleaning' system suggests that managerial audits have not been undertaken frequently in recent years. Management should programme these audits based on the frequency outlined within the Monitoring Plan in order to ensure adherence to the Cleaning Standards. We suggest they are reported quarterly within the Domestic Service report to Infection Control Committee as a separate element to supplement the assurances given following technical audits.	Agreed that the system that was in place was not sustainable. This issue will be included in the Infection Control Committee paper as a multidisciplinary team (Estates, Infection Control, Nursing, Matrons and Support Services), all need to agree how this can be resolved. The paper will be presented to ICC the aim of agreeing an approach 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	**Undated Update** A document was prepared and shared with the Infection Control Committee on the 8/02/21. Comments have been requested and a revised version will be presented to the next Committee meeting. **December 2021 Update** Following the meeting referred to above, further discussions took place outside the Committee with Infection Control colleagues. As a result of these discussions, it was agreed that managerial audits will be undertaken alongside the routine Multidisciplinary Infection Control Audits on each site.

Executive Lead – Chief Operating Officer				
SBU2021-007 **Control of Contractors** **Report Issued April 2021** **Limited Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	5b	The UHB's induction process includes classroom-based (at Singleton) and computer-based (at Morriston) induction sessions, delivered periodically at the two main sites. A record of contractors/operatives who had undergone formal induction and had agreed to follow the UHB health and safety procedures was maintained within the Estates Department. However, this central record was not always checked by Estates officers when arranging for a job to commence. Accordingly, there was the potential for contractors to be allowed to work on site without receiving appropriate induction. This was reflected in the results of 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 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, with 45% of contractors attending the Morriston site and 32% attending the Singleton site during December 2019 not having attended an induction. It was not possible during this audit to reconcile the sample of jobs under review with the induction records, noting operative names had not been recorded on the job documentation provided. A new in-house audit of induction compliance should be carried out, with the results reported to the appropriate forum/committee for scrutiny and further action where necessary	An audit was completed in December/January and will be repeated 6 monthly and reported to Senior Team at its next meeting.	**December 2021 Update** Audits were undertaken in March and September 2021, and will be undertaken twice-yearly as a minimum going forward.

Executive Lead – Director of Corporate Governance				
ABM1819-006 **Board Assurance Framework** **Report Issued March 2019** **Limited Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2	The Primary Care and Community Services development of a Unit Level Assurance Framework will include the submission of a formal review of the framework to the Unit Management Board in June 2019. The Director of Corporate Governance should undertake an evaluation of the effectiveness of the Unit Assurance Framework and consider implementation of the Framework across all other Service Units.	The Risk Management Group will review the progress and consider recommending a standard approach to other Units	November 2021 Update This action was agreed at a point in time. Since then, significant progress has been made in reviewing, resetting and developing the Health Board Board Assurance Framework, with the BAF now being regularly reported to a number of fora: – Risk Management Group – Management Board – Audit Committee – Health Board Work is ongoing to review governance arrangements relating to the mechanisms for the escalation of matters from service groups to the relevant corporate functions. It is therefore proposed that this recommendation be closed.

Executive Lead – Director of Corporate Governance				
SBU2021-024 **Concerns: Serious Incidents** **Report Issued May 2021** **Reasonable Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1a	The health board was in the process of rolling out training to staff in 2020 with training dates arranged before the COVID-19 pandemic restrictions had been announced and it was cancelled. This training was advertised on the health board's staff bulletin board on the intranet. The SI Team provided training to MHLD in June 2019 (pre COVID-19 pandemic). While we were able to verify who had been invited to the training, attendance records were unavailable. The health board should undertake a training needs analysis ahead of delivery of the 2021 programme to identify individuals that would be responsible for undertaking and overseeing an investigation within each department and ensure training resource is directed at those who require it.	Training needs analysis completed end of March 2021, Service Groups asked to identify key investigators to attend the external training provided by Consequence UK. Consequence training programme commenced on 26th April 2021. All staff identified in training needs analysis will have completed training by end of August 2021. Following completion of Consequence Training, the Serious Incident Team will deliver training and produce an annual training programme for 2021/22.	November 2021 Update Training needs analysis completed end of March 2021, Service Groups asked to identify key investigators to attend the external training provided by Consequence UK. Consequence training programme commenced on 26th April 2021, and was completed in August 2021. All staff identified in training needs analysis were included. Following completion of the training, and review of the new National Reporting Framework, the Patient Safety Incident Investigation Team, PSIIT (previously SI Team) are reviewing their training. PSIIT are also working through policies and procedures with the Lead Investigator of Consequence. Currently PSSIT are delivering Incident Awareness Sessions to new Ward Managers, junior Doctors and Nursing staff weekly, and a register of attendees is being maintained. It is anticipated that training of new Investigators will commence in March 2022.
	1b	The health board was in the process of rolling out training to staff in 2020 with training dates arranged before the COVID-19 pandemic restrictions had been announced and it was cancelled. This training was advertised on the health board's staff bulletin board on the intranet. The SI Team provided training to MHLD in June 2019 (pre COVID-19 pandemic). While we were able to verify who had been invited to the training, attendance records were unavailable. Attendance records should be maintained to support monitoring and provide assurance that all staff that are identified as requiring training have received training.	Training needs analysis completed end of March 2021, Service Groups asked to identify key investigators to attend the external training provided by Consequence UK. Consequence training programme commenced on 26th April 2021. All staff identified in training needs analysis will have completed training by end of August 2021. Following completion of Consequence Training, the Serious Incident Team will deliver training and produce an annual training programme for 2021/22.	**November 2021 Update** Training needs analysis completed end of March 2021, Service Groups asked to identify key investigators to attend the external training provided by Consequence UK. Consequence training programme commenced on 26th April 2021, and was completed in August 2021. All staff identified in training needs analysis were included. Following completion of the training, and review of the new National Reporting Framework, the Patient Safety Incident Investigation Team, PSIIT (previously SI Team) are reviewing their training. PSIIT are also working through policies and procedures with the Lead Investigator of Consequence. Currently PSSIT are delivering Incident Awareness Sessions to new Ward Managers, junior Doctors and Nursing staff weekly, and a register of attendees is being maintained. It is anticipated that training of new Investigators will commence in March 2022.
	3	The WG confirmed that the 60 day target for SI closure reporting to the WG would be removed from the NHS Wales Delivery Framework from 1 April 2020. However, NHS organisations would still be required to work towards the 60 day target as a guide. The health board has not achieved its internal 80% target of achieving the 60-day timescale for SI closure during 2020/21. The reported reason for the failure to meet the target is due to changes in the reporting requirements for	Report to Quality & Safety Committee has been updated to include information on the numbers and age profiles of open SI's, the report will also highlight progress made from previous month.	**November 2021 Update** Report to Quality & Safety Committee has been updated to include information on the numbers and age profiles of open SI's, the report will also highlight progress made from previous month. Quality and Safety Committee Report completed, report updated to now include above information from July 2021.

		Mental Health and Learning Disabilities (MHLD) serious incidents (SIs). In February and March 2020, the QSC received an In Committee report that provided data on the numbers of open SIs and the backlog from previous years. While reference is made narratively to actions to address backlog within subsequent reporting, the QSC has not received further figures to demonstrate progress against any backlog. Reporting to the QSC should include information on the numbers and age profile of SIs that remain open to provide assurance on progress made in closing them and the sharing of any necessary learning.		

Executive Lead – Director of Finance				
ABM1819-006 **Board Assurance Framework** **Report Issued March 2019** **Limited Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	4v	Our review of selected areas and discussion with management indicated difficulties in correlating invoice records relating to bed usage with records received from the supplier Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	Noted. The Procurement and finance teams will review the finding of the MEMS report and conduct reconciliation activity based on the date to ensure that payments reflect beds in use.	**November 2021 Update** The recommendation has been actioned with the procedure tightened resulting in a reduction in issues. The requirement to ensure physical tracking of beds forms part of the planned renewal of the Bed Management contract but that has had to be deferred to the summer of 2022 due to a legal challenge received.

Executive Lead – Director of Workforce & OD				
ABM1819-043 **Staff Performance Management & Appraisal** **Report Issued April 2019** **Limited Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	3	The last three available meeting minutes for the Hotel Modernisation Board, June, September and December 2018, were reviewed. Compliance figures were reported in the last two meetings, however, the Head of Support Services informed the auditor that they do not have an action plan for improving PADR compliance. Hotel Services management should ensure that the review of PADR compliance includes actions to improve current compliance levels, completion deadline dates for actions and regular progress review at local Board meetings.	The Management accept this recommendation. Working with the Associate Head of HR, the Head of Support Services and senior team will work to produce a 12 month action plan by the end of May 2019 (this take into account the Bridgend changes and the impact that this will have). This action plan will be monitored at relevant management meetings.	**November 2021 Update** A Plan has been presented to the Workforce & OD Committee. The recommendation is therefore considered to be closed.
ABM1920-039 **W & OD Framework** **Report Issued February 2020** **Substantial Assurance**	**1**	The May 2019 Board paper indicated that a suite of detailed supporting plans which would include a multi-disciplinary education training and development plan would support the Framework. Whilst discussion with the Assistant Director of Workforce indicated that plans are in place for separate initiatives being progressed, a single plan has not been developed. Following the agreement of future resources available to management for delivery of the framework, we would recommend that the plan or plans in place supporting framework commitments with respect multi-disciplinary training & education to be clarified & reported as part of a future Board/Committee update.	Although funding has been agreed to support the WOD and OD function the details of the allocation of the resource are yet to be finalised and agreed. At this point there is no time line in place for recruitment of resources. As this action, references multi-disciplinary education and training this assumes ownership from all professional leads across the organisation (which were clarified within the SOS engagement document.) As other areas of professional accountability for delivery of education and training are also going through changes and resourcing challenges, this should be considered in the timelines set for the action. There will need to be joint working to ensure a multidisciplinary training and education approach and management will consider reinstating the 'Education Forum' to discuss this once resources are appointed. The need for overarching plan will be discussed and the actions around this clarified to a future Board / Committee. Subject to that discussion, an approved plan, or suite of plans, will be in place by 31/3/2021.	**November 2021 Update** Framework no longer applicable. As part of the identified workforce priorities in 21/22 a Workforce plan/strategy to be developed by Q4 2022/23. Issues/action in respect of staff training and development are also monitored and reported through various elements of the Health Board Risk Register. Noting the forgoing, and following discussion with NWSSP Audit & Assurance colleagues, it has been agreed that this recommendation be closed.
	2	The May 2019 Board paper indicated that a suite of detailed supporting plans which would include a recruitment and retention plan would support the Framework. The WOD Forum has been informed of work being undertaken to streamline initiatives to support medical recruitment, retention and engagement, and the ongoing development of a wider recruitment and retention strategy, to be supported by a task & finish group. A comprehensive recruitment & retention plan has not been completed yet. Following the agreement of future resources available to management for delivery of the framework, we would recommend that progress towards completion of the recruitment & retention strategy/plan be reported at future Board/Committee updates.	The resource can be recruited from April onwards and that will help with the medical and dental recruitment and retention only. Resources will be included in the Invest to save bid for overseas recruitment for nursing. A workshop is being held at the end of February. The outcome of this work is likely to be reported to the Exec Team to consider if any resources are needed to support this work. A strategy for the recruitment of medical & dental staff will be in place by 30/06/2020. The development of strategies & plans for other staff groups will be discussed within the Executive Team and timescales for implementation of those required will be agreed by 30/06/2020 and reported to a subsequent Board/Committee.	**November 2021 Update** Recruitment and retention plan to form part of the Workforce plan/strategy mentioned above. Issues/action in respect of staff recruitment and development are also monitored and reported through the Health Board Risk Register. Noting the forgoing, and following discussion with NWSSP Audit & Assurance colleagues, it has been agreed that this recommendation be closed.

Executive Lead – Director of Workforce & OD				
ABM1920-032 **W & OD Directorate** **Report Issued August 2020** **Reasonable Assurance**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2	Concluding testing of 15 PADR forms, we noted the following: – One instance where a completed PADR could not be supplied. – Five instances where the PADR provided remained in incomplete (including performance rating). – A further three instances where the documentation was more fully completed but performance rating had not been completed at the close of the review. Additionally we would note that only a small number had explicit records of agreement. We would recommend that the DOWOD seek assurance from her management teams that the Personal Appraisal Development Review Forms (including Personal Development Plan) are fully and accurately completed for every employee. Consideration should be given to further actions to raise awareness of these requirements and to clarify expectations in respect of the recording of agreement to PADR records.	It is a concern to the senior management team that so much emphasis is placed on the completion of paperwork related to the PADR and the correct ticking of boxes. In the 3 cases mentioned it was clear from the text that the PADR was of satisfactory standard. As part of the compassionate care leadership agenda, Just Culture and national NHS Wales work around Healthy Working Relationships, the Health Board need to discuss the importance of PADR documentation in relation to the discussion that happens. Agreed actions: 1. Where appropriate managers will be referred to the Health Board PADR Training once this recommences which discusses the expectations around PADR and completion of documentation. 2. The Director of WOD will ask the L+OD Department to randomly check a number of PADRs paper work twice yearly to ensure accurate completion April 2021 and September 2021. **Audit and Assurance comment:** Our testing of completion of paperwork was against compliance with Health Board policy.	**August 2021 Update** PADR Training has recommenced in the Health Board. Referral to PADR Training where needed October 2020. Audit April 2021 and September 2021 **November 2021 Update** Based on the above update, this recommendation is considered to be closed.
SBU2122-024 **Staff Wellbeing & Occupational Health** **Report Issued February 2020** **Substantial Assurance**	**2.1**	The Staff Health and Wellbeing Service utilise the health board's intranet homepage and regularly post bulletins to inform staff and raise awareness of wellbeing initiatives and resources. A closer review of the Wellbeing page noted that some of the advice appears outdated, with some pages not being reviewed since 2012. Some schemes are no longer running, with references to the previous health board title (ABMU). The Staff Health & Wellbeing Team need to update its intranet page and review on a regular basis to ensure all information supplied is up to date and relevant.	Since March 2020 staff have been able to access COVID-19 Wellbeing information via the front page of the intranet and this has been the main portal for staff to access up to date information as described above. The Wellbeing intranet pages containing out of date information will be updated or closed down in liaison with the Communications team.	**November 2021 Update** Out of date information has now been removed by Communication teams colleagues