BOARD ASSURANCE FRAMEWORK (BAF)

Swansea Bay University Health Board Control Framework

High Quality Care

Controls:
Evidenced within:
- Annual Plan
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

Assurance: gained via:
- Q&S Committee
- Divisional Quality Groups
- Management Board
- Annual Quality Report
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections
- Patient Stories and Feedback
- Complaints/Litigation
- Risk Registers
- External Benchmarking

Performance Management

Controls:
- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting
- Performance Framework

Assurance: gained via:
- Unit Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Safety, Finance and Audit Committees
- Internal/External Audits
- Staff & Patient Feedback

Risk Management

Controls:
- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register
- Reports to the Board, Senior Leadership Team and sub committees
- Policies and Procedures
- Scheme of Delegation

Assurance: gained via:
- Delivery Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees

Levels of Assurance

VISION AND STRATGEIC PRIORITIES

REGULATORS

EXTERNAL AUDIT

First Line
Operational

- Management Board and substructures – evidence of delegation of responsibility through line Management arrangements
- Compliance with appraisal process
- Compliance with Policies and Procedures
- Incident reporting and thematic reviews
- Compliance with Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Safety Committee
- Remuneration Committee
- Risk Management Group, Health and Safety Groups etc.

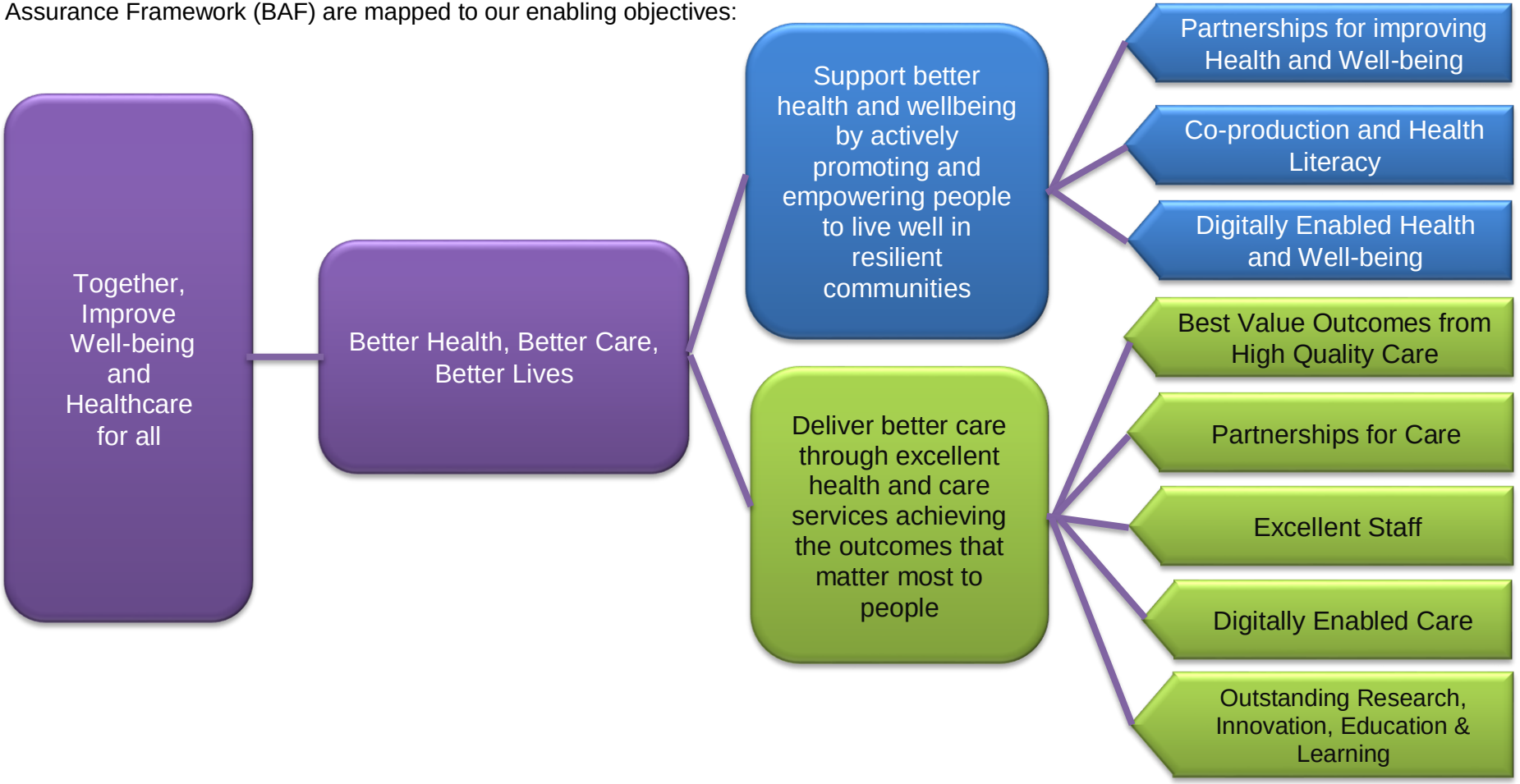
Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification

Third Line
Independent Assurance

- Internal Audit Plan
- Wales Audit Office (WAO) (Structured Assessment)
- External Audits (e.g. Annual Accounts and Annual Report)
- Health Inspectorate Wales (HIW) Inspections
- Visits by Royal Colleges
- External visits and accreditations
- Independent Reviews
- Patient/Staff/Public surveys, feedback etc.

Aligning Board Assurance with Swansea Bay University Health Board (SBUHB) Strategy

The Swansea Bay University Health Board (SBUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Assurance Framework (BAF) are mapped to our enabling objectives:



Board Assurance Framework Summary Against SBUHB Enabling Objectives – March 2022

	Nov 2021	Current
Partnerships for improving Health and Well-being		
Failure to reduce inequalities and deliver improvements in population health for our population	→	→
Co-production and Health Literacy		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	→	→
Digitally Enabled Care, Health and Well-being		
Failure to have IM&T systems in place which do not meet the requirements of the organisation	→	→
Best Value Outcomes from High Quality Care		
Risk that the Health Board will be unable to maintain the quality of patient services and financial sustainability	→	→
Partnerships for Care		
Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	→	→
Excellent Staff		
Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements.	↑	→
Outstanding research, Innovation, Education and Learning		
Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	→	→

Key	Improvement ↑	Deterioration ↓	No Change →

Approach to Risk Assessment - Risk scoring = consequence x likelihood

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 9	Moderate risk
8 -15	High risk
16 - 25	Very High risk

The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 Catastrophic					
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Enabling Objective 1 – Partnerships for Improving Health and Wellbeing	
Principle Risk – Failure to reduce inequalities and deliver improvements in population health for our population	
Executive Lead – Director of Public Health	Assuring Committee – Quality & Safety Committee

1.1	**Population Health Improvement**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Public Health Strategy and work plan • Strategic Immunisation Group • Immunisation action plan • Childhood Imms Group; • Primary Care Influenza Group • Support from PHW HeaPlth Protection • Local smoking cessation services • Nutrition Skills for Life Programme to be expanded • Exercise and Lifestyle pilot • Area Planning Board (APB)	• Public Health measures are included in the Performance Report • Progress against the Public Health work plan • A&A Report ABM-1819-012 Vaccination & Immunisation Limited Assurance • A&A Report ABM-2021-014 Vaccination & Immunisation (F/Up) Reasonable Assurance	✓ ✓		✓ ✓	Data quality issues identified in respect of immunisation records. No effective reporting on immunisation performance through a group with operational responsibility for delivery. All childhood immunisation targets below trajectory with the exception of school immunisation targets. There is a national proposal to create an 'integrated vaccination service' in each Health Board area as a legacy of the COVID vaccination programme. However its form, scope and timetable for implementation have yet to be decided.	The development of an intended business case to undertake data cleansing across primary care and child health record systems has not progressed. Noting the time which has lapsed since this issue was originally raised, the Director of Public Health will now revisit this issue and establish the current situation and necessary action in terms of the accuracy of immunisation records. **30/06/2022** Establishment of Population Health Group of the Management Board. **30/06/2022** Development of a Population Health Strategy and associated action plan by Q4 21/22 to outline recovery actions **31/03/2022** The Strategic Immunisation Group will be reformulated, with an operational immunisation group and a strategic immunisation group that will report through to the Population Health Group but operational control sits in multiple locations. **30/06/2022**

1.2	Pandemic Framework						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Health Board-wide response in place. • Command and Control structure established • Non COVID-19 activity reviewed and controlled in line with the resources and requirements of the response plan • Patient flow pathways established • Support service pathways established (e.g. cleaning, decontamination etc.) • Test, Trace and Protect mechanisms established. • PPE guidance in place • Engagement with all-Wales planning and delivery functions • Field hospital(s) developed and commissioned • Primary care models adapted to current situation. • Work undertaken with local authorities to maintain the care sector. • Health Board Recovery and Reactivation plans put in place. • 2021/22 Annual Plan developed and reported to Welsh Government.	• Command and control structures are monitoring effectiveness of response. • Regular detailed activity and performance reports received and scrutinised at appropriate fora (e.g. Quality & Safety Committee, Finance and Performance Committee, Health & Safety Committee etc.). • Separate COVID-19 risk register established and regularly monitored and reviewed • A&A Report Governance Arrangements During COVID-19 Pandemic Advisory Review • Healthcare Inspectorate Wales (HIW) review of mass vaccination centres	✓ ✓ ✓		 ✓ ✓	There is not a Recovery Group process established because of increasing incidence. Lack of alignment of groups involved in shaping TTP delivery and overall response with no clear regional focus for whole system response. Reporting to Board is only via Annual Plan reports / CEO update at present.	Continued receipt and scrutiny of regular and detailed activity and performance reports in order to inform the pandemic planning process. **(Ongoing)** Currently there is a review of ongoing Command and Control structures with a decision to continue with Gold and Silver and a rationalisation of Bronze structures. **(Ongoing)**

1.3	Paediatric Dental GA Services	Associated HBRR Entries: HBRR 61 – Paediatric Dental GA Services (Parkway Clinic)				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Consultant Anaesthetist present for every General Anaesthetic clinic. • Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients • New care pathway implemented - no direct referrals to provider for GA. Roll out of new pathway to encompass urgent referrals • Multi-drug sedation ceased (Sep 2018) in line with WHC 2018 009 • Revised SLA/Service Specification • HIW Inspection Visit Documentation provided to HB • All extended GA cases require approval from paediatric specialist prior to treatment	Referral and treatment outcome data collated and reviewed by Paediatric Specialist. Regular clinical meeting arranged with Parkway to discuss individual cases/concerns Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising	✓ ✓ ✓			There is no immediate access to crash team/ICU facilities in Parkway Clinic – the client group are undergoing G/A/sedation. Medical Safety risk GAs performed on children outside of an acute hospital setting.	The planned transfer of the service from Parkway Clinic has been deferred due to the lack of theatre sessions for paediatrics and beds to accommodate the children. The transfer will be considered as part of the wider recovery plans for paediatric surgery at Morriston. A paper is being prepared for Management Board outlining the current issues with a recommendation of extending the current arrangements with Parkway for a period of 12 months. **31/05/2023**

Enabling Objective 2 – Co-Production and Health Literacy	
Principle Risk – Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working	
Executive Lead – Director of Public Health	Assuring Committee – Quality & Safety Committee

2.1	Healthy Behaviours

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Local Smoking Cessation Service Childhood Immunisation Programme Flu Vaccination Programme Programme for healthy eating for the under 3's Rollout of training health literacy and MECC	Integrated Performance Report contains statistical performance and trend data on key areas including: • Childhood immunisation (including MMR) • Flu vaccine uptake • Smoking cessation services	✓			Due to Covid-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	Development of a Population Health Strategy and associated action plan by Q4 21/22 to outline recovery actions **31/03/2022**

2.2	Substance and Alcohol Misuse

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Joint working with Regional Area Planning Board to move to an integrated model for the delivery of substance misuse services. Working group established under the APB to develop proposals for a Swansea Drugs Commission / External Advisory Panel.	Update paper provided to Quality & Safety Committee Proposed revised model supported by Police and Crime Commissioner, Public Health Wales and Welsh Government.		✓	✓	Decision making is currently through APB where all partners are represented. Some partners have expressed concern over these arrangements. Reporting is not yet agreed but is likely through Joint PSB	Establish External Advisory Panel to help inform service change, and to be a 'critical friend' in terms of Service Delivery. **31/05/2022** Complete work on developing a commissioning approach for the revised integrated model **31/03/2022**

Enabling Objective 3 – Digitally Enabled Care, Health and Wellbeing	
Principle Risk – Failure to have IM&T systems in place which do not meet the requirements of the organisation	
Executive Lead – Director of Digital	Assuring Committee – Performance & Finance Committee

3.1	**Digitally Enabled Care, Health & Wellbeing**	**Associated HBRR Entries:** **HBRR 27 – Digital Transformation** **HBRR 36 – Paper Record Storage** **HBRR 37 – Data Informed Decisions** **HBRR 60 – Cyber Security** **HBRR 70 – National Data Centre Outages**

Key Controls	**Forms of Assurance**	**Levels of Assurance 1st**	**2nd**	**3rd**	**Gaps in Control and/or Assurance**	**Agreed Action**
Digital Strategy and Strategic Outline Plan. IMPT/Annual Planning process. Financial impact of expansion identified, and a financial plan covering 2021/22 commitments has been established and is being implemented. Digital Leadership Group (DLG) in place, supported by a Digital Service Management Group and Digital Transformation Programme/Project Boards. The DLG provides governance and assurance for the delivery of the HB's Digital Strategic Plan, and has oversight of the Digital Transformation Programmes and their delivery plans. These include: • Office 365 rollout • Attend Anywhere • Swansea Bay Patient Portal • Hospital Electronic Prescribing and Medicines Administration (HEPMA) • Welsh Nursing Care Record • Medicine Transcribing and Electronic Discharge • GP Electronic Test Requesting • Dashboards • SIGNAL • Virtual clinics • Welsh Community Care Information System (WCCIS) • Support the redevelopment of Theatre Operational Management System (TOMS) Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place.	The DLG is accountable to the Executive Board and reports to the Senior Leadership Team Priority focus for digital transformation programmes are agreed as part of the operational planning process. The SLT receive update reports on progress against digital transformation programmes Update reports also provided to the Board and Audit Committee. Operational Plan performance tracker reports. Annual Cyber Security progress reports to Senior Leadership Team, Audit Committee and Board Monitoring of complaints and incident reporting in respect of paper records Monitoring of availability of national services through IMB, NSMB and DSMG A&A Report SBU-1920-028 Discharge Summaries No Rating Given A&A Report SBU-1920-029 IT Application Systems (TOMS) Reasonable Assurance A&A Report SBU-2021-021 Information Technology Infrastructure Library Service Management Review Reasonable Assurance A&A Report SBU-2021-029 Digital Technology Control & Risk Assessment. No Assurance Rating Given	✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓ ✓ ✓	Issues identified in respect of the operation and functionality of the Theatre Operational Management System (TOMS) Discharge summaries recovery plan paused pending national development of an interface between MTED and TOMS Rapid deployment of digital solutions and hardware has resulted in increased pressures on the Digital Services Team and Digital Operations Team, with an average increase of 45% in calls logged. Despite the rollout of digital solutions (e.g. Radio Frequency Identification (RFID)), significant volumes of paper records remain, exacerbated by the enforced halt of record destruction as part of the infected blood enquiry. Cyber security training in not currently mandatory within the Health Board. Process for ensuring the clinical adoption of electronic ways of working, and cessation of adding to paper records that already exist electronically, needs to be agreed and enforced by the Health Board. Impact of national architecture and governance reviews not yet known. Uncertainties over funding streams and quantum. Increased adoption of digital solutions and devices requires increased proportion of discretionary capital to support required technology refresh. Impact of CTMUHB ceasing parts of the Digital Services SLA COVID pressures have interrupted the Business Intelligence Strategic Plan production and approval process. Operational impact of the requirements of the Network and Information Services Directive (NISD) have yet to be established. Reliance on Digital Health & Care Wales (DHCW) for delivery of the solution to for a fully electronic patient record.	Redevelopment of the TOMS system to be undertaken. **30/11/2022** Discharge summaries recovery plan to be developed and agreed by Execs. Aim to get 90% of discharge summaries to GPs within 24 hours of discharge - currently at 75%. **31/05/2022** Approved Business Intelligence Strategy in place. An operational implementation plan will now be produced following feedback and further engagement. **TBC** Digital workforce plan currently being developed as part of the IMPT/annual planning process. SBUHB has also contributed to a national workforce review and are awaiting outcomes. **31/03/2022** To establish a 5-year financial plan for Digital, including the risks of the termination of the CTM SLA **31/03/2022** Continued rollout of digital solutions to reduce the volume of paper being used/added. Multi-faceted to include: • HEPMA (Singleton initially) • WNCR (NPTH initially) • SIGNAL V3 • Digital O/patient Transformation **31/03/2026**

Digital Risk Management Group and Risk Register in place. HB Capital Prioritisation Group considers digital risks for replacement technology, which is fed into the annual discretionary capital plan. Capital management Group monitors capital expenditure position against the plan HB Business Case Assurance Group process provides scrutiny to ensure digital resources are considered for all projects. Digital Services prioritisation process introduced to ensure that requests for digital solutions are considered in terms of alignment to the strategic objective, technical solutions and financial implications. Project Boards established for all significant projects. Creation of a Health Board Cyber Security Team. Firewalls in place at a local and national level, with national security tools in place to highlight vulnerabilities and provide warnings when potential attacks are occurring. Patching regime in place which ensures desktops, laptops and servers are protected against known security vulnerabilities. Digital Services Management Group ensures systems are compliant with security standards. Cyber Security training and phishing simulation in place to increase staff awareness. West Glamorgan Regional Digital Transformation Group. Clinical Reference Group established, providing a forum for engagement with and feedback from clinicians in respect of digital solutions and enhancements, and the strategic direction of digital services. Meetings recommenced in June 2021. Digital meetings with Service Delivery Groups to identify and prioritise	A&A Report SBU-2122-019 Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) Reasonable Assurance			✓		Progress with implementation of Hospital Electronic Prescribing and Medicines Administration (HEMPA) across the HB. Singleton completed. Funding for Morriston approved by WG, and project planning currently underway. **31/07/2022** Continue to develop a case for improved record storage and management. **31/03/2022** Work is ongoing at a national level to put a joint mandatory Cyber and IG training solution in place across Wales. **TBC (all-Wales)** Complete subsequent Cyber Security Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW. **31/03/2022** Work ongoing to replace out of date systems. **Ongoing** Clinical Services Plan Strategic Business Case will be drafted, which will include the major capital projects required to support the delivery of the Health Board's Digital Ambition. **Aligned to the development of the CSP** To complete/resolve all agreed actions stemming from the A&A Report on Digital Technology Control & Risk Assessment (SBU-2021-029 refers) **28/02/2022** To complete/resolve all agreed actions stemming from the A&A Report on Information Technology Infrastructure Library Service Management Review (SBU-2021-021 refers) **31/12/2022** To complete/resolve all agreed actions stemming from the A&A Report on the Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) (SBU-2122-019 refers) **31/12/2022**

requirements, monitor progress with implementation, and address issues with business-as-usual activities. Digital Cell reporting into COVID Gold. Receipt, approval and recording of changes/updates made to all existing digital solutions via the Digital Services Change Advisory Board. Internal Digital Business meetings monitor performance of business-as-usual activities and achievement of internal objectives Business Intelligence Modelling Cell established to prioritise the delivery of BI requirements Joint Executive Team for Boundary Change provides oversight of the disaggregation process in respect of Digital Services. Records managed by medical records libraries are Radio Frequency Identification (RFID) tagged and location tracked. Medical records libraries are regularly risk assessed for fire by Health & Safety. Alternative offsite storage arrangements for paper records have been identified Requirement for all records to be documented on the Information Asset Register Implementation of a system to record patient outcome measures (PROMS) The Health Board has representation on national groups such as Advanced Analytics Group (AAG), all Wales Business Intelligence & Data Warehousing Group and Welsh Modelling Collaborative. Health Board representation at Informatics Management Board (IMB) and National Services Management Board (NSMB) to hold Digital Health & Care Wales (DHCW) to account for service provision and outages.						

Digital Services representation at Emergency Preparedness Resilience & Response for escalation, and Digital Services Management Group to report progress in respect of data outages. Implementation of the new National Data Centre by DHCW Business Continuity plans in place within the Service Delivery Units to allow operational services to continue during a data centre service outage						

Enabling Objective 4 – Best Value Outcomes from High Quality Care	
Principle Risk – The Health Board will be unable to maintain the quality of patient services and financial sustainability	
Executive Lead – Chief Operating Officer, Executive Medical Director, Director of Nursing and Patient Experience	Assuring Committee – Quality & Safety Committee

4.1	**Urgent & Emergency Care Services**	**Associated HBRR Entries:** **HBRR 1 – Access to Unscheduled Care Services** **HBRR 80 – Clinically Optimised Patient Numbers**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
An integrated Unscheduled Care Plan has been developed with partners, based around the WG Six Goals for Urgent & Emergency Care, and approved by the West Glamorgan Regional Partnership Board. An Urgent and Emergency Care Network Board has been established to oversee the Health Board's Unscheduled Care Plan. Programme management office in place to improve Unscheduled Care Daily Health Board-wide conference calls/escalation process in place. Regular reporting to Executive and Health Board/Quality & Safety Committee. Health Board Representation on the National Unscheduled Care Board. Development of a 'Phone First for ED' model in conjunction with 111 to reduce demand. Implementation of Consultant Connect for major referring specialties H2H implemented, developed into Rapid Discharge to Assess pathway in line with WG directive. Monitored via H2H implementation group and reported to Community Silver. SAFER – Patient Flow and Discharge Policy in place 24/7 Ambulance triage nurse in place.	Monitoring of the implementation of the integrated Unscheduled Care Plan via the Unscheduled Care Board and Community Silver Command (Regional Partnership Board) Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board, which has continued throughout the Pandemic Progress against Unscheduled Care Action Plan reported to and monitored by Q&S Committee. Operational Plan performance tracker reports. A&A Report (SBU-1920-025) Discharge Planning Limited Assurance WAO Report 255A2017-18 Discharge Planning No Assurance Rating Given			✓ ✓ ✓ ✓ ✓ ✓	Need for robust data collection in respect of Hospital to Home Need for clear definitions for MFFD patients and SOP for MFFD meeting Need for development of bespoke urgent and emergency care system reporting Oversight of the urgent and emergency care system versus operational management arrangements that fragment the system Inconsistencies in the documentation of inpatient clinical Management Plans. Inconsistent methods in setting, recording and changing Expected Discharge Dates (EDD) within patient records, sometimes with little evidence of senior medical input. Inconsistent use of the Red Day / Green Day process Detailed patient information being recorded on SIGNAL but not in the patient notes, which may result in a loss of data post discharge. Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. Continuation in funding for Hospital to Home Service Continuation in funding for Phone First Financial gap to deliver the priorities against the six goals for urgent and emergency care mandated by WG including: • Contact First • Ambulatory Emergency Care • Right sizing community services • Urgent Primary Care Centres Patient records do not record the discussion of the EDD with the patient or their family Patient COVID-19 status has added an additional level of complexity to decision making. The secondment of the Head of Nursing (Patient Flow) has caused a delay in implantation of agreed action resulting from audit reviews of the Discharge planning process.	Establish a group to work with the Local Authority on reducing numbers of Medically Fit For Discharge (MFFD) Patients with clear Terms of Reference for the Service Group Meetings **Ongoing** The Health Board's 'SAFER Patient Flow and Discharge Policy' is to be reviewed and updated. This will be followed by a comprehensive training and communication programme for staff. **Ongoing** Development of a new Corporate Audit Management Tool and SOP to accompany the revised SAFER Policy **Ongoing** SIGNAL User Group to consider further enhancements in phase 3 around clinical recording, including reasons for changes to EDD, a standardised approach to Board Rounds, and risks around limitations of storage capacity. **Ongoing** Following engagement with Carers via Stakeholder Reference Group, a leaflet will be produced outlining patient and family communication and involvement in EDD planning. **Ongoing** Re-establish Short Stay unit on Ward D at Morriston Hospital. Target date dependent on COVID numbers and bed occupancy. **28/02/2022** Increase Same Day Emergency Care working hours and throughput of patients. Medical model pathways and workshop to be held in February 2022 **28/02/2022**

Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. Review is undertaken on a patient-by-patient basis, with explicit action agreed in order to progress transfer to appropriate clinical setting. Patient level dashboard allows breakdown of clinically optimised patient numbers by delay type Joint working with WAST • Implementation of 'zero tolerance' of over 6-hour handover delays – to be brought down to 4 hours • Ambulance offload and cohorting area. Cohorting vehicles in place • Identification of patient pathways that can bypass ED Direct Pathway to Older Person's Assessment Service (OPAS) implemented and operational hours extended. WAST Stack Triage commenced January 2022 Redesign of Acute Medical Services, including Same Day Emergency Care. The HB has procured additional care home beds to provide additional discharge capacity. Close management of utilisation in place Establishment of 4 virtual wards aligned to GP clusters. RAU Frailty Short Stay Unit in Operation from Jan 2022						Third phase of procurement to be undertaken to commission further care home beds. **31/03/2022** Business Case to take virtual wards up to eight – to be submitted to Management Board **31/03/2022** To complete/resolve all agreed actions stemming from the WAO Report on Discharge Planning (255A2018-19 refers) **Ongoing**

4.2	Infection Prevention and Control	Associated HBRR Entries: HBRR 4 – Infection Control Targets				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Provision on Antimicrobial Pharmacist Service, Antimicrobial Guidelines, and a Framework for Antimicrobial Stewardship. • Infection Prevention & Control related training programmes provided. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination. • Recruitment of key personnel to support improvements in strengthening governance of decontamination processes (Achieved November 2021) • Recruitment of key personnel to support improvements in prudent antimicrobial prescribing (Achieved January 2022)	Clear Corporate and Service Group IPC Assurance Framework in place, which also reflects the HCAI Quality Priority actions. Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups. Infection Control Committee monitors infection rates, receives assurance reports from Service Groups and sub groups to the Infection Control Committee, and identifies key actions to drive improvement. Training compliance. IPC, antimicrobial, decontamination and cleaning audit programmes. Compliance and validation systems for water safety, ventilation systems and decontamination of medical devices, patient care equipment, and the environment. Audit & Assurance Report Infection Control - Cleaning (SBU-2021-025) Reasonable Assurance	✓ ✓ ✓ ✓ ✓ ✓	✓ ✓		High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes. Varying levels of IPC responsibility embedded across all disciplines and groups, with a lack of medical engagement in infection prevention-elated Quality Improvements programmes. Lack of Board oversight regarding IPC training compliance for all staff groups, as a result of inadequate systems, including ESR, for recording compliance. Lack of Board oversight regarding ANTT competence assessments for all clinical staff undertaking aseptic procedures, as a result of inadequate systems for recording. Need improved systems for Ward to Board oversight of infection risks, by bringing together in one place data from several sources, e.g. infection cases, cleaning compliance, decontamination, ventilation and water safety compliance, training compliance, ANTT competence, etc. This would facilitate triangulation of risk. Ventilation in majority of clinical wards does not provide the recommended six air changes per hour. Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.	Development of a ward to board dashboard on key Tier 1 infections. **31/03/2022.** Achieve compliance with staff IPC mandatory training **31/03/2022.** Drive improvements in prudent antimicrobial prescribing **31/03/2022.** Documented Cleaning Strategy/Policy to be produced and considered by the Infection Control Committee. **31/03/2022**

4.3	Planned Care Services	Associated HBRR Entries: HBRR 58 – Opthalmology FUNB HBRR 75 – Whole-Service Closure HBRR 16 – Access and Planned Care

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, and to offer leadership and support in addressing risks and issues within systems, and to create an enabling framework to allow care to be delivered appropriately. Outpatients • Outpatients Clinical Redesign and Recovery Group established in June 2020. • Use of Doctor Dr and Consultant Connect to prevent unnecessary referral and attendance. • Increased use of virtual appointments • Restart of face-to-face appointments for Essential Services. • Improved management of waiting lists (validation) and patient pathways • DNA monitoring and management • Opthalmology Gold Command established and meeting on a monthly basis, chaired by Deputy COO, reporting to Q&S Committee • All ophthalmology patients categorised by condition • Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on the follow-up list. • Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow-up backlog. • Outsourcing of cataract activity to reduce overall service pressure. • Redesign of approaches to improve waiting list management. Rollout of See On Symptom and Patient Initiated Follow-Up principles and processes where clinically appropriate have been implemented. Surgical Services • The Health Board is following Royal College of Surgeons guidance for all surgical procedures and patients on waiting lists have been categorised accordingly.	Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board, which has continued throughout the Pandemic Update report on “Reset & Recovery” of Essential Services Regular reports from Ophthalmic Gold Command received by Q&S Committee. Planned Care update report received by the Q&S Committee in November 2020. A&A Report SBU-1920-021 WHO Checklist Limited Assurance A&A Report SBU-2021-015 Adjusting Services: Quality Impact Assessment Reasonable Assurance		✓ ✓ ✓ ✓	 ✓	Lack of robust demand and capacity plans for all specialties, based on core capacity Planned Care Programme Board with associated infrastructure to support and oversee recovery plans not established Resource envelope for implementation of Planned Care Recovery Plan not confirmed. Confirmation on a risk stratification approach to the future delivery of planned care not received. Three serious incident reports were reported in Ophthalmology during 2021. There is a need to review Business Continuity Plans in place, in the context of the impact of a site needing to ‘close the front door’	The roll-out of key elements of the Outpatient Transformation Programme within high priority specialty areas identified with DU’s/Service Groups has commenced. **Ongoing** A bespoke Outpatients Dashboard, reporting ‘real time’ analytics across all departments has been implemented. A GP facing page is currently in development **30/04/2022** Collaborative working/redesign to identify areas where it would be suitable to transfer outpatient services to primary care/community settings in key areas has commenced and is ongoing. For example: • Dermatology • Ophthalmology • Cardiology • ENT **Ongoing** Development of clinical pathways prioritising COPD, Heart failure and diabetes to ensure seamless patient journey from primary/community and secondary care services. Facilitation of shift left maximising care closer to home providing access to diagnostics, specialist community services and expert secondary care advice. These have been identified as a priority for 2022/23 **31/03/2023** **Surgical Services** Plans are currently being developed for Post Anaesthetic Care Units in Singleton and NPTH to support the flow of elective cases. **31/05/2022** **General** • Completion, collation and review of specialty specific harm assessments **Ongoing**

• Treatment stage RTT patients clinically prioritised against RCoS guidelines during weekly meetings. • Ongoing work within Delivery Unit operational structures and established Surgery and Theatre planning groups to maximise available theatre capacity. • A live dashboard for all surgical demand has been developed, supplemented by a scheduling tool to ensure that available capacity can be used to maximum benefit. • Bi-weekly Recovery meeting for assurance on the recovery of our elective programme. • Work has been undertaken in conjunction with Productive Partners to develop monitoring tools that use the data derived from TOMS to improve monitoring and efficiency of theatre capacity utilisation and benchmark performance • Implementation of WPAS update in order to enable reporting of planned care wait times using new deferred target dates based on clinical assessment. General • Clinically and where necessary MDT-led review and prioritisation of patients on waiting lists. Where appropriate, alternative treatments or regimes are agreed. • Quality Impact Assessment process set-up to manage the re-start of essential services • Annual plan based on specialty level capacity and demand models which set out baseline capacity and solutions to bridge the gap. • Focussed intervention in train to support the 10 specialties with the longest waits. • Fortnightly performance reviews to track progress against delivery • Sites have business continuity plans in place in the event that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate • Long waiting patients are being outsourced to the Independent Sector • Additional internal Activity is being delivered on weekends (via insourcing) The Planned Care Recovery Programme Board has been established supported work streams for outpatients, theatres/surgery and diagnostics						Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments. **31/03/2022** Implement a full range of interventions to support patients to keep active and well whilst on a waiting list. The focus will be on cancer patients awaiting surgery and long waiting orthopaedic patients. **31/03/2022** Develop Robust demand and capacity plans for delivery in 2022/23 **31/03/2022** An overall Regional Ophthalmic Sustainability Plan to be delivered **31/03/2022** An additional ophthalmology day case theatre will be operational at Singleton during 2022. **31/07/2022**

Review of HB-Wide Local Choices Framework and Service Group Managed Retreat choices undertaken during January 2022						

4.4	Deprivation of Liberties Safeguards	Associated HBRR Entries: HBRR 43 – Assessment Authorisation and Compliance with Legislation				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Oversight via Mental Health Legislation Committee (MHLC) • DOLS assessment supervisory body signatories increased (Feb ’18) • DOLS Improvement Action Plan produced by Supervisory Body (March ’18) • DOLS Improvement Subgroup Established, with reps from all SDUs and Corp Safeguarding. (Feb ’18) • Rota for internal non-substantive HB BIA Implemented. • 2 x substantive BIA posts and additional admin post created. • Introduction of referral triage process and prioritisation tool. • DoLS database updated and Dashboard devised to enable more accurate monitoring and reporting. • Funding for HB Management lead secured until March 2022 • DoLS training continues via virtual platforms and staff attendance is reported to MHLC • A webinar providing training on the application of DoLS in 16 and 17 year olds has been developed and is available for staff on the intranet • Successful bid to WG for additional funding to manage DOLS assessment backlog and implementation of Liberty Protection Safeguards. • Head of Nursing for Liberty Protection Safeguards in post (December 2021). Providing support for consultation on LPS code of practice and guidance. • Continuing to review elements of MCA DoLS service and development in readiness for implementation of LPS	• Update reports to the Mental Health Legislative Committee. These include performance data. • Scrutiny via Service Group and Safeguarding Committee meetings. • Monitoring via DOLS dashboard. • NWSSP A&A follow-up review on implementation of previously agreed recommendations attained reasonable assurance (Nov. 2019). Updates on progress against recommendations reported to Mental Health Legislation Committee.	 ✓ ✓	✓	 ✓	Insufficient BIA resource available. Limited rota uptake due to inability to release staff. Workforce availability Date of implementation of Liberty Protection Safeguards delayed by Welsh Government. New implementation date has not yet been confirmed.	Business case for the revised service model to deliver Liberty Protection Safeguards is being developed. **TBC** Agency commissioned to support backlog of assessments by end of March **31/03/2022** Overtime agreed to fund sign-off from nurse assessor team to process the backlog assessments to end of March to support above process. **31/03/2022**

4.5	Trans-catheter Aortic Valve Implementation (TAVI)						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
The Health Board has commissioned the Royal College of Physicians to undertake a review of the service. Recommendations made as a result of the review(s) have been fully implemented. TAVI recovery action plan(s) implemented Appointments made to key medical and nursing posts. Quality Dashboard put in place to monitor the quality and safety of the service.	Royal College of Physicians reports Recovery action plans receive regular oversight at TAVI Operational Gold meetings, with progress also reported to the Quality & Safety Committee and the Board. Reporting to Q&S Committee and Board confirms backlog has been cleared Reduction in procedure waiting times Monitoring and reporting of quality dashboard. Risk Register score further reduced from 16 (initially 25) to 12 Confirmation received from the RCP that they are content with the corrective action taken Welsh Health Specialised Services Committee (WHSSC) have confirmed that the TAVI service has been taken out of escalation.	 ✓ ✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓	None identified	Process ongoing to address breach of duty and redress with families. **(Ongoing)**

4.6	Cancer & Palliative Care Services	Associated HBRR Entries: HBRR 50 – Access to Cancer Services				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Diagnostic procedures for USC maintained throughout pandemic in line with Essential Service guidance. National Endoscopy Programme (NEP) deferred patient spreadsheet utilised to track deferred procedures, surveillance, screening and USC patients. Establishment of Health Board Cancer Performance Group, which will support execution of service delivery plans for improvements and report to the Cancer Performance Board Process developed to manage each individual case on the Urgent Suspected Cancer pathway. Enhanced/weekly monitoring of action/improvement plans for top 6 tumour sites. Prioritised pathway in place to fast track USC patients. Initiatives to protect surgical capacity to support USC pathways have been put in place. Additional investment in MDT coordinators, with cancer trackers appointed (April 2021). Weekly cancer performance meetings for both NPTS and Morriston Service Groups. Additional endoscopy sessions (3) implemented from October 2020 Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy. Endoscopy contract has been extended for insourcing Faecal Immunochemical Testing (FIT) implemented for low risk groups. Primary care roll-out commenced 07/02/2022	Performance reports received by the Q&S and P&F Committees. Update report on “Reset & Recovery” of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports. Backlog trajectory to be monitored in weekly enhanced monitoring meetings.	 ✓ ✓ ✓ ✓	✓ ✓		The Health Board scores below average in all but two of the seven priorities of care from the National Audit of Care at the End of Life (NACEL) 2019/20. Further work required to ensure that all patients referred for USC radiology investigations are registered for monitoring and reporting purposes in support of the implementation of the Single Cancer Pathway (SCP) Performance and activity data monitored, but delays in treatment continue while sustainable solutions found.	Phased and sustainable solution to the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services **31/03/2022** Implement process for Clinical Harm Review **28/02/2022** Cancer Performance Board to be established. **28/02/2022** Capacity increased within CT/MRI via recruitment and extended working hours. Further increase to 6 day working planned for 22/23, subject to funding. **31/03/2023 (Subject to Funding)** Business case for delivery of Acute Oncology Services (AOS) from Morriston Hospital approved by Business Case Advisory Group. Currently out to advert to recruit workforce. Implementation planned for end of Q2. **30/09/2022** 10-Year regional transformation and development plan for SWWCC in conjunction with Hywel Dda. Business case to presented by and of Q2 (ARCH) **30/09/2022** Agree scope for a review of EOLC by NWSSP Audit & Assurance Services. **30/06/2022** Work has commenced on developing the use of digital technology (SIGNAL) to map compliance and notification of patients who require or are receiving EOLC. **31/03/2022**

Redesigned endoscopy Straight To Test (STT) pathway implemented 01/12/2021 Increased service provision in respect of Capsule Endoscopy, PH Manometry and hydrogen breath test procedures during 2021/22. A draft EOLC Training plan has been put in place, approved by the EOL Steering Group in February 2022.						

4.7	Access to Cancer Services (SACT)	Associated HBRR Entry: HBRR 66 – Access to Cancer Treatment (SACT)				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Review of Chemotherapy Delivery Unit by Improvement Science practitioner. Additional funding agreed to support increase in nursing establishment. Review of scheduling by staff to ensure that all chairs are used appropriately. Daily scrutinising process in place to micro-manage individual cases, deferrals etc. Number of Chemotherapy chairs reduced in order to reflect COVID-19 controls (social distancing). Utilisation/capacity rate target set. Option appraisal completed by Service Group. Business case for shift of capacity to home produced and endorsed by CEO and agreed at Business Case Advisory Group and Management Board.	Performance reports received by the Q&S and P&F Committees. Update report on “Reset & Recovery” of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports.	 ✓ ✓ ✓	✓ ✓		Shortfall in ‘Chair’ capacity identified, with lack of approved solution for 2021/22. No plan for increasing capacity to meet social distancing requirements and growth in demand in 2022/23. Capital and revenue assumptions and resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.	Recruitment to posts to allow increase in homecare capacity **Ongoing** Second business case being developed to propose relocation of Chemotherapy Day Unit to a vacant ward area, which would increase chair capacity. **28/03/2022** Subject to approval of the above, relocation will progress with the aim of completion following the relocation of the acute medical intake to Morriston **31/10/2022 (Estimated)**

4.8	Radiotherapy	Associated HBRR Entry: HBRR 67 – Access to Radiotherapy Treatment				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place. Requests for treatment and treatment dates monitored by senior management team. Outsourcing of appropriate radiotherapy cases. Additional outsourcing for Prostate RT commenced June 2021.	Performance and activity data monitored and shared with radiotherapy management team and cancer board. Performance reports received by the Q&S and P&F Committees. Update report on "Reset & Recovery" of Essential Services Self-Assessment against framework for the reinstatement of Cancer Services in Wales during COVID-19 Cancer Services performance update reports to the P&F and Q&S Committees. Operational Plan performance tracker reports. Reduction in Risk Register score from 25 to 15	✓ ✓ ✓ ✓	 ✓ ✓ ✓		Additional capacity sought through outsourcing. Business case to rollout hypo fractionation not approved by Management Board Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.	Explore further implementation of revised radiotherapy regimes (hypo fractionation) for specific tumour sites. **Ongoing** Submission of business plan for additional resources required to implement hypo fractionated Prostate technique. **31/03/2022** Case agreed with Welsh Government for third Linear Accelerator **31/07/2022** To explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Finance Teams at SBUHB and HDUHB are meeting to finalise cost for case prior to submission to WHSSC **01/04/2022**

4.9	Fetal Growth Assessment	HBRR 63 – Screening for Fetal Growth Assessment in line with Gap-Grow

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
All staff have received training on Gap & Grow, and detection of small for gestational age (SGA) babies Obstetric scanning capacity across the HB is being reviewed, and compliance with criteria for scanning is being monitored. A local health Board policy has been written and ratified by the antenatal forum to prioritise the available scanning capacity based on level of risk. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening, and to comply with Gap & grow recommendations. Maternity services have employed a lead sonographer band 8a for a fixed contract to support training, policy preparation and audit for midwife sonographer service Two further midwives commenced sonography training in January 2022. Funding for a 2nd ultrasound scan machine has been secured.	Gap & Grow training compliance monitored Audit of compliance with guidance being undertaken. Detection rates of babies born below the 10th centile is being monitored via DATIX and audited by the service. The birthweight centile has been included in the latest update of the electronic maternity system	✓ ✓ ✓ ✓			Critical midwifery staffing levels have reduced training opportunities and reduced compliance Challenges in achieving required levels/volume of scanning due to capacity issues. Radiology have introduced 30-minute scan timings for fetal anomaly scan in line with Antenatal Screening Wales standards. This has further reduced capacity by 20-25 scans per week conducted by radiology department. Ultrasound scan department have been unable to support training for the trainee midwife sonographers. COVID 19 necessitated further change to the serial growth scan regime due to staff availability and women's ability to attend the department if self-isolating.	Lead midwife sonographers to develop action plan for increased compliance with training standards **Ongoing** Two Midwife Sonographers have been appointed and completed training. They are currently in a preceptorship period. It is anticipated that they will provide an increase of ultrasound scan capacity by 3,000 scans per annum in structured clinics commencing January 2022. **31/12/2022** **Realise increased capacity** Ultrasound working group to work with HEIW, the Maternity Network and all Wales Imaging Academy toward a Wales Ultrasound accredited training Programme **Ongoing**

4.10	Cardiotocography (CTG)	HBRR 65 – Misrepresentation of Abnormal Cardiotocography (CTG) Readings				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
All relevant staff undertake mandatory training in line with the all-Wales Intrapartum Fetal Surveillance Standards for Maternity Services. Protocol in place for an hourly "fresh eyes" on intrapartum CTG's, and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. An appropriate fetal monitoring system (the K2 system) has been identified as the best option for central monitoring CTG envelopes placed in every set of records for safe storage of CTG. Fetal Surveillance Midwife and lead obstetrician appointed. Maternity Services Improvement Plan in response to recommendation made in Phase one of Health Inspectorate Wales National Review of Maternity Services.	Monitoring of compliance with rate of annual mandatory training Initial capital funding for central monitoring system agreed. Updates on progress against this risk monitored at QSGG. Welsh Risk Pool have established an improvement programme to build on previous work in this area. Health Inspectorate Wales National Review of Maternity Services.	✓ ✓ ✓ ✓		✓	Central monitoring system to store CTG recordings of foetal heart rate in electronic format not yet in place CTG traces can be lost if not filed correctly Fetal surveillance midwife and obstetrician have to spend an excessive amount of time preparing for reflection sessions having to film and copy CTG traces to share.	Approval received for capital spend on K2 central monitoring system. Procurement process to be finalised by Divisional Manager and key stakeholder. • 8-12 weeks for system delivery • 6-8 months for implementation To set up a project steering group once purchase of system completed. Sub groups of the steering group will include; • Clinical group • Informatics group **Ongoing**

4.11	Clinical Standards and Audit Performance

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
National Clinical Audit and Outcome Review Advisory Committee Programme Health Board Clinical Audit & Effectiveness Team in place. HB Clinical Outcomes and Effectiveness Group (COEG) established. NICE Guidance Review of LocSSIP and WHO Surgical Checklist audits form standing agenda items at meetings of the Clinical Outcomes and Effectiveness Group (COEG) Approved local SBUHB Mortality Review Framework document and SOP in place.	• Midyear and annual reports received and scrutinised by the Audit Committee, together with an update report to the Quality & Safety Committee • COEG update reports to the Quality & Safety Governance Group • Quarterly mortality review reports to the Quality & Safety Committee (commenced August 2021) • Local Delivery Group Clinical audit programmes • Delivery Group Clinical Audit Groups • HIW Inspections • A&A Report ABM-1819-022 Clinical Audit & Assurance Limited Assurance • A&A Report ABM-1819-025 Mortality Reviews Limited Assurance • A&A Report SBU-2021-028 Mortality Reviews Limited Assurance • A&A Report SBU-2021-026 WHO Surgical Safety Checklist (F/UP) Limited Assurance	 ✓ ✓ ✓	✓ ✓	 ✓ ✓ ✓ ✓ ✓	Absence of formal policies and procedures relating to the mortality review system. TOMS Checklist completion data and output from observational audits not reported consistently at Unit/Group level. (WHO Checklist) Monitoring of WHO checklist compliance not evident at corporate groups. Unknown impact of NHS England's proposed withdrawal from the national clinical audit programme Scope identified to improve assurance reporting to the Q&SC in respect of outcomes and action taken following mortality reviews.	Changes to the national programme, and implications for all-Wales guidance and UHB clinical audit coverage to be monitored via the work programmes of the Audit and Quality & Safety Committees. **Ongoing** Medical Examiner service being rolled-out across Wales with expectation that it will become a statutory function from April 2022. An audit of the mortality review process is planned once the ME system has had an opportunity to bed in. **30/09/2022**

4.13	Test, Trace and Protect

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Multi-agency COVID-19 Prevention & Response Plan in place. Local testing framework developed and agreed through multi-agency arrangements 'Drive Through' testing units established, supported by mobile testing units and 'walk-in' facilities. Epidemiology data and intelligence reviews to identify clusters/outbreaks, and use of mobile testing units to provide rapid response testing events. Care home and home testing also undertaken as required, as is pre-care home admission and pre-elective procedure testing. Weekly 'screening testing' at care homes. Flexible workforce capacity plan developed. Production of weekly TTP activity summary reports Multi-agency Regional Response Team established to oversee and support local contract tracing teams. Multi-Agency Communication Plan developed utilising multiple media platforms. RAID log (Risk, Action, Issues and Decisions) maintained for the TTP programme. Priorities set and documented within the 2021/22 Annual Plan	Board reports detailing testing capacity within the system, and uptake. Testing data included in Integrated Performance Reports, including staff testing data. Operational Plan delivery and performance tracker reports. Weekly TTP activity summary reports are reviewed at Regional Response Team and TTP Silver. Notes of the TTP Silver meeting are then considered at Health & Social Care Interface Group and HB Gold meetings.	 ✓ ✓ ✓	✓		None identified. – Regional Multiagency TTP Silver meets fortnightly and updates via SITREP to Multiagency and HB Gold on issues including any for escalation. – Testing provision plan (for all provision) agreed and any changes agreed through TTP Silver and notified to Gold. – Workforce plan for TTP developed and agreed based on WG funding. Revised to align with new funding allocations. Signed off by Gold. – RRT established, recently combined with Operational Cell, reports to each TTP Silver and then to Gold. – Multiagency Comms Group in place, reporting to TTP Silver, which implements agreed comms plan on key activities and reports through to Gold.	Maintain regular reviews of guidance and adapt TTP actions and plans accordingly. **Ongoing**

4.14	Mass Vaccination

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Set-up of Strategic Immunisation Silver group as part of the overall COVID command structure, to oversee implementation of vaccine delivery programme, supported by the following Work Cells: – Clinical Governance – Workforce – Digital – Supply & Logistics – Operational Delivery COVID Vaccine Delivery Plan in place and shared with Welsh Government and regularly updated. Vaccinations targets clearly set and documented within the 2021/22 Annual Plan Multi-Agency Communication Plan developed utilising multiple media platforms. Mass vaccination centres established, supported by satellite facilities, 'in reach' capacity, and hospital sites for Health Board staff. Mobile unit also in place. Primary care commissioned to support the vaccination programme as part of the Primary Care COVID Immunisation Scheme. RAID log (Risk, Action, Issues and Decisions) maintained	Strategic Immunisation Silver share regular highlight reports with Gold command. Update reports to the Board A&A Report SBU-2021-045 Mass Vaccination Programme Advisory Review Report No Assurance Rating Given	✓	✓	✓	Oversight of primary care activities is through self-reporting whereas Health Board activities are overseen by internal clinical and operational audits and reporting through Silver to COVID Gold. Primary care participation is voluntary Booster campaign	Assessment of the capacity needed to deliver a booster programme, potentially alongside flu vaccinations, including the potential for further primary care involvement and additional local vaccinations centres is being undertaken. **Ongoing** Vaccination programme activity and performance to be reported to and overseen by the Performance & Finance Committee, which will provide assurance to the Board. **Ongoing** Scenario planning has commenced to scope out issues in respect of re-vaccination. **Ongoing** Identification of immunosuppressed eligible for third primary dose of vaccine (in line with updated JCVI guidance) is underway **Ongoing**

4.15	Impact of COVID on HB Underlying Financial Position	Associated HBRR Entry: HBRR 73 – Impact of COVID on HB Underlying Financial Position				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Financial plan reported to and approved by Board as part of the Annual Plan. Risk-assessed savings plan in place, linked to opportunities pipeline developed with the support of KPMG. Mechanisms establish to record, monitor and report the financial impact of the COVID response, to include impact on savings delivery and investment impact as well as direct costs. Additional COVID-related funding secured from WG. Multi-disciplinary scrutiny group to review investment service proposals related to the reset and recover programme, within the context of the operational plan Finance Review Meetings with Service Groups Regular reporting to and dialogue with WG and Finance Delivery Unit regarding the financial plan and position Clear financial plan being developed for 2022/23	Regular reporting/monitoring of the financial position, movements and risks, notably at Performance & Finance Committee and the Board. Performance against savings targets separately reported. Financial impact of COVID separately reported. Monthly monitoring returns to and regular meeting with WG A&A Briefing Paper SBU-2122-004 Delivery Framework No Assurance Rating Given	 ✓ ✓	✓	 ✓ ✓	There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. The residual cost base risk remains difficult to assess as the Health Board continues to respond to the impact of the pandemic Reporting on savings opportunities and service change impacts to be developed.	Critical review of all costs related to COVID response to be undertaken in February 2022 **28/02/2022** Welsh Government appraised of content of revised revenue plan to consider possibilities of support for key areas. Awaiting feedback **TBC** All Wales work through Directors of Finance to benchmark costs and work with WG on solutions. **31/03/2022** .

4.17	Controlled Drugs	Associated HBRR Entries: HBRR 57 – Compliance with Home Office Controlled Drug Licensing Requirements				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Health Board "Policy to Determine the Requirement for Home Office Controlled Drugs Licenses" has been shared with the Home Office, and a meeting requested.	Audit & Assurance Briefing Paper Controlled Drugs Governance (SBU-2122-006) No Assurance Rating Given			✓	HB does not currently hold a Home Office Controlled Drugs license in respect of HMP Swansea. The HB currently has limited assurance regarding compliance with Home Office CD licensing requirements. A requested meeting with the HO has not yet taken place. There is a need to address completeness (PCT) and out of date actions contained within Service Group Controlled Drug Management & Assurance Plans (CDMAP)	HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO. **01/03/2022** Upon agreement of policy with the HO: HB to undertake baseline assessment of current CD management (including any HO CD licenses currently held) in line with agreed policy on requirements for HO CD licenses **01/03/2022** Upon agreement of policy with the HO: HB to develop and implement a control system to ensure compliance with agreed policy on HO license requirements. **01/03/2022** HB to apply for a Home Office Controlled Drugs license in respect of HMP Swansea **01/03/2022**

4.18	Health, Safety & Fire	Associated HBRR Entries: HBRR 64 – Health, Safety & Fire Function Resource				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place. Fire risk assessments are being prioritised with temporary additional resources put in place in March 2021 to reduce the number of FRA overdue. Fire training in place and fire wardens in place Two fire advisors were successfully appointed, with expected commencement in February 2022	Monitoring and reporting through the appropriate group/committees (e.g. Health & Safety Operational Group, Health & Safety Committee) to receive assurance and/or identify gaps for key compliance and adherence to applicable legislation. Site visits to identify compliance and/or gaps HBRR 13 (Environment of Premises), which relates to compliance in terms of appropriate accommodation in line with H&S Regulations has reached and maintains its target score of 12.	✓ ✓ ✓	✓		Agreement of funding for resources identified in business case to implement structure in business case by Q2/3 2022/23 financial year.	Health and safety department structure reviewed and proposals & business case produced. Discussion ongoing to determine funding. **31/03/2022** Health and safety structure review to be presented to the H&S Committee when funding has been agreed (the target date has been adjusted to reflect this). **31/03/2022**

4.19	Integrated Medium Term Plan (IMTP)	Associated HBRR Entry: HBRR 39 – Approvable IMTP for 2022/23				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Draft Annual Plan within a 3 year context considered by the Board in March 2021 and submitted to WG. Final Annual Plan approved by the Board on 23 June 2021, including a balanced financial plan, and submitted to WG on 30 June 2021. • The Health Board is developing a 3 – 5 Recovery and Sustainability Plan which will provide the foundation to deliver an agreed IMTP for 2022/23. • Recovery and Sustainability Working Group has been established, chaired by CEO with independent members and Executive leads. • IMTP Executive Steering Group (ESG) in place	SBUHB de-escalated from targeted intervention to 'enhanced monitoring' status.			✓		Development of draft Recovery and Sustainability Plan for approval by the Board **31/03/2022**
	Oversight of the R&S Plan provided by existing IMTP Executive Steering Group	✓				
	Performance and Finance Plans assured by P&F Committee.		✓			
	Workforce plan overseen/assured by W&OD Committee		✓			
	Quality and safety element assured/overseen by Q&S Committee		✓			
	JET meetings with WG.			✓		
	Update on Annual plan progress as at Q2 was reviewed by Board in Nov 2021 and adjustments to off track actions approved in Dec Special Board.		✓			
	A&A Report SBU-2122-012 Annual Planning Approach Reasonable Assurance			✓		

4.20	Singleton Hospital Replacement Cladding	Associated HBRR Entries: HBRR 41 – Singleton Hospital Replacement Cladding				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Fire risk assessments. • Evacuation plans (both vertical and horizontal) in place • Fire safety training. • Professional advice sought on compliance of panels. • East and West flank panels removed • Full business case and planning approval south panel removal and updating obtained. Work is progressing on site.	A&A Report SSU-SBU-2122-001 Singleton Hospital Replacement Cladding Reasonable Assurance			✓	Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. South Wales Fire and Rescue Service may issue a Fire Enforcement notice due to the ongoing risk of fire spread.	Change in fire evacuation plans and alarm and detection cause and effect **28/02/2024** Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate **04/03/2024**
	Monitoring through Health & Safety Committee	✓				
	Site visits/tours	✓				
	Project Board meetings	✓				
	Regular reports to H&S committee		✓			

4.21	Child & Adolescent Mental Health Services (CAMHS)	Associated HBRR Entries: HBRR 48 – Child & Adolescent Mental Health Services HBRR 69 – Adolescent Patients Admitted to Adult Mental Health Wards

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
CAHMS Commissioning Group in place. Children and Young Peoples Emotional and Mental Health Planning Group 3-Year plan 2021-2023 in place. Performance Scrutiny is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. A CAMHS performance improvement plan against waiting list targets has been shared by CTMUHB. Action to mitigate the risk to young people waiting to access the service is being taken, including utilization of the third sector for support. --- Safeguarding training for staff Joint protocol with Cwm Taf LHB CAMHS (currently subject to review) Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. Only adolescents in the 16-18 age range are admitted to the adult Ward, into individual Rooms with *en suite* facilities	A&A Report SBU-2122-018 CAMHS Commissioning Arrangements Limited Assurance CAMHS performance against local and WG targets included in Integrated Performance Reports Monthly monitoring of progress against waiting list improvement plan via the CAMHS Commissioning Group, with quarterly updates to the Management Board, and to Performance & Finance Committee when required. --- Monitoring of staff training Monitoring of admissions by the MH&LD Service Group Legislative Committee		✓	✓	Lack of SLA/Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS The CAMHS Commissioning Group Terms of Reference are in need of review and enhancement Roles and responsibilities for the management and monitoring of CAMHS internally, including governance arrangements and escalation of issues highlighted at the CAMHS Commissioning Group, are not fully documented. Scope identified to review and enhance the content and level of detail within the CAMHS Commissioning Group meeting action notes. The HB has not identified quality measures in respect of CAMHS being provided to the patients or the outcomes for those patients. The Mental Health Legislative Committee felt the CAMHS governance report provided by CTMUHB did not provide sufficient assurance. Scope identified to enhance the content and level of detail within the waiting times action plan in respect of CAMHS Scope identified to improve clarity around reporting, review and escalation of operational and/or commissioning risks in respect of CAMHS CAMHS service have developed an action plan including strengthening staffing arrangements in short term, but performance not currently improving so risk score stays the same. --- The Service Group continues to flag the risk of adolescent patients being admitted to Adult MH Wards, particularly in light of Ward F [NPTH] being identified as the SPOA for AMH in the HB, which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission. This has served to increase the already identified risks for young people in the environment.	Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS to be developed. **30/06/2022** A paper setting out Governance arrangements in place relating to the CAMHS Commissioning process will be taken to the March 2022 meeting of the Management Board **31/03/2022** The CAMHS Commissioning Group Terms of Reference have been reviewed and updated, and will be taken to the March 2022 meeting of the Management Board **31/03/2022** Following the release of admin resource which is currently supporting work relating to the pandemic response, minuting of meetings of the CAMHS Commissioning Group will be reinstated **31/03/2022** Through work to develop the Service Specification, the Health Board will identify further quality measures and outcomes for CAMHS patients. **31/07/2022** Issues around the content of reports provided to the Mental Health Legislative Committee will be followed up and addressed as the reporting arrangements restart following the pandemic. **31/03/2022**

4.22	Nosocomial Transmission	Associated HBRR Entry: HBRR 78 - Nosocomial Transmission				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Nosocomial transmission Silver cell established to report to Gold Command. A nosocomial framework has been developed to focus on: • Prevention • Response. Preventative measures are in place including: • Testing on admission • Segregating positive, suspected and negative patients • Reinforcing PPE requirements • Focus on behaviours relating to physical distancing. Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas such as PPE and physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.	Standing Work Plan item for the Quality & Safety Committee, with regular updates received. Monitor Outbreaks throughout the HB Review Nosocomial Deaths and lessons learnt	 ✓ ✓	✓		Outbreak remains in Morriston Service Group and evidence has shown that sustainability of IPC processes are challenging. Indications that testing is not as effective on staff who have been fully vaccinated. Audit of compliance of sustainable IPC practices and training compliance. Implement lessons learnt from outbreaks and death reviews.	Additional reviews are being undertaken with the authorised engineer to assess options of providing more localised systems to increase air flows. **Ongoing**

4.23	Managing Financial Risk	Associated HBRR Entry: HBRR 79 – Availability of Resources to Provide Improved Assess				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• Working with specialists to develop plans to maximise Health Board capacity safely and within extant COVID guidelines • Developing more advanced service models to test scenarios to allow for accurate demand and capacity plans to be developed • Ensuring that financial controls are in place to enable swift decisions to be made on allocation of additional resource but also ensuring that the commitment made do not exceed the allocation sum (when known) • Transparent reporting to Performance and Finance Committee and Quality and Safety Committee on progress and plan development. • Prioritisation of key services via clinical leaders	Monthly financial recovery meetings Performance & Finance Committee and Audit Committee reporting Routine reporting to the Board of the most recent monthly position and availability of national funding to support recovery. A&A Report SBU-2122-015 Procurement & Tendering (STA/SQA) Limited Assurance A&A Report SBU-1920-016 Procurement (No PO / No Pay) Limited Assurance A&A Report SBU-2021-043 Integrated Care Fund: Banker Role No Assurance Rating Given	✓	✓ ✓	 ✓ ✓ ✓	Significant backlog for patients to access across elective and cancer care in the following areas: • Diagnostics • OP • IP&DC • Therapy • Oncology The Health Board funding requirement is in excess of the funding available and therefore choices will need to be made on priority schemes for funding. The full list of ambitions/schemes is not affordable.	Develop a final annual plan setting out prioritised recovery plans with the available funding. **31/03/2022** Ensure that overall financial plan for 2022/23 can accommodate as much clinical capacity as possible by delivering savings and taking a risk assessed approach **31/03/2022** Undertake a robust prioritisation exercise with clinical leaders to identify core service areas to be funded **28/02/2022** Identify opportunities for further improvement to enable swift decision making and provide clarity to WG of the potential services that could be delivered if constraints removed. **31/03/2022** To complete/resolve all agreed actions stemming from the A&A Report on Procurement & Tendering (SBU-2122-015 refers) **01/04/2022** Complete review of SLA with Procurement Services, as part of the deployment of the National Operating Model (NOM) for procurement. **30/04/2022**

4.24	Critical Midwifery Staffing Levels	Associated HBRR Entries: HBRR 81 - Critical Midwifery Staffing Levels				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• All midwives are working at the hours they require up to full time. • A small midwifery bank has been created. • All midwives are offered additional hours. Enhanced overtime promoted, provided and accepted. • Where able, block booking agency midwives to improve the baseline numbers in the obstetric unit. • Bank and agency SOP in place and working effectively. Bank and a limited number of agency midwives have been employed as appropriate to maintain safe staffing levels within the Obstetric Unit and Community Services. • Band 6 recruitment in train. • Student midwives on pre-qualifying placement are supporting in the clinical areas within their student capacity. • 11 new midwives have been employed from September- October 2021. 6 started. • Risk assessments are currently taking place with OH and H&S leads support for matrons to return staff to clinical front facing roles where possible • Centralisation of community services to improve staff availability • NPT Birth Centre temporarily suspended - services relocated to The Bay Birth Centre in S'ton Hosp. • Daily escalation call with the SG Service Director and Nurse Director to do 24 hour lookback on potential harm events, patient and staff experience, and 3 day look forward of staffing • On call manager for Women and Child Health available 24/7. • Hywel Dda UHB are buddying up to provide support	Datix reports are submitted when appropriate. Daily briefings with the senior team are taking place for updated position	✓ ✓			Unplanned absence resulting from COVID-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels	Working with 2020 band 5 midwives to support achievement of their preceptor passport for transition to band 6 **Majority Complete** **Remainder March 2022**

4.25	Delays in Induction/Augmentation of Labour	Associated HBRR Entries: HBRR 74 – Delays in Induction/Augmentation of Labour				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Diary is maintained for booking of IOL with agreed numbers of IOL per day. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. If IOL's/ Augmentation of labour are put on hold/delayed the women are reviewed by the MDT to assess for any potential risk to mother or baby. Escalation to the appropriate senior staff takes place and the Escalation Policy is implemented. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The senior midwife will review staffing across all areas and deploy staff if possible including the specialist midwives and the community midwifery on call team. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women.	Daily acuity is gathered and sent to the senior midwifery management team If any delays for transfer to Labour Ward occur, this is incident reported and reviewed.	✓ ✓			The IOL is booked and it is anticipated this should take place as planned within the standards set. However, for reasons of acuity in either maternity services or neonatal services, admission for IOL, continuation of IOL that has commenced or augmentation of labour is sometimes not possible	Ongoing review of risk by Head of Midwifery **Ongoing**

4.26	Burns Anaesthetic Consultant Cover	Associated HBRR Entry: HBRR 82 – Risk of Closure of Burns Service / Burns Anaesthetic Consultant Cover				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
The general ITU consultants to support the Burns service in its current location on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide critical care input for burns patients Plans in place to co-locate the Service with General ITU. Managing sickness and job planning process to sustain existing consultant workforce as far as possible. Maintenance of urgent assessment/stabilisation service for patients in Wales with severe burns, with onward transfer for inpatient care to another unit in the UK following the initial assessment. The service in SBUHB will fully reopen with the support of GITU Consultants on 14/02/2022	Future final model of co-location with GITU consistent with provision of Burns service elsewhere in the UK. Model will comply with burns care standards.	✓		✓	• Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants to cover while building work is completed in order to co-locate the burns service on General ITU	Submit bid for capital funding to Welsh Government for both phases of work required to co-locate the burns Service with General ITU **TBC**

4.27	Impact of COVID on Capital Plan and Resource Limit	Associated HBRR Entry: HBRR 72 – Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2021/22				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Regular dialogue with Welsh Government regarding capital requirements. Clear communication and reporting of the capital position, the risks and limitations. Close management of all schemes to ensure slippage is understood along with the impact on service. Clear prioritisation of any new requirements recognising the current constraints Routine assessment of local demands for discretionary capital spend through internal capital prioritization group which meets monthly.	Monthly capital prioritisation group Performance and Finance Committee Monthly Monitoring Returns to Welsh Government.	✓	✓	✓	The Health Board has been advised that its discretionary capital allocation for 2022/23 as been reduced from £11.1m to £8.5m. There is a risk that funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment Reporting on impact of constraints to the capital programme on service delivery.	Formal review of existing capital plan to revise schemes and scheduling of schemes to move to balance ongoing. Updated 2022/23 Capital Plan to be tabled for discussion at Management Board **31/03/2022** Welsh Government appraised of content of revised capital plan to consider possibilities for support for key areas. Awaiting feedback. **TBC**

4.28	Release of Bed Capacity	Associated HBRR Entry: HBRR 83 – Release of Bed Capacity to Achieve Savings Scheme Requirements					
Key Controls		**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
			1st	**2nd**	**3rd**		
Extensive bed modelling and benefits realisation checks being carried out in February 2022 Change in front door model at Morriston to reduce admissions Escalation of length of stay improvement via performance framework Monitoring COVID patient numbers and cohorting of patients to reduce surge requirements Commissioning additional care home beds		Assurance would be gained via monitoring and reporting on KPI's • Length of stay reduction • Fewer admissions • Reduced COVID patients in beds • Reduction in surge bed numbers	✓ ✓ ✓ ✓			There is a risk that the health board will not be able to release sufficient bed capacity to meet the requirements of savings schemes predicated on bed release. Signed off plan of beds to be decommissioned	Mitigation plan developed to support savings whilst enabling actions embed. **28/02/2022** Focus on front door redesign to manage patients away for admission to alternative services **TBC** Agree bed plan including agreed occupancy level supported by the modelling **31/03/2022** Delivery of Acute Medical Services Redesign (AMSR) **30/09/2022** Delivery of Virtual Ward model across all clusters **30/04/2022**

4.29	Quality & Safety Framework

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Quality & Safety Process Framework in place, Approved by Q&SC and Executive Board Quality & Safety Committee in place with approved Terms of Reference, supported by a Quality & Safety Governance Group.	A&A Report SBU-2122-002 Quality & Safety Framework Limited Assurance			✓	Implementation of the Quality & Safety Process Framework has been adversely impacted by the need to focus on the COVID response Scope to enhance membership of the Q&SGG, and improve attendance at meetings Variation noted between the Terms of Reference in place in Service Group Q&S Groups. The Quality & Safety Process Framework requires review in light of the impact of COVID-19, revised Health Board quality priorities and the recently issued National Quality & Safety Framework Q&SGG Terms of Reference contain 42 objectives, not all of which are being met. Exception reporting from the Q&SGG into the Q&SC does not prompt information on the operation of service group quality and safety groups.	Externally facilitated Q&S Workshops to review Q&S arrangements and support a refresh of the Quality & Safety Process Framework **30/04/2022** Update Q&SGG and Q&SC work programmes to include a review of the implementation of the Framework. **30/05/2022** A review of the Terms of Reference, role and Function of the Q&SGG to be undertaken. **30/05/2022** A Q&SGG work programme/business cycle will be put in place **30/06/2022** The exception report from the Q&SGG to the Q&SC will be reviewed and a revised template agreed **30/06/2022** Membership of the Q&SGG to be reviewed, which will include confirmation of joint chairpersonship and ensuring consistent Executive Director attendance. **31/05/2022** Key content ‘Golden Threads’ within the revised Quality & Safety Process Framework and Q&SGG Terms of Reference will be identified and shared with quality and safety groups across the Health Board. **31/07/2022**

Enabling Objective 5 – Partnerships for Care	
Principle Risk – Failure to establish and maintain effective relationships with our partners to lead and shape our joint strategy and deliver plans, based on the principles of sustainability, transformation and partnership working	
Executive Lead – Director of Strategy	Assuring Committee – Health Board

5.1	**Partnerships for Care**	**Associated HBRR Entry:** **HBRR 52 – Partnerships for Care (Effective Governance)**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Band 6 recruited and Band 8b Head of Engagement & Partnership appointed to provide additional support for engagement. Formal joint partnership arrangements in place with a number of external partners through: - West Glamorgan Regional Partnership Board, - Swansea Public Services Board - Neath Port Talbot Public Services Board - West Glamorgan Substance Misuse Area Planning Board - NPT Youth Justice & Early Intervention Services Management Board - Swansea Youth Justice Management Board Formal joint partnership arrangements in place with a number of NHS and external partners. Priority areas for joint working are established identified in the Annual plans and by operational service plans such as: • Oesophageal and gastric cancer • HepatoPancreatroBiliary Services • Progressing a Regional Pathology Service SOC with all partners • City Deal Campuses Programme • Development of a Regional Dermatology Service • Development of a Regional Eye Care service • Endoscopy planned care proposals • Service Disaggregation and longer terms plans for pathology, surgical pathways	Consistent attendance is ensured from the Health Board at these partnerships to ensure that the organisation's perspective is reflected and issues are fed back. Formal reports are prepared 3 times a year for Management Board and then Health Board on progress of the various strategic external partnerships listed here and identifying implications for the Health Board from these. Progress reports and minutes of joint meetings are provided to and reviewed by the Board Annual Plan quarterly delivery tracker reports to Management Board and Board. Swansea Bay Regional and Specialised Services Oversight Group. Regional & Specialised Services Provider Planning Partnership ARCH National Endoscopy Group Cwm Taf & Swansea Bay UHB Joint Exec Group	✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓ ✓	 ✓ ✓	Scope to enhance and review processes in place for undertaking Equality Impact Assessments.	Review of the current process for developing Equality Impact Assessments around service change, engagement and consultation. **30/04/2022** Robust policies and processes to be in place for Impact Assessment going forward. **31/07/2022** Equality Impact Assessment responsibilities are incorporated into new planning roles as vacancies arise. **30/04/2022** Conclude work on exec equalities portfolios **31/12/2022** Priorities for the RPB are: - Stabilisation and Reconstruction - Remodelling Acute Health and Community Services - Transforming Complex Care - Transforming Mental Health Services **Ongoing**

5.2	Wellness Centres						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Outline Business Case produced and submitted to Welsh Government Project Board in place.	Board Briefing to the Board in advance of approval of Business Case.		✓		None Identified	Regular updates to be provided to the Board. **(Ongoing)**

5.3	Welsh Language Standards				**Associated HBRR Entry:** **HBRR 53 – Welsh Language Standards Compliance**	
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
• An independent baseline assessment of the Health Board's position against the Standards has been undertaken. This is in addition to the Health Board's own self-assessment. • Work to implement the recommendations contained within the above baseline assessment has commenced. • An online staff Welsh Language Skills Survey has been launched. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst WLO across NHS Wales to inform learning and development of responses to the Standards. • In-house translation team established.	RAG-rated Welsh Language Standards Action Plan in place (although review and update has lapsed) Production of Annual Report. Translation Team workload monitored. Significant increases noted.	✓ ✓ ✓			The RAG-rated Welsh Language Standards Action Plan has not been formally reviewed since January 2020. COVID-19 and Staffing issues have meant that meetings of the Welsh Language Delivery Group had been stood-down since 2020. Issues in respect of ESR functionality mean that the HB does not have a complete picture of workforce welsh language skills.	Reinstate meetings of the Welsh Language Delivery Group **31/03/2022** Review and update the Welsh Language Standards Action Plan. In doing so, reflect the findings of the independent assessment. **31/03/2022** Implement local solution(s) to establish workforce welsh language skills, whilst continuing to explore solutions to issues within ESR **31/03/2022**

Enabling Objective 6 – Excellent Staff	
Principle Risk – Failure to have an appropriately resourced, focussed, resilient workforce in place that meets service requirements	
Executive Lead – Director of Workforce & OD	Assuring Committee – Workforce & OD Committee

6.1	**Workforce Health and Wellbeing**	**Associated HBRR Entry:** **HBRR 77 – Workforce Resilience**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding management of health in the workplace, including Covid-19 related guidance. Multi-disciplinary Staff Wellbeing Service in place providing staff with support for mild-moderate musculoskeletal and mental health problems. Staff wellbeing services also continue to support the needs of COVID-related health impacts, including mental health, trauma and bereavement. Group and 1-2-1 trauma support has been developed and is being accessed appropriately, with an average of 120 new staff referrals each month (Oct 2021). Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to staff health and wellbeing services. The Health board has invested in the TRiM programme (Trauma Risk Management) with 59 TRiM personnel trained to support teams. Over 1200 staff have undertaken REACT (brief trauma training) and evidence shows that this is being implemented successfully in the workplace Support provided for staff with Post COVID Syndrome via an Occupational Therapist based in OH, involving self-management strategies and RTW support where appropriate.	Both the Staff Health and Wellbeing Service and Occupational Health Service have won national awards October 2020, and again in January 2022 from Case-UK Limited Employers positive contribution to their workforce well-being Award. Monthly management data for Occupational Health and Staff wellbeing services regularly reviewed regarding capacity/demand and waiting times. Regular Sickness, Wellbeing and Occupational Health update reports received and reviewed by the W&OD Committee as part of its work programme (3 times per year) Staff sickness rates form part of the Integrated Performance Report received by the W&OD Committee. The report also sets out trends and planned action. Operational/Annual Plan performance tracker reports. A&A Report SBU-2122-024 Staff Wellbeing & Occ Health Reasonable Assurance		✓ ✓ ✓ ✓	✓	Imminent departure of OH Consultant and reduced medical capacity mitigated by agency support and the potential to work with AB and C&V UHB's on a joint procurement for medical support It is still too early to be sure that long term impacts of the pandemic will have already manifested themselves. The health board has a number of staff with long Covid whose return to work is not certain and whose sick pay protection will end in Mid 2022.	Locum OH Consultant continuing to provide SBU OH Weekly sessions for complex Management Referrals. Broader South Wales plan still being considered. Expected date revised. **30/04/2022** Additional Wellbeing support facilitated by limited L&D Coaches and Wellbeing team. **31/03/2022** Occupational Health team to undertake work to evaluate the service from various stakeholder perspectives. **30/06/2022**

Charitable funds and Welsh Government Covid resources utilised to enhance the staff counselling service and partnership working with MH&LD psychology colleagues. This enabled 1:1 support for trauma and complex bereavement and included specialist treatments for trauma (eg EMDR) and group trauma interventions. Additional available resource used to enhance the Occupational Health service in order to meet the increased demand. Wellbeing Champions in place, supporting teams and services Post Covid Syndrome ('Long Covid') service for staff has been delivered by the team's Occupational Therapist (OT) with over 110 staff receiving timely assessment, support and advice to return to work/remain in work where appropriate. The OT has worked closely with the pulmonary rehabilitation team, who have been delivering the community Long Covid service, to ensure wider staff needs are met. Post-Covid Staff Wellbeing Strategy has been developed to outline additional support available for staff during 2021/22, which was approved by WOD Committee in August 2021						

6.2	Workforce Efficiencies

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
		1st	2nd	3rd		
Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to digital workforce solutions strategy and implementation, and workforce resource planning. Extension of contract for the supply of AHPs and Medical Locums The CEO has met with all Service Group Medical Directors to review their approach to medical workforce efficiencies. Local bank/Agency booking processes have been reviewed, and revised management controls introduced. (Feb 2022) Regular periodic review of block booked bank staff taking place. (Feb 2022) KPI's for nurse roster management have been reviewed, and form part of the regular nurse staffing meetings (Feb 2022)	Operational Plan performance tracker reports. A&A Report SBU-1718-046 EWTD Limited Assurance A&A Report SBU-1819-043 Staff Performance Mgmt. & Appraisal Limited Assurance		✓	✓ ✓	Lack of Health Board-wide policy or procedure which supports EWTD. Need for bank and agency continues.	Local bank/Agency booking processes have been reviewed, and revised management controls introduced. The position will be reviewed with the COO and DoN to address the post-COVID position. **01/09/2022** Review of HB WOVEN compliance complete, and action plan to address issues produced. Implementation of action plan delayed due to priority actions elsewhere. Recruitment to vacancies within the WF plan to take action plan forward approved and underway **31/12/2022** Procurement of the final part of the Allocate package for the medical workforce complete, and the system is being rolled-out. **31/03/2022** Transfer of ESR responsibility from Finance to Workforce, and produce a service improvement plan based on the full implementation of ESS, SSS and MSS. This is on track, with consultation document developed and agreed with Finance. **01/04/2022** EWTD guidance has been drafted, and will be circulated for comment **31/03/2022**

6.3	Staff Experience	Associated HBRR Entry: HBRR 76 – Partnership Working/Trade Union Partners				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to: – Interventions to enhance staff engagement and experience – Reviewing the outcomes of national and organisational staff surveys to inform action and improvement plans – Leadership development and management development. Staff Experience & Organisational Development Plan in Place Leadership and management programmes have been updated to take into consideration the effects of COVID on the workforce. All areas have been allocated a L&OD support for development of local staff actions plans to improve the staff experience. Every Service Group has provided assurance that they have an action plan and are being invited to WOD committee to present their plans. The NHS Wales Staff Survey 2020 Action Plan Group has been formed, and met for the first time in September 2021. This group has representation from all Service Groups and areas. A Health Board Wide Action Plan has been written and shared with committees, including the Partnership forum. Clearly articulated organisational values. Employees encouraged to raise concerns via existing mechanisms, and directly to the Chief Executive.	Results of HB Working From Home Survey reported to the W&OD Committee. Operational Plan performance tracker reports. Results from NHS Wales Staff Surveys Guardian Service Annual report received and reviewed by the Workforce & OD Committee PADR and Statutory & Mandatory training performance forms part of the Integrated Performance Report received by the W&OD Committee. The report also sets out trends and planned action. Relationship with staff side monitored through a range of contact points, notably the Partnership Forum		✓ ✓ ✓ ✓ ✓		Functionality and usage of ESR to be able to record and report on timely data. PADR completion performance is below the Welsh Government target of 85%	A Health Board Wide Action Plan has been written and shared with committees, including the Partnership forum. In line with feedback from the Forum, and the Health Board Staff Survey Action Plan Group (including the lead for the disability reference group), additional time has been taken to work on the branding and language of a campaign which will now be called *'We Said, We did Together*'. This aims to promote collective ownership and connect with all levels of staff, and will be aligned to the timescales surrounding the Health Boards Culture work and the next NHS Wales Staff Survey to support promotion and engagement of the next survey. This, together with the position and capacity of the organisation as a result of the 3rd Wave of COVID, has meant that the deadline for this work has moved from November 2021 to September 2022. **01/09/2022**. Develop a cohort of practitioners to drive forward the cultural change required for the JUST culture. **31/03/2022** Identification and training of 'Resolution Facilitators' **31/03/2022** Joint action plan resulting from October 2021 facilitated partnership workshops currently with staff side for final approval.. **30/04/2022** Meet with TU partners to establish links into management training programmes. **31/03/2022** Prepare options appraisal for the refresh and continued emphasis of organisational values so that these are at the fore front of everything that is done in the Health Board **31/03/2022**

Chief Executive and other Executive Directors attend HB Partnership Forum on a regular basis. Partnership principles and ways of working emphasised as the most effective approach to secure progress. The Health Board continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum. Frequent meetings continue to take place, supplemented by local discussions when required. Facilitated Partnership workshops took place in October 2021. A number of measures have been introduced, including an agreed action plan which was produced from agreed actions from the workshop. Health Board Wellbeing Champions have been trained during January 2021 to act as Resolution Champions, directing people to focus on resolution rather than formal process (Feb 2022)						

6.4	Recruitment & Retention	Associated HBRR Entry: HBRR 3 – Recruitment of Medical & Dental Staff					
Key Controls		**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
			1st	**2nd**	**3rd**		
Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to: – Recruitment and retention. – Staff education and development, building teams, talent management and succession planning – Relationships with educational partners Regular monitoring of recruitment position with reports to Exec Team and Board via Medical Director and Medical Workforce Board. Speciality based local workforce boards established to monitor and control specific issues Weekly workforce delivery meetings with CEO to review progress against critical medical and clinical posts. Working with specialist agency to help to fill 'hard to recruit' posts. Medical Workforce Board continue to monitor recruitment and junior doctor's rota. Over-establishment of Locum posts in key specialities in anticipation of training gaps and turnover. Contract in place with marketing and advertising company to improve Health Board branding and attraction. Partnership working and a range of engagement initiatives with key stakeholders, including: – Provision of information and guidance to local schools in relation to opportunities within SBUHB – Working with Careers Wales Business Engagement Adviser to provide sessions on mock interview support, teams sessions, virtual fairs, alumni input and school sessions.		Workforce and OD Committee oversight Workforce and OD Committee updates to the Board Workforce planning and recruitment issues and updates are reported through various committee fora and to the board via a number of service-specific update reports. Vacancy levels and turnover rates form part of the Integrated Performance Report received by the W&OD Committee. The report also sets out trends and planned action. A&A Report SBU-1920-039 WOD Framework Substantial Assurance A&A Report SBU-1920-042 DBS Checks Reasonable Assurance		✓		Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework. Ability to flexibly deploy doctors in training Identified potential to enhance clarity and detail of reporting to the Workforce & OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken Issues regarding lack of NHS experience of some medical and dental appointments locum appointments International recruitment medical and dental recruitment in progress, but delayed due to COVID.	Work with local communities, schools, colleges and universities, via the Career Development Team, to further develop career pathways. **31/03/2022** Develop an organisation-wide approach to developing talent within the Health Board. This will draw together the talent approach and the barriers to leadership work. To date, the team have completed interviews with Executive Team and Service Group Directors to inform this work. Feedback and input is currently being reviewed, and the approach will be presented to Executive team. **01/04/2022** Extend opportunities for apprenticeships in both clinical and non-clinical functions. The team have met with NPTC Group and will continue to work on this **31/03/2022** In conjunction with professional heads, develop and implement a recruitment strategy to support the development of a sustainable workforce. This includes the establishment of a team to support and accelerate the recruitment of key clinical and clinical support roles. **(30/09/2021) - Development** **(31/03/2022) – Implementation.** In conjunction with professional heads, develop and implement a retention strategy to address retention issues. **31/03/2022** Medical training initiatives being pursued in a number of specialties to ease junior doctor recruitment **31/03/2022** Report to be produced for Workforce & OD Committee in respect of completion of DBS Clearance of staff currently employed but not previously checked, to include clear reporting of progress against milestones. **30/06/2022**
			✓				
				✓			
					✓		
					✓		

– Partnering with Jobcentre Plus, presenting fortnightly at sessions for adult and youth virtual hubs for the unemployed. – Contact with a range of agencies in line with guidelines/restrictions being lifted, including young homeless agencies, prisons and ethnic youth centres.						

6.5	**Workforce Planning (Supporting the Annual Plan)**					
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to prudent workforce resourcing encompassing workforce planning, role redesign, and new role opportunities aligned to clinical services strategies. Anticipated staff absence rates have been factored into the 2021/22 annual planning process. Workforce Planning function in place which facilitates the design, redesign and development of workforce plans for all staff groups to align the required workforce design based on demand capacity modelling. (Feb 2022) HB Home working and flexible working policies have been revised and reissued, incorporating the principles explored as part of the work on agile working (it was determined that a separate policy was not required). Feb(2022)	Both the Staff Health and Wellbeing Service and Occupational Health Service have won national awards. Detailed staff Attendance Management update reports received and reviewed at W&OD Committee Results of HB Working From Home Survey reported to the W&OD Committee. Operational Plan performance tracker reports. A&A Report SBU-1819-042 Junior Doctor Bandings (Follow-Up) Reasonable Assurance		✓ ✓ ✓ ✓	✓ ✓	Progress on adoption of draft guidance documents in respect of junior doctors' hours and handover procedures.	Support the Engagement Plan at Health Board-wide and local service level. This is ongoing **Throughout 2021/22** Develop and support the roll-out of the Consultation Plan, in line with the all-Wales OCP **30/09/2022** Draft guidance documents in respect of junior doctors will be reviewed. This has slipped due to workforce pressures and priorities. Aim is that matters will progress during Q1/2 2022/23, pending exploration of new junior doctor contract. **31/06/2022**

6.6	Nurse Staffing Levels Act 2016	Associated HBRR Entry: HBRR 51 – Non-compliance with Nurse Staffing Levels Act				
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Nurse Staffing Act Steering Group meet monthly, which provides update and assurance elements of the NSA. Reports to NMB and W&OD Committee. Setting up of appropriate sub groups, including Paediatrics, Mental Health and Learning Disabilities, District nursing and Health visiting. Bi-annual re-calculation, following acuity audits in January and June, and formal review undertaken across all Service Groups, to ensure a consistent triangulated approach to re-calculating the nurse staffing requirements. Scrutiny panels are held for each Service Group following the submission of acuity templates. Updated Nurse Staffing Act (Wales) Operational guidance issued in April 2021, Statutory guidance updated in March 2021 and Welsh Levels of Care circulated. Health Board Operating Framework ratified in Health Board NSA meeting in November 2021. Training provided as necessary by both HEIW and within our health board. Enhanced Supervision Framework introduced in March 2020 in response to increased patient acuity levels. Workforce plans have been developed to agree staffing in light of escalation to surge and super surge due to COVID, with consideration of all reasonable steps. During COVID-19, Service Groups appropriately deployed off ward nurses to support clinical areas. During this time student nurses remained in clinical placements, although have since returned to their study. Nursing Efficiency Transformation Programme has now been re-commenced, with a weekly rolling	Periodic assurance and statistical reporting to the W&OD Committee and the Board, outlining compliance and key risks. Annual Report to Health Board, submitted May 2021 and Annual Mandatory Assurance report submitted to Board in November 2021. Preparation underway for Assurance report to Board in May 2022 First three yearly caveated report to Welsh Government submitted 05.05.2021 and Board in October 2021, final report to Welsh Government in October 2021. Audit & Assurance Report (SBU-1920-041) Reasonable Assurance Audit & Assurance Report Follow-up Review only (SBU-2021-040) Substantial Assurance Roster scrutiny continues to provide assurance that all rosters are optimised. Ongoing monitoring and reporting of clinical indicators as outlined in the annual Nurse Staffing Levels (2016) Act. Annual report on clinical indicators to the Board. All NSA reports go through Health Board Nurse Staffing Act Meeting, for example All Wales work stream updates, Service group risk assessment, HEIW updates and SBARs. All Wales Nurse Staffing Group provides overarching governance, Adult and Paediatric Work streams now merged (Combined Adult and Paediatric Work Stream) following extension of 'the Act' into paediatric inpatient areas on October 1st 2021.	✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓ ✓	IT systems lack the ability to easily gather information in a useable format to meet the needs of the Nurse Staffing Act reporting schedule. All Wales work involving HIEW has worked towards establishing a Power BI system to create visualisers on a bi-annual basis to meet requirements of 'the Act' this system will also allow additional visualisers to be generated as required. Delayed by HEIW until June 2022. HEIW withdrawing some support, particularly around provision of visualisers and feedback. HEIW will generate our visualisers, original plan for HBs to generate own visualisers, originally planned for visualisers following January 2022 acuity audit, although has been delayed until June 2022 bi-annual audit. Safecare System, which is part of Allocate and HealthRoster, should improve access to up to date/live data, with the ability to influence care and nurse staffing. Safecare implementation plan has been agreed, training provided in January to first implementation areas. Safecare went live on 1st February 2022 within five surgical wards/areas in Morriston Hospital. Ongoing support and training provided by e-rostering team and Corporate Matrons. Roll out across the inpatients areas of SBUHB is expected to take approximately 32 weeks. The annual assurance paper to the Board does not present data on the extent to which the calculated nurse staffing levels are achieved during the year, due to limited IT support to gather this information accurately and consistently. All Wales work is looking at the ability to provide this information going forward, however will not be part of the 2021/2022 reporting period.	Rollout of 'Safecare' which allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster (All Wales). The rollout is at differing stages across Wales. SBUHB rollout went live in five areas on 1st February 2022, and is anticipated to take approximately 32 weeks to complete. **30/09/2022** Continue discussions with HEIW regarding support through 2021/2022. Training by HEIW planned for April 2022. Further sessions will be planned in 2022. **Ongoing** Bank and agency usage is monitored; action plans are being developed by Service groups to decrease agency usage. These will be incorporated into the SBUHB Overarching Rostering Headline Report which will be submitted to the Management Board. **31/03/2022**

programme focusing on the grip and control for each Service Group. Health Board representation at the all-Wales Nurse Staffing Group and its subgroups. Continue to interview student nurses and, where possible, place in preferred area prior to qualifying to aid recruitment through Student streamlining. Continue to conduct exit interviews to learn from nurses' experience and to improve retention. Compliance with the Nurse Staffing Act is on the HB Risk Register (Number 1759), discussed at HB Nurse Staffing Act meeting and updated monthly. Currently, has a score of 25, expected to be review at February 2022 HB NSA meeting and reduced to 20.	Weekly meetings with minutes recorded, RAID log, roster headline report, vacancies, bank and agency reports and financial report. HBRR entry score reduced to 20 in February 2022	✓ ✓				

Enabling Objective 7 – Outstanding Research, Innovation, and Education & Learning	
Principle Risk – Failure that the Health Board will not be able to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	
Executive Lead – Executive Medical Director	Assuring Committee – Quality & Safety Committee

7.1	**Outstanding Research, Innovation, and Education & Learning**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**		
Research & Development Committee Board for Joint Research Facility IMTP/Annual Planning Process Annual meetings with Health Education & Improvement Wales Deanery visits Recommencement of research activity (post COVID) is overseen by the Reset & Recovery programme. Quality Impact Assessments submitted to ensure that clinical research is able to be conducted safely.	Updates to the Research & Development Committee and Joint Research Facility Annual Report to the Board Performance data reports from Health & Care Research Wales GMC Feedback Feedback from Deanery visits	✓	✓	✓ ✓ ✓	Lack of a Health Board research, development and innovation Strategy.	Commissioned scoping and development of a detailed Research, Development and Innovation strategy for SBUHB **Workshop 10/03/22** **Completion 31/05/22**