BOARD ASSURANCE FRAMEWORK (BAF)

Forms of Assurance

VISION AND STRATGEIC PRIORITIES

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.

REGULATORS

EXTERNAL AUDIT

Assurance Rating

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control in the achievement of the objective, are suitably designed and effectively applied, with **low impact on residual risk**.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in the achievement of the objective, are suitably designed and effectively applied. Some matters require attention in control design, compliance or assurance with **low to moderate impact on residual risk**.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control in the achievement of the objective, are suitably designed and effectively applied. More significant matters require attention with **moderate impact on residual risk**.

 **No assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control in the achievement of the objective, are suitably designed and effectively applied. Action is required to address the whole control framework in this area with **high impact on residual risk**.

Assurance Trend

	Position has **improved** since the last report to the Board
	Position has **remained stable** since the last report to the Board
	Position has **deteriorated** since the last report to the Board

Board Assurance Framework Summary Against Strategic Objectives – July 2023

Objective	March 2023		July 2023	
	Trend	Ass	Trend	Ass
Demonstrably Improved Quality, Safety & Reduced Harm				
Delivering an Excellent Staff Experience				
Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, Working Effectively Through a Systems Approach				
• Primary & Community Care				
• Mental Health & Learning Disabilities				
• Urgent & Emergency Care				
• Planned Care				
• Cancer Care				
• Children, Young People & Maternity Services				
Focus on Population Health Needs				
Adopting and Developing Innovative Digital Solutions to Support Care Delivery				
Maintain and Deliver Sustainable Financial Health				
Delivering Care in Safe, Modern Environments				

BAF 1: Demonstrably Improved Quality, Safety & Reduced Harm			**Trend: Improving**	
Executive Lead(s):	Executive Director of Nursing Executive Medical Director Director of Therapies & Health Science	**Assuring Committee:** Quality & Safety Committee	**Assurance: Reasonable**	
Associated HBRR Entries: **HBRR 4 – Infection Prevention Control & Decontamination (20)** **HBRR 51 – Non Compliance with Nurse Staffing Levels Act 2016 (20)**		**HBRR 53 – Welsh Language Standards (15)** **HBRR 57 – Controlled Drugs: HO Licenses (12)** **HBRR 78 – Nosocomial Transmission (12)** **HBRR 84 – Cardiac Surgery – Getting It Right First Time Review (16)**		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Clinical Audit & Effectiveness Policy, which sets out the hierarchy of audit reviews
- Clinical Audit & Effectiveness Team in place
- Clinical Outcomes & Effectiveness Group (COEG) established
- Audit Management and Tracking (AMaT) system in place to support Service Delivery Groups and departments with improved monitoring and reporting on clinical audit progress.
- 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.
- National Infection Control Manual supplemented by local policies, procedures, protocols and guidelines.
- We have IPC action plans in place for all service groups with clear accountability lines for improvement
- Infection Prevention Control Committee in place, which includes oversight of decontamination
- BI support for quality improvements and quality outcomes supported with data required down to ward level with early warning of infection risks.
- Infection prevention and control related training programmes
- Documented Cleaning Strategy/Policy in place. Enhanced ward cleaning by domestic staff being considered to free nursing time for direct patient care
- Quality & Safety Committee in place with approved Terms of Reference, supported by a Quality & Safety Group.
- Quality & Safety Process Framework in place, Approved by Q&SC and Executive Board
- Established Quality & Safety forums in place at Service Group level.
- Approved 5-Year Quality Strategy in place.

Sources of Assurance – Level 1	**Sources of Assurance – Level 2**	**Sources of Assurance – Level 3**	
All levels of clinical audit activity will be monitored by COEG and reported to the Quality & Safety Group, who in turn report to the Quality & Safety Committee. Decontamination Subgroup reporting bi-monthly to the IPC	Clinical Audit midyear and annual reports received and scrutinised by the Audit Committee Quarterly mortality review reports to the Quality & Safety Committee (commenced August 2021) Clear corporate and Service Group IPC assurance framework in place, which reflects the HCAI quality priority actions. 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 improvements. Reports regularly to Quality & Safety Committee	A&A Report ABM-1819-025 – October 2018 Mortality Reviews (Follow Up) – Limited Assurance A&A Report SBU-2021-028 – April 2021 Mortality Reviews – Limited Assurance A&A Report SBU-1920-021 – July 2019 WHO Checklist – Limited Assurance A&A Report SBU-2021-026 – April 2021 WHO Surgical Safety Checklist (F/UP) – Limited Assurance A&A Briefing Paper SBU-2122-006 – December 2021 Controlled Drugs Governance – No Rating Given A&A report SBU-2223-019 – November 2022 Controlled Drugs – Reasonable Assurance A&A report SBU-1920 – July 2019 Infection Prevention Control – Reasonable Assurance A&A Report SBU-2021-025 – January 2021 Infection Control (Cleaning) – Reasonable Assurance A&A Report SBU-2223-007 – May 2023 IP&C: SG Gov Arrangements – Reasonable Assurance A&A Report SBU-2223-003 – May 2023 Quality Governance – Reasonable Assurance A&A Report SBU-2223-017 – June 2023 End of Life Care – Reasonable Assurance	A&A Report ABM-1819-022 – April 2019 Clinical Audit & Assurance – Limited Assurance Audit Wales 2714A2021-22 Review of Quality Governance Arrangements A&A Report SBU-2122-001 – February 2022 Risk Mgmt & BAF – Reasonable Assurance A&A Report SBU-2223-001 – July 2023 Risk Mgmt & Assurance – Reasonable Assurance A&A Report SBU-2122-017 – June 2022 Safety Notices & Alerts – Limited Assurance A&A Report SBU-1920-020 – September 2019 Falls – Reasonable Assurance A&A Report SBU-2021-027 – June 2021 Safeguarding – Reasonable Assurance A&A Report SBU-2122-017 – May 2022 NICE Guidance – Limited Assurance A&A Report SBU-2021-024 – May 2021 Concerns: Serious Incidents – Reasonable Assurance A&A Report SBU-2122-002 – January 2022 Quality & Safety Framework – Limited Assurance

Gaps in Control and/or Assurance		**Agreed Action**	
Non-compliance with Home Office (HO) CD Licensing requirements. The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing requirements, nor does it have processes in place in respect of future service change compliance.		HB to develop and implement a control system to ensure compliance with HO license requirements. Corporate Governance team exploring options that could provide a control system to ensure ongoing compliance with HO CD license requirements. **30/09/23** CDAO to work with the Medical Director and Director of Corporate Governance to complete review of Home Office Controlled Drug License requirements by the Health Board. CDAO continuing to work with the Director of Corporate Governance to complete review of Home Office Controlled Drug License requirements by the Health Board. **30/09/23**	
Improvement required in controlled drugs governance arrangements in order to allow the Controlled Drugs Accountable Officer to fully discharge their accountability as outlined in the Welsh Government Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008		Ongoing. The Controlled Drug Accountable Officer continues to work closely with Service Group Controlled Drug Leads to strengthen controlled drug governance and improve assurance across the Health Board. This includes annual meetings.	
NWSSP Audit & Assurance review of Controlled Drugs Governance (November 2022) noted a number of recommendations to strengthen controlled drug governance across the Health Board.		Updates to the action plan are currently being developed, and will be uploaded to the Audit Tracker for presentation to the June 2023 meeting of the Audit Committee.	
Operational managers' approach to risk management is inconsistent, with risk registers often incomplete and missing mitigating actions.		Delivery of Service Group risk management sessions has been completed, with sessions provided to the Divisions of Surgical Services, Medicine & ECHO and Clinical Support Services in Morriston by the end of March 2023. Following delivery of these sessions, and those completed earlier in other Service Groups, further requests have been received and sessions delivered to wider groups of managers and teams at specialty level. As part of ongoing processes, the Risk & Assurance team will continue to deliver sessions in response to service requests, and will provide continued monthly Risk Management level 2 training sessions for individual managers new to the organisation or refreshing their knowledge. **Complete**	
Staff are not always aware of the HB's values and behaviours, and do not always recognise a culture that promotes learning from errors.		A report detailing findings from phases 1 and 2 of Our Big Conversation was presented to public Board at the end of March 2023, along with a proposal for taking forward the vision for SBUHB, as a quality driven organisation. The new vision for a high quality organisation is currently being finalised. Values and behaviours to be re-introduced. Phase 3, engagement on the vision document, to commence in June 2023 **Review in August 2023**	
Systems and processes for dealing with and reporting on safety notices and alerts in need of view and update, together with the associated policy/procedures		The first meeting to commence pilot of the O4W Alerts module was held in June 2023. SBU are one of the organisations that will be undertaking the pilot. The pilot aims to identify any immediate improvements that can be made to processes via the new module and reporting system, and identify potential further improvements to the module itself. The deadline has been extended provisionally to the end of September. **30/09/2023**	
Identified scope to improve oversite and reporting on the completion of WHO/LocSSIP checklists at both a Service Group and Corporate Level.		The Clinical Director for Theatres has been asked to convene a group of clinicians to review and revise current processes. The process was delayed due to the national launch of NatSSIPS2 in April and it is currently in process. **30/09/2023**	
The findings of the last National Audit of Care at the End of Life (NACEL) indicated that SBUHB was achieving less than the national average in all aspects of care at end of life.		Existing action plan to be reviewed to ensure that is it cross-referenced to the revised goals, methods and outcomes of the NACEL audit, and has clear achievable actions with realistic timescales. Once complete, this will be taken to the Quality Priorities Programme Board. **30/09/2023**	

BAF 2: Delivering an Excellent Staff Experience			**Trend: Stable**	
Executive Lead(s):	Director of Workforce & OD	**Assuring Committee:** Workforce & OD Committee	**Assurance: Reasonable**	
Associated HBRR Entries: **HBRR 3 – Recruitment of Medical & Dental Staff (20)**				

Key Controls:

- Established Workforce & Organisational Development Committee in place
- Workforce and OD Delivery Group in place. Schedule of meetings established and aligned to Workforce & OD Committee.
- Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding management of health in the workplace
- Multi-disciplinary Staff Wellbeing Service in place providing staff with support for mild-moderate musculoskeletal and mental health problems, which also continues to support the needs of COVID-related health impacts
- The Health board has invested in the TRiM programme (Trauma Risk Management)
- Wellbeing Champions in place, supporting teams and services
- Post-COVID Staff Wellbeing Strategy has been developed to outline additional support available for staff
- 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) – this includes EWTD controls
- Our Big Conversation and Cultural OD Programme Plan
- All areas have been allocated L&OD support for development of local staff action plans to improve the staff experience
- Clearly articulated organisational values
- Chief Executive and other Executive Directors attend HB Partnership Forum on a regular basis.
- Speciality based local workforce boards established
- Established partnership working and engagement initiatives with key stakeholders.
- Workforce Planning function in place which facilitates the design, redesign and development of workforce plans for all staff groups
- HB Home working and flexible working policies have been revised and reissued

Sources of Assurance – Level 1	**Sources of Assurance – Level 2**	**Sources of Assurance – Level 3**
Monthly management data for Occupational Health and Staff wellbeing services regularly reviewed by Senior Occupational Health Management Team regarding capacity/demand and waiting times. This information is used to manage capacity and demand Weekly reporting of Bank and Agency usage to service groups as well as monthly Corporate Nurse staffing meetings SGs have local reporting mechanisms for bank and agency spend Monthly Roster scrutiny meetings held across all service groups and Corporate Nurse staffing meetings KPI reports are sent to service groups weekly Permanently funded central resourcing team from 2022/23 fin. year Overseas nursing campaign for 200 Nurses funded for 2022/23 Streamlined recruitment for medical staff. Retrospective VCP and anticipatory recruitment for medical posts linked to major rotations. Working with head hunter agencies to recruit hard to fill medical posts	Reporting to and oversight by the Workforce and Organisational Development Committee on the following: – Workforce Metrics (every meeting) – Medical Workforce efficiencies (quarterly) – Recruitment & Retention (every Meeting) – Attendance, Wellbeing & Occ. Health (3 x per year) – Workforce Risk Register (3 x per year) – Nurse Staffing (Wales) Act 2016 (5 x per year) – Guardian Service (bi-annual update) – Update on PADR Compliance (2 x per year) – Statutory & Mandatory Training Compliance (2 x per year) – Medical Revalidation (2 x per year) – Equality Report (Annually) – Nursing & Midwifery Board Update (every meeting) – Medical Workforce Board Update (every meeting) – Therapies & Health Science Group Update (every meeting) Service Groups are invited to Workforce & OD Committee to present local actions plans to improve the staff experience. 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. Completion reports have been provided to the Workforce and OD Committee and board for 'Our Big Conversation'.	Both Staff Health & 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. A&A Report SBU-2122-024 – September 2021 Staff Wellbeing & Occ Health - Reasonable Assurance A&A Report SBU-1718-046 – May 2018 EWTD - Limited Assurance A&A Report SBU-1819-043 – April 2019 Staff Performance Mgmt. & Appraisal - Limited Assurance Results from NHS Wales and LHB Staff Surveys A&A Report SBU-1920-039 – February 2020 WOD Framework - Substantial Assurance A&A Report SBU-1920-042 – January 2020 DBS Checks - Reasonable Assurance A&A Report SBU-1819-042 – April 2019 Junior Doctor Bandings (Follow-Up) - Reasonable Assurance A&A Report SBU-2223-013 ESR Self Service – No Rating Given (Advisory Report) A&A Report SBU-2223-010 – May 2023 Nurse Rostering – Reasonable Assurance Audit Wales Report – October 2021

		Taking Care of the Carers

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Lack of timely sickness absence data	Project to review workforce informatics **31/08/2023**
Compliance with Personal Appraisal and Development (PADR) reviews is low. A performance improvement plan should be put in place which sets out when full compliance can be achieved.	Data as at April 2023 shows a compliance rate of 72.1%, which represents an increase over the December 2022 reported figure (68.42%). Managers are provided with detailed reports on their PADR & Training compliance figures monthly, highlighting trends and areas of concern, with targeted support provided. Impact of operational changes on staffing and structure may result in a temporary reduction in compliance figures. Progress will be monitored via local service group meetings and Management Board, and reported to Workforce & OD Committee. **Ongoing**
PADR completion performance is below the Welsh Government target of 85%. Gaps in assurance around recording of PADR due to delay in implementation of roll out of supervisor self-service.	The transfer of the ESR team to the WOD Directorate is now complete and the Service Improvement plan is in progress. The detail of the SSS roll out is currently being considered and worked through. Target date for the roll out to be confirmed at a later date. **TBC**
Need to enhance clarity and detail of reports to the W&OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken	An options paper is currently being prepared regarding the approach to Disclosure & Baring Services (DBS) Checks, for consideration by the Director of Workforce & OD in the first instance.
Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework.	Work has been undertaken with an external company to develop a candidate experience and employer brand that will support the retention and drive applications and hires of staff to the Health Board, positioning us as an employer of choice. This revised branding is currently be shared with staff across the Health Board, with the intention that it go live by the end of June 2023.
Delay of national staff survey which is commissioned by Welsh Government with no fixed role out date.	The new vision for a high quality organisation has been finalised, as well as a reinstatement of our values and behaviours framework. Our Big Conversation Phase 3, engagement on the vision document and its implementation, will take place between June and July 2023. The final document will then be officially published at the end of July 2023. The National Staff Survey has been delayed, and is now expected in September 2023. **September 2023**
National Strike Action	

BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach				
3.1	**Primary & Community Care**	**Associated HBRR Entries:** **HBRR 75 – Whole Service Closure (10)** **HBRR 89 – Healthcare Nursing Staff Levels HMPS (20)**	**Trend:** **Stable**	
Executive Lead (s): Chief Operating Officer		**Assuring Committee:** Performance & Finance Committee	**Assurance:** **Reasonable**	

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Monthly PCT Board Meeting – oversight of PCT Group Risks, Performance and strategic development – with focussed sub meetings to manage specific areas of focus
  - PCT Operational Business Meeting
  - PCT Contracts Meeting (oversight of Independent Primary Care Contracts)
  - PCT Quality and Safety (and associated Health Board wide sub structure)
  - PCT Health and Safety
- Partnership governance arrangements within Regional Partnership Board (RPB) structure.
- HMP Prison Partnership Board

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 2
Monthly reporting of clinical and financial performance via PCT Operational Business meeting and PCT Board for scrutiny and assurance Monthly reporting of Q&S issues via Q&S (and the associated SBUHB wide substructure) and the and PCT Board for scrutiny and assurance Monthly reporting and management of Primary Care Contractor service developments and issues via the Primary Care Contracts Meeting.	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board Monitoring of the implementation of the Home First project and management of Integrated Community Services within the RPB Transformation Board governance framework Quarterly performance reviews Monthly finance reviews.	A&A Report SBU-2122-023 – October 2021 General Dental Services (GDS) – Substantial Assurance A&A Report SBU-2021-013 – January 2021 Primary Care Cluster Plans & Delivery – Reasonable Assurance

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Identified need to reviewed PCT Group Quality & Safety structures to mirror SBUHB structures	PCT have completed the implementation of the revised Q&S structures **Complete**

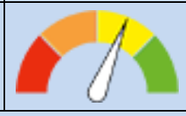
BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach				
3.2	**Mental Health & Learning Disabilities**	**Associated HBRR Entries:** **HBRR 43 – DoLS/Liberty Protection Safeguards (20)** **HBRR 75 – Whole Service Closure (10)**	**Trend: Improving**	
Executive Lead (s): Chief Operating Officer		**Assuring Committee:** Performance & Finance Committee	**Assurance: Reasonable**	

Key Controls:

- Established Mental Health Legislation Committee in place
- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Liberty Protection Safeguards task-and-finish group to meet from December 2022

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 3
	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board	A&A Report SBU-2122-023 – May 2022 Mental Health Legislative Compliance – Reasonable Assurance A&A Report SBU-2223-015 – May 2023 Transition from CAMHS to AMHS – Limited Assurance

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Mapping exercise to be undertaken in order to provide assurance regarding the completeness of reporting to the Mental Health Legislation Committee in respect of legislative compliance.	MHA – A review has been undertaken by the Mental Health Act Department Manager, which has confirmed compliance with the reporting requirements stipulated in the Code of Practice to the Mental Health Act. - **Complete** MCA – Mapping of the Mental Capacity Act requirements, related Codes of Practice and the Health & Care Standards is currently underway.
Inconsistencies in reporting noted in respect of Mental Capacity Act and Deprivation of Liberty Safeguards training.	A revised programme of training will be put in place.
Need to develop systems to monitor/capture referral and transition activity from CAMHS to AMHS	Monthly meetings now take place to ensure that transitions from CAMHS to AMHS are identified and monitored. **Complete.**

BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach			
3.3	**Urgent & Emergency Care**	**Trend: Improving**	
Associated HBRR Entries: **HBRR 1 – Access to Unscheduled Care Services (25)** **HBRR 80 – Unable to Discharge Clinically Optimised Patients (20)**	**HBRR 82 – Risk of Closure of Burns Service (16)** **HBRR 75 – Whole Service Closure (10)**	**Assurance: Reasonable**	
Executive Lead (s): Chief Operating Officer	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, 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.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Unscheduled Care reports received from the COO
- 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.
- A Six Goals Urgent and Emergency Care Board has been established to oversee the Health Board's Six Goals whole system portfolio to improve unscheduled care.
- Six Goals and Transformation Programme Management Office (PMO) teams in place to improve Unscheduled Care
- Health Board Representation on the National Unscheduled Care Board, Emergency Ambulance Steering Committee (EASC), national Six Goals Boards and national Same Day Emergency Care (SDEC) Boards
- Consolidation of acute work on the Morriston site through the Acute Medical Service Redesign (AMSR) programme.
- Consolidation of multiple ambulatory care teams into a combined Same Day Emergency Care SDEC) team
- 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.
- SAFER & D2RA – Patient Flow and Discharge Policy in place
- 24/7 Ambulance triage nurse in place.
- Patient level dashboard in place, which allows breakdown of clinically optimised patient numbers by delay type
- Direct Pathway to Older Person's Assessment Service (OPAS) implemented and operational hours extended.
- Establishment of virtual wards aligned to GP clusters.

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 2
Rapid Discharge to Assess pathway performance monitored via H2H implementation group and reported to Community Silver.	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board, Monitoring of the implementation of the integrated Unscheduled Care Plan via the 6 Goal Urgent and Emergency Care Board and Community Silver Command (Regional Partnership Board), and Quality & Safety Committee Updated UEC data dashboards focusing on acute care and flow performance	A&A Report (SBU-1920-025) – February 2021 Discharge Planning - Limited Assurance WAO Report 255A2017-18 Discharge Planning - No Assurance Rating Given

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Need for clear definition for Clinically Optimised Patients (COP) patients across all sites and utilised consistently. Failure to adhere to, as well as inconsistent application of, elements of the SAFER Patient Flow and Discharge to Recover Then Assess (D2RA) Policy. Scope to enhance the content of the policy, as well as systems and processes in respect of the setting of EDD and arrangements for patient discharge, were also highlighted as part of the NWSSP A&A review.	All sites review weekly the COP with primary and community teams – work will continue to develop a common understanding and triggers for escalation of COPs **Ongoing** The Health Board' will continue to roll-out in line with national guidance the updated SAFER Patient Flow and D2RA bundle. This includes a comprehensive training and communication programme for staff and the use of nationally approved SAFER audit tools.**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, D2RA pathways discharged too and risks around limitations of storage capacity.

BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach			
3.4	**Networked Hospitals – A Systems Approach** **Planned Care**	**Trend:** **Improving**	
Associated HBRR Entries: **HBRR 16 – Access and Planned Care (20)** **HBRR 58 – Ophthalmology F-Up Clinic Capacity (16)**	**HBRR 61 – Dental Paediatric GA Services (16)** **HBRR 75 – Whole Service Closure (10)**	**Assurance:** **Reasonable**	
Executive Lead (s): Chief Operating Officer	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, 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.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Planned Care reports received from the
- The Planned Care Recovery Programme Board has been established
- Plans based on specialty level capacity and demand models which set out baseline capacity and solutions to bridge the gap.
- Appropriate utilisation of the Independent Sector
- Focussed intervention to support the specialties with the longest waits. Fortnightly performance reviews to track progress against delivery
- Quality Impact Assessment process set-up to manage the re-start of essential services
- Outpatients Clinical Redesign and Recovery Group established in June 2020.
- Use of Doctor Dr and Consultant Connect to prevent unnecessary referral and attendance together with the development of Health Pathways
- Increased use of virtual appointments
- DNA monitoring and management
- Opthalmology Gold Command established and meeting on a monthly basis, chaired by Deputy COO, reporting to Q&S Committee
- 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.
- Following Royal College of Surgeons guidance for all surgical procedures; patients on waiting lists have been categorised and clinically prioritised accordingly.
- 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.
- Developed monitoring tools using data 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.
- Care pathway implemented with Parkway Clinic for the provision of Paediatric DA dental Services, including revised SLA/Service Specification - no direct referrals to provider for GA

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 2
Assurance documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients The risk register has been updated to reflect the reduction in the waiting times for both new and follow up ophthalmic patients. There have been no significant incidents regarding loss of lines of sight due to delay in follow up in the last two years.	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board Regular reports from Ophthalmic Gold Command received by Q&S Committee Paediatric Dental GA referral and treatment outcome data collated and reviewed by Paediatric Specialist.	A&A Report SBU-2021-015 – April 20213 Adjusting Services: QIA - Reasonable Assurance A&A Report SBU 2122-013: Planned Care Recovery Arrangements Reasonable Assurance (February 2022) Parkway Clinic HIW Inspection Visit Documentation provided to HB

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
There is currently a gap in assurance around our ability to deliver >52 (Stage 1) by the revised target date of June 23 and 99% of >104 day waits (All Stages) by end of March 2024 together with the elimination of diagnostic waits of over 8 weeks by the end of March 24.	Fortnightly meeting with service groups taking place to discuss the specialties of greatest concern. Revised trajectories have been developed to monitor progress. Insourcing and outsourcing continues to provide additional capacity to reduce backlog. Monthly reports provided to Planned Care Board and P&F Committee. Regional plan to address endoscopy waiting times submitted to WG and approach approved

BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach			
3.5	**Networked Hospital – A Systems Approach** **Cancer Care**	**Trend:** **Stable**	
Associated HBRR Entries: **HBRR 50 – Access to Cancer Services (25)** **HBRR 66 – Access to Cancer Treatment SACT (15)**	**HBRR 67 – Access to Radiotherapy Treatment (15)** **HBRR 75 – Whole Service Closure (10)**	**Assurance:** **Reasonable**	
Executive Lead (s): Executive Medical Director	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Performance & Finance Committee in place, with Terms of Reference which detail a responsibility to provide advice on aligning service, workforce and financial performance matters into an integrated whole systems approach, as well as scrutinise and monitor the performance of the organisation and individual delivery units in respect of cancer services, to ensure the trajectories and plans set out in the annual plan are achieved.
- Establishment of Health Board Cancer Performance Group, which will support execution of service delivery plans for improvements and report to the Cancer Performance Board
- Prioritised pathway in place to fast track Urgent Suspected Cancer patients. Process developed to manage each individual case on the USC pathway.
- Enhanced/weekly monitoring of action/improvement plans for top 6 tumour sites.
- Weekly cancer performance meetings for both NPTS and Morriston Service Groups.
- Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy.
- National Endoscopy Programme (NEP) deferred patient spreadsheet utilised to track deferred procedures, surveillance, screening and USC patients.
- Faecal Immunochemical Testing (FIT) implemented for low risk groups. Primary care roll-out commenced (February 2022)
- Redesigned endoscopy Straight To Test (STT) pathway implemented (December 2021)
- Increased service provision in respect of Capsule Endoscopy, PH Manometry and hydrogen breath test procedures
- Review of Chemotherapy Day Unit scheduling by staff to ensure that all chairs are used appropriately. Daily scrutinising process in place to micro-manage individual cases, deferrals etc.
- Chemotherapy 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.
- Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place.
- Requests for radiotherapy treatment and treatment dates monitored by senior management team.
- Hypo Fractioning for prostate RT (where appropriate) commenced November 2022.
- SACT bi-monthly reports now in place demonstrating oncology SACT waiting times performance to support ongoing improvements in the pathway

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 3
Backlog trajectory to be monitored in weekly enhanced monitoring meetings	Annual Plan/R&S Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board Cancer performance update reports are received and considered by the Performance & Finance Committee. Operational Plan performance tracker reports. Radiotherapy performance and activity data monitored and shared with radiotherapy management team and cancer board.	A&A Report SBU-2223-014 – June 2023 Access to Cancer Services – Reasonable Assurance

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
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)	There has been no decision regarding the weekend working business case. Increased capacity within CT/MRI via extended working hours continues. A Situation-Background-Assessment-Recommendations report (SBAR) has been produced which recommends the temporary recommissioning of an existing scanner in order to provide additional capacity. A decision is awaited.
Performance and activity data monitored, but delays in treatment continue while sustainable solutions found. The current trajectories do not effectively link with D&C, and practical actions being undertaken at tumour site level.	A National Cancer recovery and Improvement Task Force has been established which will focus on support health boards to improve SCP performance in the areas of colorectal, urology and gynaecology. These are already three of the tumour sites where the Health Board have action/improvement plans.
Capital and revenue assumptions and resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.	10-Year regional transformation and development plan for SWWCC in conjunction with Hywel Dda. Strategic Programme Business case approved for onward submission to Welsh Government by Management Board in January 2023. **Ongoing** Increase capacity within Radiotherapy pathway by looking at weekend working for CT and Pre-Treat. Developing case to look at piloting this extended working **30/09/2023** Move of Chemotherapy Day Unit onto main hospital site following closure of COP wards in Singleton **30/09/2023**

BAF 3: Networked Hospitals and Excellent Primary, Community Care and Mental Health & Learning Disability Services, working effectively through a systems approach			
3.6	**Children, Young People & Maternity Services**	**Trend:**	
Associated HBRR Entries: **HBRR 48 – CAMHS Sustainability (12)** **HBRR 63 – Screening for Foetal Growth Assessment in line with Gap-Grow (20)** **HBRR 65 – Misrepresentation of Abnormal Cardiotocography Readings (20)** **HBRR 69 – Adolescent Pats. On Adult Mental Health Wards (20)**	**HBRR 74 – Delays in Induction/Augmentation of Labour (15)** **HBRR 81 - Critical Midwifery Staffing Levels (25)** **HBRR 85 – Non-Compliance with ALNET Act (20)** **HBRR 75 – Whole Service Closure (10)**	**Assurance:**	
Executive Lead (s): Executive Director of Nursing	**Assuring Committee:** Performance & Finance Committee		

Key Controls:

- Established Nursing & Midwifery Board in place
- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Project Board established to oversee installation of central cardiotocograph monitoring system, and necessary training
- Health Board Maternity Ultrasound Group convened to develop future ultrasound services
- ~~CAMHS Commissioning Group in Place~~
- Children & Young People's Emotional and Mental Health Planning Group 3-Year plan 2021-2023 in place.

Sources of Assurance – Level 1	Sources of Assurance – Level 2	Sources of Assurance – Level 3
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.	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board CAMHS performance against local and WG targets included in Integrated Performance Reports	A&A Report SBU-2122-018 – December 2021 CAMHS Commissioning Arrangements – Limited Assurance External review of Swansea Bay University Health Board Maternity Services Governance Process conducted by the Wales Maternity & Neonatal Network

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Lack of SLA/Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS	CAMHS is now hosted by Swansea Bay – Mental Health & LD Service Group. A Project Board has been established ensuring a smooth transition of the service from Cwm Taf Morgannwg UHB to Swansea Bay University HB. The project Board meets fortnightly with a detailed Project Plan. Agency staff arrangements to continue to ensure service continuity. **Ongoing**
The HB has not identified quality measures in respect of CAMHS being provided to the patients or the outcomes for those patients.	A workshop has been held to develop further outcome measures and additional measures will be reported from Q4

BAF 4: Focus on Population Health Needs			**Trend: Improving**	
Executive Lead(s): Director of Public Health		**Assuring Committee:** Partnership, Planning & Pop. Health Committee	**Assurance: Reasonable**	
Associated HBRR Entries: **HBRR 52 – Engagement & Impact Assessment (12)**				
Key Controls: – Programme/Project structure in place to drive delivery of Annual Plan/R&S Plan priorities – Public Health strategy and work plan – Strategic Immunisation Group (SIG) and immunisation action plan in place – Childhood Immunisation Programme – Primary Care Influenza Group and Vaccination Programme		– Support from Public Health Wales Health Protection Team – Local Smoking Cessation Services – Joint working with Regional Area Planning Board – Approved Population Health Strategy in place. – Population Health Development Board in place		
Sources of Assurance – Level 1	**Sources of Assurance – Level 2**		**Sources of Assurance – Level 3**	
Dedicated population health and commissioning Management Board to be held three-times a year.	Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board Key Population Health measures included in integrated performance reports (P&F Committee): • Childhood Vaccinations • Flu Vaccinations • Alcohol attributed hospital admissions • Hospital admission rates which mention intentional self-harm		A&A Report ABM-1819-012 – August 2018 Vaccination & Immunisation - Limited Assurance A&A Report ABM-2021-014 Vaccination & Immunisation (F/Up) - Reasonable Assurance Audit Wales Report – September 2022 Equality Impact Assessments (More Than Just a Tick Box Exercise?)	
Gaps in Control/Assurance or Identified Areas for Improvement		**Agreed Action**		
Public bodies should review their overall approach to EIAs, considering the findings of the Audit Wales report 'Equality Impact Assessments' and the detailed guidance available from the EHRC and the Practice Hub.		The newly appointed Head of EDI will lead a review of the Health Board's existing EIA process, learning from recent experiences and from best practice elsewhere. Building on this and the guidance from the EHRC and Practice Hub the Health Board will revise its EIA process, building in any guidance received from Welsh Government. **30/06/2023**		
Lines of reporting assurance in respect of vaccination & immunisation systems, processes and performance are not clear.		The publication of the National Immunisation Framework has provided some additional clarity over Welsh Government intentions for the immunisation model. Recruitment has begun to the National Immunisation Framework mandated SBUHB Immunisation team with the Immunisation Co-Ordinators (2 posts) appointed and a preferred candidate identified for the Head of Immunisation Service post. Recruitment to the remainder of the posts is underway: this is not a 'slotting in' of the existing COVID vaccination workforce as the new roles are materially different. The expectation is that the team will be at establishment before end Q2 23/24 – 30/09/2023.		
Scope identified to enhance governance arrangements and oversight around the work of vaccination & immunisation subgroups.		The Welsh Framework will guide the reconfiguration of arrangements to provide strategic direction to and operational oversight of vaccination activity within SBUHB. There will be a need for a SBUHB programme group to be established to support the migration to compliance with the NIF arrangements. Currently this is being overseen by the Exec Director of Public Health in concert with the ongoing COVID Immunisation programme machinery and the support of corporate colleagues in Workforce and OD and Finance. When the Immunisation Service is established then oversight will be via the Strategic Immunisation Group: by end Q2 23/24 – 30/09/2023.		
Due to COVID-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.		A meeting of a reconvened and reconstituted Strategic immunisation Group has taken place (18/05/2023). This identified a need for additional members to attend to capture all relevant operational groups and corporate functions and to bring Local Authorities into the group (due to their statutory roles in infectious disease management).A risk register has been compiled. The overall governance and reporting lines are not yet active. Further work is required to establish systems and processes to identify and investigate incidents where harm occurs to enable these to be addressed in a consistent manner across direct and contracted providers. The SIG will meet again on 13/07/2023.		
Previously identified resource issues in respect of maintaining vaccination & immunisation records for those aged 17-19		There remains no definitive solution to this issue. Workarounds are in place using Welsh Immunisation System in relation to COVID vaccination for individuals in these age groups. There is ongoing liaison between the COVID vaccination team and Child Health. The underlying issue is failure to invest in Child Health records team. Additional input from the central immunisation records team will mitigate the current risk pending development of a definitive solution during Quarter 2 2023-24.		

BAF 5: Adopting and Developing Innovative Digital Solutions to Support Care Delivery			
Principle Risk:	If our digital infrastructure and systems are not sufficient or adequately protected, then this could compromise connectivity and access to key/critical systems, resulting in compromised patient care (including patient delays, cancellation of services), reputational damage and potential fines.	**Trend:**	
		Assurance Rating:	
Executive Lead(s): Director of Digital		**Assuring Committee:** Performance & Finance Committee	
Associated HBRR Entries: **HBRR 27 – Digital Transformation (16)** **HBRR 36 – Paper Record Storage (16)**		**HBRR 37 – Data Informed Decisions (12)** **HBRR 60 – Cyber Security (20)** **HBRR 90 – Non Compliance with GDPR (SARs) (16)**	

Key Controls:

- Digital Strategy and Strategic Outline Plan
- 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.
- Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place.
- 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.
- 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.
- 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 requirements, monitor progress with implementation, and address issues with business-as-usual activities.
- 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 Joint Executive Team for Boundary Change provides oversight of the disaggregation process in respect of Digital Services (CTMUHB boundary change process).
- Business Intelligence Modelling Cell established to prioritise the delivery of BI requirements. Approved Business Intelligence Strategy in Place.
- 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.
- 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
- 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.
- Mandatory Cyber Security training is in place, which is supplemented by phishing simulation to increase staff awareness.

Level 1 – Forms of Assurance	**Level 2 – Forms of Assurance**	**Level 3 – Forms of Assurance**	
The Management Board receive update reports on progress against digital transformation programmes	The DLG is accountable to the Executive Board and reports to the Senior Leadership Team 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	A&A Report SBU-2021-029 – February 2021 Digital Technology Control & Risk Assessment. No Assurance Rating Given A&A Report SBU-2122-020 – May 2022 Digital Project Management - Substantial Assurance A&A Report SBU-2021-021 - October 2021 Information Technology Infrastructure Library Service Management Review – Reasonable Assurance A&A Report SBU-2122-005 – April 2022	A&A Report SBU-2122-019 – December 2021 Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) - Reasonable Assurance A&A Report SBU-1920-029 – January 2020 IT Application Systems (TOMS) - Reasonable Assurance A&A Report SBU-1920-028 – June 2020 Discharge Summaries - No Rating Given A&A Report SBU-2223-021 – January 2023 Cyber Security - Reasonable Assurance A&A Report SBU-2223-023 – February 2023

	Quarterly reports to the Workforce & OD Committee	Network & Info Systems (NIS) Directive - Reasonable Assurance A&A Report SBU-2223-020 – May 2023 Digital Strat. Implementation – Substantial Assurance	Information Governance – Limited Assurance A&A Report SBU-2223-022 – May 2023 Mgmt. of Physical Health Records – Reasonable Assurance

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Issues identified in respect of the operation and functionality of the Theatre Operational Management System (TOMS)	Previously approved WG DPIF funding for TOMs development was not provided for 2022/23. Work has progressed with support of discretionary capital and extensive planning and ways of working assessments undertaken. TOMs redevelopment completion revised to March 2024. **31/03/2024**
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.	SBUHB has contributed to a national workforce review and are awaiting outcomes. Digital Services will use the findings to build a SBUHB Digital Services workforce plan with appropriate support from Workforce & OD. **31/12/2023**
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.	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 **31/03/2026**
Cyber security training is not currently mandatory within the Health Board.	Joint Mandatory Training went live on ESR in May 2023. From this point, when an individual's previous IG competency expires, they will be required to complete the joint IG and Cyber competency. **Complete**
Lack of a holistic review of current/future gaps in digital services staff expertise/knowledge	The National Digital Services skills assessment has yet to be published. Revised timeline for completion is therefore to be confirmed. **TBC**
Scope to implement a more formal structure around problem management processes and recording and communicating known errors.	Due to resources, it has not been possible to recruit to a post to address this issue as intended. It is anticipated that the system used for call management within Digital will be replaced and SBU will request functionality in the new system to address the issue. **TBC**
Scope to improve the recording of information in respect of the completion of the Cyber Assessment Framework (CAS).	A suitable information recoding mechanism will be agreed with the Cyber Resilience Unit (CRU) for the next assessment cycle. **30/06/2023**
WEDs implementation into Morriston delayed whilst assurances on system are sought from the supplier.	An action plan has been requested from the supplier to address this issue **30/06/2022**
There is insufficient discretionary capital finding available to replace the Health Board's Storage Area Network (SAN) when the warranty/support ends in February 2023.	A funding bid for a replacement to the SAN has been approved by Welsh Government. Orders have been placed, and interim maintenance support agreed. **Complete**
Scope to improve the level resources within the IG team and enhance the use of performance measures to assess resilience	A revised IG structure has been agreed internally to incorporate the provision of a SAR Lead. The process to implement the structure has commenced, including the process needed to recruit to the post of SAR Lead.
Scope to improve the Health Board's policy and procedure to deal with Subject Access Requests (SARs)	A Health Board-wide SAR policy has been drafted and will be presented to IGG in June 2023 for approval. **30/06/2023**
The capital requirement for Technology Refresh is increasing due to rapid digital adoption, and the availability of capital funding is decreasing. Risk stratification of replacement of equipment has been in place for a number of years, however in 2024/25 there will be a requirement to replace the core network across major sites. The estimated cost is £7m.	A briefing paper outlining the options for the refresh of the Network Infrastructure is to be drafted and presented to the Management Board. **31/12/2023**
Impact of national architecture and governance reviews not yet known.	

BAF 6: Maintain and Deliver Sustainable Financial Health			**Trend: Deteriorating**	
Executive Lead(s):	Director of Finance	**Assuring Committee:** Perf. & Finance Committee	**Assurance: Reasonable**	
Associated HBRR Entries: ~~**HBRR 72 – Reduced Discretionary Capital Funds and National NHS Funds (20)**~~		~~**HBRR 73 – Detrimental Impact of COVID on Underlying HB Financial Position (20)**~~ ~~**HBRR 79 – Resource Available to Provide Improved Access to Services (15)**~~		

Key Controls:

Audit Committee in place, with Terms of Reference which cover the following:

- Review the adequacy and effectiveness of the Health Board's Standing Orders and Standing Financial Instructions
- Monitoring the integrity of financial statements, including the schedule of losses and compensation
- Ensuring systems for financial reporting, including those of budgetary control, are subject to review as to completeness and accuracy
- Review of the annual report and financial statements before submission to the health board
- Review the effectiveness of system which allow staff to raise concerns about possible improprieties in financial (and other) matters.

Performance & Finance Committee in place, with Terms of Reference which cover the following:

- Scrutiny and review of financial planning and monitoring, including delivery of savings programmes.
- Seeking assurance that finances are managed in a prudent way, and that financial targets are met, including value for money targets

Financial Control Procedures in place, with ongoing cyclical programme of review and update
Standing Orders, which include Standing Financial Instructions and Scheme of Delegation
Internal and External Audit (NWSSP Audit & Assurance and Audit Wales) programmes of work
In-House Counter Fraud Service
Monthly financial review meetings with service groups and quarterly financial review meetings with corporate directors
Board agreed reserve management plan
Savings PMO established to support the delivery of savings plans and create a pipeline of opportunities for future savings
Weekly scrutiny meetings held with Finance Delivery Unit and routine reporting of the detailed monthly position to Welsh Government and Finance Delivery Unit
Capital risks on the HBRR
Capital funding requirements considered by the Business Case Approval Group.
Monthly Capital Prioritisation Group Meetings
Weekly meetings for Service Groups who are off plan held with Chief Executive and Director of Finance & Performance to manage and deliver recovery actions
External support commissioned to drive corporate director savings

Sources of Assurance – Level 1	**Sources of Assurance – Level 2**	**Sources of Assurance – Level 3**	
	Regular reports on financial matters, performance and position (including counter fraud) to the Performance & Finance Committee, Audit Committee and the Board Annual Accounts presented to Audit Committee (draft) and the Board Reporting and scrutiny of STA/SQA at Audit Committee Periodic reporting and scrutiny of Losses and Special Payments at Audit Committee Capital Resource Plan Updates reported to P&F Committee three times per year. Capital risks on the HBRR reported to and discussed at P&F Committee Capital Financial Position reported to P&F Committee as part of integrated Perf Rep Capital funding requirements considered by the Business Case Approval Group, and reported to Management Board.	Audit Wales assurance of the annual accounts A&A Report SBU-1920-016 – December 2019 Procurement (No PO/No Pay) - Limited Assurance A&A Report SBU-2021-018 – December 2020 Charitable Funds - Substantial Assurance A&A Report SBU-2021-016 – May 2021 Fin. Delivery (High Level Monitoring) - Reasonable Assurance A&A Report SBU-2021-043 – June 2021 Integrated Care Fund (Banker Role) No Assurance Rating – Limited Scope Review Audit Wales Report – October 2022 The National Fraud Initiative in Wales 2020-21 A&A Report SBU-2223-009 – June 2023 C19 Cost Mgmt: Recovery Funding & Deployment Reasonable Assurance	A&A Report SBU-2122-015 – October 2021 Procurement and Tendering - Limited Assurance A&A Review SBU-2122-004 – January 2022 Delivery Framework - No Assurance Rating Revised Delivery Framework incomplete A&A Review SBU-2122-003 – May 2022 Financial Reporting & Monitoring - Reasonable Assurance Monthly WG Monitoring Returns reporting on all areas of the financial position, which included a detail commentary, approved by CEO and DOF and independently scrutinised by WG Finance and FDU. The commentary is also provided to PFC.

Gaps in Control/Assurance or Identified Areas for Improvement		**Agreed Action**	
Scope identified to enhance the Service Level Agreement between SBU and NWSSP for the provision of procurement Services.		NWSSP colleagues have confirmed that the revision of SLAs will follow the full deployment of the National Operating Model (NOM), which will bring national contracts under the management of Health Board-based procurement teams. **Ongoing**	
Budget delegation letters are not being signed and returned by Service Group Directors Scope identified to widen the use/distribution of budget delegation letters.		Aligned to the revised Health Board Budgetary Management approach approved by performance and Finance Committee, accountability letters were issued in June 2023 for Financial Year 2023/24 to all Executive Directors and Service Group Directors, which clearly set out both the recurrent budget brought forward from 2022/23, the investment agreed by the Board as part of the 3 Year Financial Plan (2023-2026) and the 2023/24 savings targets. The letter requires the recipients to reply within a set deadline and responses will be monitored and where no reply is received follow up correspondence will be issued. **Complete**	
Scope identified to enhance support provided to budget holders.		A work stream has been established, and a work programme has been put in place. Implementation will now be taken forward as business as usual. **Complete.**	

BAF 7: Delivering Care in Safe, Modern Environments			**Trend:**	
Executive Lead(s):	Director of Finance	**Assuring Committee:** Health & Safety Committee	**Assurance:**	
Associated HBRR Entries: **HBRR 13 – Compliance with Health & Safety Regulations (Accommodation) (16)**		**HBRR 41 – Fire Regulation Compliance – Singleton Hospital Cladding (16)** **HBRR 64 – Insufficient Health, Safety & Fire Function Resource (16)**		

Key Controls:

Health & Safety Committee in place, with Terms of Reference which cover the following key areas:

- Monitoring and assuring delivery of objectives set out in the health & Safety action plan in line with agreed timescales
- Setting and monitoring standards in accordance with relevant Standards for Health Services in Wales
- Ensuring that robust proactive and reactive health and safety plans are in place across the health board
- Actively pursue and review policy development and implementation
- Ensure that health & safety incidents are investigated, and action taken to mitigate the risk of future harm
- Reports and audits from enforcement agencies and internal sources are considered and acted upon
- Ensure employee health and wellbeing activities are in place
- Assuring mitigation of health and safety risks

Health & Safety Operational Group in place, which supports the work of the Health & Safety Committee

Health & Safety Policy in place, supported by other key related operational policies including:

- Fire Safety
- Violence & Aggression
- Manual Handling
- Asbestos Management

Health, Safety and Welfare Strategy Implementation Plan in place

Key Performance Indicators (KPIs) developed by the Health & Safety Team, and approved by the H&S Committee

Health & Safety Audit Tool Template developed to support site-based reviews.

Sources of Assurance – Level 1	**Sources of Assurance – Level 2**	**Sources of Assurance – Level 3**
	Health & Safety Ops Group 'Key Issues' report to Health & Safety Committee Rotational presentation of Service Group and Non-Service Group H&S Exception reports to H&S Committee Regular review of H&S risk on HBRR, as well as a summary of operational risks recorded within Service Groups and Directorates on DATIX, by the H&S Committee Periodic review of progress against the H&S Strategic Action Plan at H&S Committee Estates Health and Safety reports received and considered by the H&S Committee	A&A Report SBU-1920-006 – March 2020 Health & Safety – Limited Assurance A&A Report SBU-2021-004 – January 2021 Health & Safety Framework (F/Up) – Reasonable Assurance A&A Report SBU-2223-016 – September 2022 Health & Safety – Limited Assurance A&A Report SBU-2021-007 – April 2021 Control of Contractors – Limited Assurance A&A Report SBU-1920-007 – November 2019 Capital Systems: Financial Safeguarding – Limited Assurance A&A Report SBU-1617-009 – October 2017 Backlog Maintenance – Limited Assurance A&A Report SBU-2021-008 – June 2021 Water Safety – Limited Assurance A&A Report ABM-1819-009 – May 2019 Safe Water Management – Limited Assurance A&A Report SBU-2021-009 – April 2021 Fire Safety Management – Limited Assurance A&A Report (No Ref Given) – October 2022 Decarbonisation – No assurance rating given

Gaps in Control/Assurance or Identified Areas for Improvement	Agreed Action
Scope to enhance clarity/assurance over which areas are and are not being addressed by H&S Ops Group deep dives	Following the stepping down of the Health & Safety Committee, the Health & Safety Operation Group (HSOG) Key Issues Report will now be received by the Quality & Safety Committee. This Key Issues report details any Deep Dive review undertaken during the reporting period. An updated exception reporting template has been implemented for Service Groups to report into HSOG in order to assist with this. Going forward, the forward plan of Deep Dives will form a standing item on the HSOG Key Issues report to Q&S Committee. **30/06/2023**
Scope identified to enhance clarity and content of Estates reports received by the H&S Ops Group	Further review and update is being undertaken to ensure that appropriate information relating to Estates KPI's in being captured. The deadline for his action has been extended in line with the Health & Safety Ops Group meeting calendar. Estates reports will be received by the Performance and Finance Committee from July 2023. **31/08/2023**
Scope identified to enhance clarity of performance reporting against agreed KPIs at H&S Ops Group and H&S Committee	Updated exemption reports now have a section specifically for KPIs for the Service Groups. Further review and update is being undertaken to ensure that appropriate information relating to Estates KPI's in being captured. The deadline for his action has been extended in line with the Quality & Safety Committee meeting calendar. **30/09/2023**
Health and safety team resource business case requires review/update in order to reflect the current and intended structure.	Work to finalise the structure is currently ongoing. 4 additional posts already funded and recruited to with corresponding reduction in Risk Register rating. Formal OCP to restructure the Health & Safety Department under development. Engagement to commence in August 2023.
Scope to enhance systems and processes around contractor insurance and competency checks	A tender has been developed for an appropriate management system. This has been forwarded to NWSSP Procurement Services colleagues to complete the tendering exercise. **30/09/2023**
Scope identified to enhance Estates Stores processes across health board sites	The Assistant Director of Estates has approached NWSSP Procurement colleagues and the Head of Support Services in order to identify any further good practice already in place with regard to stores systems and processes. The Assistant Director of Estates will then combine any good practice identified with the findings of the recent NWSSP Audit & Assurance review, and produce a SOP document for the management of Estates Stores
No Estates Strategy in place	Estates Strategy approved at May 2023 meeting of the Board. **Complete**
Staff training in respect of water safety requires updating	Further staff have undertaken responsible person training, and are awaiting formal appointment by the Authorised Engineer (AE). A revised draft training matrix has been developed, and will be presented to the Water Safety Committee for approval. **30/06/2023**