Meeting Date	**29th July 2021**	**Agenda Item**	**2.1**
Report Title	**Board Assurance Framework (BAF) Quarter 1**		
Report Author	Len Cozens, Head of Compliance		
Report Sponsor	Pam Wenger, Director of Corporate Governance		
Presented by	Pam Wenger, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide the Health Board with an update on work to review and update the Health Board's Board Assurance Framework (BAF) document.		
Key Issues	The development of the Board Assurance Framework (BAF) has been agreed by the Board, and it is owned by the Accountable Officer and the Board. The Audit Committee has a key role in overseeing the development and implementation of the BAF. The Director of Corporate Governance is the lead Executive with responsibility for the delivery of the BAF. The Head of Compliance is responsible for facilitating and coordinating the maintenance/review and update of the BAF by the Executive and their teams. The BAF has been considered at the July 2021 meetings of both the Management Board and Audit Committee.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the progress on the development of the Board Assurance Framework (BAF), acknowledging that it is an iterative document which will be continually updated; and • **AGREE** any specific areas which will require further assurance in order that these can be reviewed by the relevant Board Committee		

BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 1

1. INTRODUCTION

1.1 The purpose of this report is to provide the Health Board with an update on the work to review and update the Health Board's Board Assurance Framework (BAF) document.

1.2 The Audit Committee has reviewed previous iterations of this emerging document and it was been agreed by the Board to ensure implementation of the Board Assurance Framework during 2021/22.

2. BACKGROUND AND CONTEXT

2.1 The Audit Committee is responsible for overseeing the overall operation of the Board Assurance Framework and providing assurance the Board in that respect. While this is the case, individual sections have been assigned to other Board committees for more detailed scrutiny and assurance, with the intention that committee work programmes be aligned so that progress made to address key risks is reviewed in depth.

2.1 The process of gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. With this in mind, the BAF is intended to enable the Board to:

- Identify and understand the principle risks to achieving its strategic objectives
- Establish sources of assurance in respect of the adequacy, suitability, completeness and operation of the controls in place to manage those risks.
- Receive assurance that, where gaps in control or assurance are identified or the need for improvement has been highlighted, action plans are in place and being delivered.
- Provide an overall assessment of the risk to achieving the objectives based on the strength (or otherwise) of the controls and assurance in place.

2.2 In summary, the BAF provides a framework for identifying which of the Health Board's strategic objectives are at risk because of inadequacies in controls or insufficient assurance about them. At the same time it provides structured assurance about risks which are being managed effectively, and objectives that are being delivered.

2.3 The most objective assurance comes from independent external review sources. These are supplemented by internal sources such as clinical audit, internal management, performance management and self-assessment reports.

3. STATUS UPDATE

3.1 The BAF was previously presented to, and considered by the Audit Committee in March 2021. At this meeting, the Committee approved the BAF for use within

the Health Board, noting that it was an iterative document, and as such would be continually reviewed and updated.

3.2 11th May 2021, the Head of Compliance forwarded relevant sections of the document to Executive colleagues with a request that they and their teams provide further updates in terms of:

- Key controls in place
- Any further perceived gaps in control and/or assurance, and proposed action to address them.
- Any relevant progress/update in respect of action already taken.

3.3 Following the issue of the email referred to above, the Head of Compliance received contact from a number of Executive colleagues (or members of their teams), and provided support and assistance wherever requested. All updates received have been incorporated into the BAF.

3.4 Further work has also been undertaken to update the document to reflect:

- The content of final versions of recently issued NWSSP Audit & Assurance Reports
- The inclusion of target dates for agreed action where these have been available/communicated.
- Key elements of the revised draft 2021/22 Annual Plan

The updated document was subsequently presented to the July 2021 meeting of the Audit Committee for scrutiny.

3.5 In addition to the foregoing, the BAF has also recently been reviewed by the Chief Executive Officer, and the feedback received communicated to Executive colleagues in order to assist in informing further development of this iterative document.

The following table provides a summary of the assessment against the enabling objectives as detailed in Appendix 1.

	June 2021
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.	

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations in this report.

5. RECOMMENDATIONS

5.1 Members are asked to:

- **NOTE** the progress on the development of the Board Assurance Framework (BAF), acknowledging that it is an iterative document which will be continually updated; and
- **AGREE** any specific areas which will require further assurance in order that these can be reviewed by the relevant Board Committee

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Ensuring that the Board and its Sub-Committees make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making the decisions. Informed decisions are most likely to impact favourably on the quality, safety and experience of patients and staff.		
Financial Implications		
There are no direct financial implications arising from this paper		
Legal Implications (including equality and diversity assessment)		
Ensuring that the organisation has an effective and evolving Board Assurance Framework (BAF) that supports the Board in delivering its plans and achieving its objectives, is an essential component of the Health Board's governance arrangements going forward.		
Staffing Implications		
The further development and embedding of the BAF will require a significant amount of work on the part of Executive colleagues and their teams.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The development of the BAF will assist the Board in assessing risk and gathering assurance across all corporate objectives, which span the five ways of working, and the wellbeing goals identified in the Act.		
Report History	Audit Committee – July 2021 Management Board – July 2021	
Appendices	Appendix 1 Board Assurance Framework (BAF)	

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.

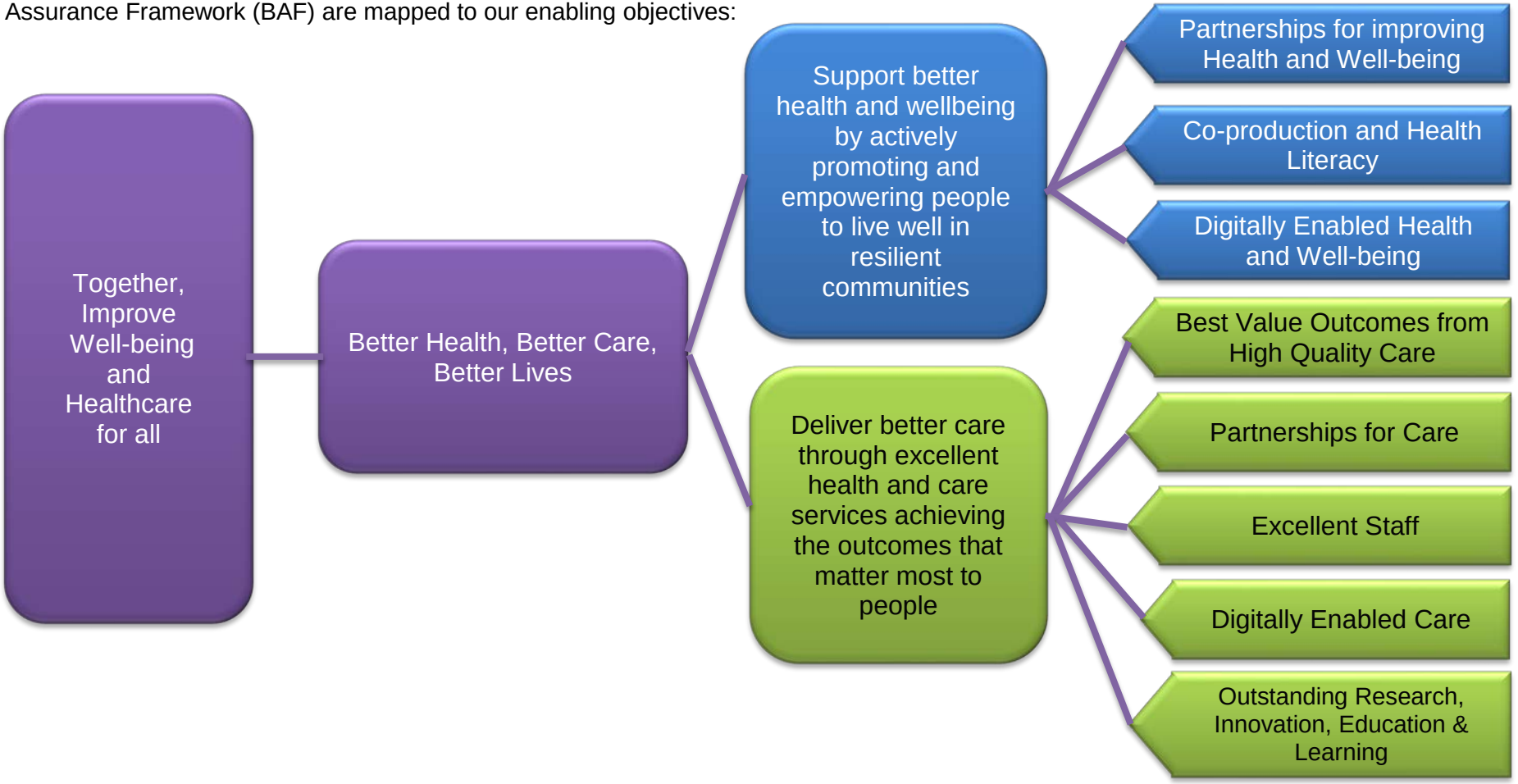
Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification

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 2021

	June 2021
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.	

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 (HBRR15)**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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 Health 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.	Business case to be developed in order to undertake data cleansing across primary care and child health record systems. Deliver immunisation awareness training for pre-school settings to promote key vaccination messages **(31/03/2021)** Contribute to the implementation of recommendations made in the “MMR Immunisation: process mapping of the child’s journey” report. **(31/03/2021)** Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins **(31/03/2021)** Improve uptake of Men ACWY in primary care. Establishment of Population Health Sub-Group of Management Board 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 Sub-group

1.2	**Pandemic Framework (HBRR68)**							
Key Controls		**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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	✓ ✓ ✓		✓ ✓	None Identified	None Identified	Continued receipt and scrutiny of regular and detailed activity and performance reports in order to inform the pandemic planning process. **(Ongoing)**

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	**Wellness Centres**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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	None Identified	Regular updates to be provided to the Board. **(Ongoing)**

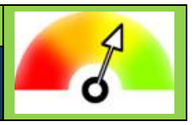
2.2	**Healthy Behaviours**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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	✓			None Identified	Due to Covid-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	Delivery of all outstanding school vaccination programmes delayed by COVID-19 **(31/03/2021)**

2.3	**Substance and Alcohol Misuse**

Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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.	Update paper provided to Quality & Safety Committee Proposed revised model supported by Police and Crime Commissioner, Public Health Wales and Welsh Government.		✓	✓	None Identified	None Identified	None Identified

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 Health & Wellbeing**

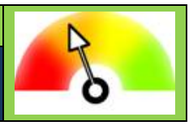
Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Digital Strategy and Strategic Outline Plan. IMPT/Annual Planning process. Financial impact of expansion identified, and a financial plan covering 2021/22 commitments has been established 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. Digital Risk Management Group and Risk Register 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. A&A Report SBU-1920-028 Discharge Summaries No Rating Given A&A Report SBU-1920-029 IT Application Systems (TOMS) Reasonable Assurance	✓ ✓ ✓ ✓	 ✓	 ✓ ✓	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.	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.	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%. **31/03/2022** Draft Business Intelligence Strategy presented to Management Board in July 2021 for comment, which includes detail on the proposed BI governance structure to be put in place. A subsequent BI operational implementation plan will be produced following feedback and further engagement. **30/09/2021** Digital workforce plan currently being developed as part of the IMPT/annual planning process. **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 roll-out of: • HEPMA (Singleton initially) • WNCR (NPTH initially) • SIGNAL V3 • Digital Outpatient Transformation **31/03/2026** Progress with implementation of Hospital Electronic Prescribing and

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. Health Board representation on National Infrastructure Management Board (IMB) and Service Management Board (NSMB), who hold NWIS to account for the delivery of services. 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 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							Medicines Administration (HEMPA) across the HB. **30/06/2021 – S'ton** **31/07/2022 – M'ton (Subject to funding)** Continue to develop a case for improved record storage and management. **31/03/2022** Cyber security module developed and available on ESR. Currently working through the process within the Health Board to make completion of the training mandatory. **01/08/2021** 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**

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.							

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	**Access to Unscheduled Care Services (HBRR1)**

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in 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. Health Board Representation on the National Unscheduled Care Board. Phone First' task and finish group established, with representation on the national group also. H2H implemented, developed into Rapid Discharge to Assess pathway in line with WG directive. Monitored via H2H implementation group and reported to Community Silver. The cohort of MFFD patients is monitored and discussed at Gold and Silver Command meetings. SAFER – Patient Flow and Discharge Policy 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		✓	✓	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.	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	Delivery and installation of ambulance offload PODS at Morriston ED to support timely patient handover. **(31/03/2021)** The introduction of the 'Phone First' model, redirecting patients into appropriate alternative pathways. **(31/03/2021)** 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 Implementation of Consultant Connect for major referring specialties **(30/09/2021)** Subject to successful application for ongoing WG funding, continuation and expansion of Urgent Primary Care Centre service provision across SBUHB to support WAST stack triage, ED workload and Phone First redirection. Further roll out and enhancement of Cluster Virtual wards to coordinate patient care for frail and elderly patients, facilitate early supported hospital discharges and deliver safe community based interventions for acutely unwell patients with defined ceilings of care, EOL decisions and high frailty index when clinically appropriate. **(30/06/2021)** 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. **(01/05/2021)** Development of a new Corporate Audit Management Tool and SOP to accompany the revised SAFER Policy

							(01/05/2021) SIGNAL User Group to consider further enhancements in phase 3 around clinical recording, including reasons for changes to EDD and a standardised approach to Board Rounds. **(31/03/2021)** Following engagement with Carers via Stakeholder Reference Group, a leaflet will be produced outlining patient and family communication and involvement in EDD planning. **(30/05/2021)** The all-Wales newly developed and piloted digital risk assessments will be rolled-out across the Health Board. **(31/03/2022)**

4.2	**Infection Control Targets (HBRR4)**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**	**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**

		1st	2nd	3rd			
• Infection Prevention & Control Committee. • Health Board Infection Prevention & Control Framework, approved by the Infection Prevention & Control Committee. • A 4-weekly *C.difficile* Scrutiny Panel has been put in place • Three-month programme of proactive deep cleaning successfully implemented across Health Board acute sites. • Maximising the use of virtual consultations where possible, and minimising footfall • Appropriate Infection control (re)training for new, returning or redeployed staff • Review of bed spacing undertaken across the Health Board to ensure minimum distancing Non-compliant beds were removed, or mitigating measures put in place. • Policies, procedures and guidelines in place • Bug stop quality improvement programme • IPC Team support clinical teams for all issues relating to infection control • ICNet information management system for infections is in place • Additional staff in post including permanent Infection Control Doctor, Decontamination Lead and Asst. Director of Nursing • Environmental decontamination and infection control needs are considered for all refurbishment and new works, to ensure our hospitals provide suitable facilities for infection control • Infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	• Clear assurance framework in place at Corporate level with - HB Infection Prevention & Control Committee - Health Board C. difficile Infection Improvement Group; - Corporate Infection Prevention & Control Nursing Team - Water Safety Group - Directly Managed Unit Infection Prevention & Control Groups. • Incident reporting • Root Cause Analysis to ensure monitoring and lessons continue to be learnt from Healthcare Associated infections (HCAI). • Infection Prevention & Control Committee monitors infection rates and identifies key actions to drive improvements • Subgroups to the IP&C Committee such as the Decontamination Group provide assurances and drive key areas of operational work. • Regular reporting and monitoring of infection and compliance data, for example at Q&S Committee. • IA report Infection Prevention & Control July 2019 (1920-019) – Reasonable Assurance • Regular HCAI update reports to the Q&S Committee • Operational Plan performance tracker reports. • Delivery Unit C.difficile Improvement Plans reviewed and monitored at C.difficle Scrutiny Panel. • De-escalation to enhanced monitoring with reference to improved performance on infections. • A&A Report SBU-2021-025 Infection Control – Cleaning Reasonable Assurance	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓	✓ ✓	No overarching cleanliness policy or strategy in place. Lack of decant facilities when occupancy is at acceptable levels on acute sites. Decant facilities and deep-cleaning of areas considered a 'reservoir of risk' have been affected by increased use of areas for surge capacity Domestic hours required to meet National Standards of Cleanliness recommendations. There is no Epidemiologist as present within SBUHB	ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.	• Draft Cleaning Strategy presented to ICC (Feb 2021). Comments and feedback received will be incorporated into the Final document, which will be presented to the next ICC meeting for approval. **31/08/2021** • The Health Board will participate in a Public Health Wales-led review exploring the relationship between COVID-19, secondary bacterial infections, and *C. difficile*. **In line with PHW Timetable** • Develop a costed local research proposal to understand better the local epidemiology of *C. difficile*, including screening patients at the point of admission, to be submitted for approval. **TBC, linked to current Epidemiologist vacancy** • Medical representatives from gastroenterology and general surgery to become members of the C.difficile Scrutiny Panel. **30/09/2021** • Clinical Outcome and Effectiveness Group (COEG) are currently investigating further restriction of broad-spectrum antibiotics in the antimicrobial guidelines. **Ongoing** • Cleaning staff recruitment continues. This is an ongoing process due to turnover in this staff group. **Ongoing** • Development of Ward dashboards on key infections data, with ongoing IT support. **31/12/2021** • The feasibility including a decant facility in Morriston will form part of a capital plan for Morriston, aimed at minimising infection prevention & control risks. **TBC** • Procurement exercise has commenced to identify a safe and appropriate managed environmental decontamination service for cases of ongoing transmission. **30/09/2021** • Review pilot of SSAs undertaking the whole deep clean of patient care areas. Determine efficacy and

							propose a long-term solution **30/09/2021**. Review and Implement reduction targets for both primary and secondary care, in line with best performing organisations. **31/03/2022** Focussed work within Primary and Community care to understand mechanisms of transmission in the top 3 tier 1 target infections, and to achieve reductions. Ensure learning is shared across the Health Board. **31/03/2022**

4.3	**Access to Planned Care (HBRR16)**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**	**Gaps in Control**	**Gaps in 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 **Surgical Services** • Services currently delivered in line with RCoS *Clinical Guide to Surgical Prioritisation during the Cronoavirus Pandemic*, in conjunction with the WG *Four Harms* principle • 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. **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	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 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 Local Safety Standards for Invasive Procedures (LocSSIPs) have not yet received corporate approval. Observational audit and associated reporting requirements to be clarified within LocSSIPs Unit-Specific SOP's to be reviewed.	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.	• Maximise roll-out of key elements of the Outpatient Transformation Programme within high priority specialty areas identified with DU's/Service Groups. **(31/03/2021)** • Redesign approaches to improve waiting list management. Rollout of See On Symptom and Patient Initiated Follow-Up principles and processes where clinically appropriate. **(31/03/2022)** • Design and commission a bespoke Outpatients Dashboard, reporting 'real time' analytics across all departments. **(31/03/2021)** • Collaborative working/redesign to identify areas where it would be suitable to transfer outpatient services to primary care/community settings. **(31/03/2021)** • 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. **(31/06/2021)** **Surgical Services** • Development of a Post Anaesthetic Care Unit to support the flow of elective (and emergency) cases. • Develop and Implement a Theatre Operations Management System (TOMS) development plan to improve monitoring and efficiency of theatre capacity utilisation • The development of an elective musculoskeletal centre at NPTH • Develop an integrated workforce plan for theatres and anaesthetics. • Working Group to be established in order to review LocSSIPS. **(31/03/2022)** • Theatre Board to oversee review of Unit-Specific SOP's **(31/03/2022)** **General** • Reinstatement of quarterly Planning, Quality & Delivery meetings with Service Groups.

							• Completion, collation and review of specialty specific harm assessments. • Implementation of WPAS update in order to enable reporting of planned care wait times using new deferred target dates based on clinical assessment. Development of a Planned Care Programme Board, supported by clinical reference groups. Undertake demand and capacity analysis for each speciality, followed by the setting (and monitoring) of improvement trajectory. Develop and roll-out a Health Board-wide MDT Teaching Programme covering the recognition of patients at risk of SEPSIS and acute deterioration **(31/12/2021)** Establish a dedicated SEPSIS TEAM, and identify Ward-based SEPSIS Champions. **(31/03/2022)** Ensure Sepsis compliance is captured across the HB to benchmark on a national basis **(31/03/2022)**

4.4	**DoLS Authorisation & Compliance with Legislation (HBRR43)**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**	**Gaps in Control**	**Gaps in 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 Dashboard devised to enable more accurate monitoring and reporting. • Actions agreed and reported in response to adverse impact of COVID and restrictions on the service. QIA's undertaken in line with reset and recovery process. • Guidance on revised systems and processes during COVID-19 Outbreak produced by Corporate Safeguarding Team and reported to Q&S Committee.	• Update reports to the Mental Health Legislative Committee. These include performance data. • 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.	None identified at this time	Further discussions to take place between Primary Care & Community Services Service Group and Corporate Team around requirements to change service model and delivery as a result of upcoming legislative changes coming into force in April 2022 (a draft report has been produced to support this process). **30/09/2022**

4.5	**Trans-catheter Aortic Valve Implementation (TAVI) (HBRR49)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			

The Health Board has commissioned the Royal College of Physicians to undertake a review of the service. Reports have been received, and recommendations made. 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.	 ✓ ✓ ✓	 ✓ ✓	✓	None identified	None identified	To implement recommendations made within Royal College of Physicians (RCP) reports. **(Ongoing)**

4.6	**Access to Cancer & Palliative Care Services (HBRR50)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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. Additional endoscopy sessions (3) implemented from October 2020 Protected capacity rate for Chemotherapy treatment set as part of 2020/21 Operational Plan. Weekly Clinical Lead Recovery Planning meetings being held in Endoscopy.	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.	 ✓ ✓ ✓	✓ ✓		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)	Explore options for sustainable uplift in Endoscopy capacity. **(01/04/2021)** Increase capacity within CT/MIR via recruitment and extended working hours. Additional services planned at NPTH for Capsule Endoscopy, PH Manometry and breath test procedures. Faecal Immunochemical Tests (FIT) implemented for low risk groups, and to roll out within Primary Care. Complete work to redesign endoscopy Straight to Test (STT) pathway. Fully introduce COVID testing for Oncology and Haematology patients and staff in line with national guidance. **(28/02/2021)** Ongoing education and support to primary and community services to ensure early diagnosis/referral via single point of access cancer services. Deliver 7-day Acute Oncology Services from Morriston Hospital **(31/12/2021)** Develop Regional Transformation Programme & Implementation Plan for SWWCC.

							(31/12/2021) Develop a clinical workforce plan for South West Wales Cancer Centre (SWWCC) **31/03/2022)** Implement recommendations for Improving End of Life Care, and increase Ty Olwen Capacity. **(30/09/2021)** Review of statutory and mandatory training to ensure that End of Life care is adequately provided. **(30/09/2021)** Review and update TOR for EOLC Board to ensure that they are relevant, fit for purpose, and effectively operationalised. **(30/06/2021)** Agree scope for a review of EOLC by NWSSP Audit & Assurance Services. **(31/12/2021)** Develop the use of digital technology (SIGNAL) to map compliance and notification of patients who require or are receiving EOLC. **(31/03/2022)**

4.7	**Access to Cancer Services (SACT) (HBRR66)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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. Number of Chemotherapy chairs reduced in order to reflect COVID-19 controls (social distancing). Utilisation/capacity rate target set. Business case approved to increase provision of intravenous therapy at home (May 2021)	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.	Option appraisal to be completed by service group for review by Service Group senior team. **Completed** Business case endorsed by CEO for shift of capacity to home care, for Management Board approval July 2021. **(31/07/2021)**

4.8	**Radiotherapy Target Breaches (HBRR67)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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. Protected capacity rate set as part of 2020/21 Operational Plan. 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.	✓ ✓ ✓ ✓	 ✓ ✓		Additional capacity sought through outsourcing. Business case to rollout hyperfractionation 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 for specific tumour sites. Develop and implement a case to utilise additional RT capacity released by implementation of revised radiotherapy regimes for specific cancer sites. **Completed** Review of the patient pathway by the Asst. Gen. Manager (Cancer Services). **Completed** Work with HEIW to develop a case for a clinical leadership fellow to support quality improvement work and shortened fractionation. **Completed** To explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB. **(31/08/2021).**

4.9	**Screening for Fetal Growth Assessment in line with Gap-Grow (HBRR63)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
All staff have received training on Gap & Grow, and detection of small for gestational age (SGA) babies	Gap & Grow training compliance monitored	✓			Challenges in achieving required levels/volume of scanning due to capacity issues.	None Identified at this time	Two Midwife Sonographers have been appointed, and are currently training at the University of West of England for

Obstetric scanning capacity across the HB is being reviewed. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening, and to comply with Gap & grow recommendations.	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	✓ ✓ ✓			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 scan department have been unable to support training for the trainee midwife sonographers. Consultant Obstetrician taken off obstetric rota to provide training while recruitment process for training ultrasound practitioner. 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.		appropriate qualification. 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** Prepare a business case to offer two further midwives the opportunity to undertake ultrasound scan training commencing January 2022. This will ensure enhanced ultrasound scan capacity and lead to a sustainable service. **(31/07/2021)** Preparation of second scan room and further investment in 2nd ultrasound scan machine for midwife sonographer new training cohort **(31/01/2022)** Ultrasound working group to work with HEIW, the Maternity Network and all Wales Imaging Academy toward a Wales Ultrasound accredited training Programme **(31/12/2021)**

4.10	**Misrepresentation of Abnormal Cardiotocography (CTG) Readings (HBRR65)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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.	Monitoring of compliance with rate of annual mandatory training Initial capital funding for central monitoring	✓ ✓			Central monitoring system to store CTG recordings of foetal heart rate in electronic format not yet in place	None identified at this time	Procurement process for K2 central monitoring system now complete and capital funding identified. Further

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.	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.	✓ ✓		✓	CTG traces can be lost if not filed correctly Fetal surveillance midwife and obstetrician have to spend an excess of time preparing for reflection sessions having to film and copy CTG traces to share.		submission to next meeting of Business Case Assurance Group for approval. **(31/08/2021)** To set up a project steering group once purchase of system completed. Sub groups of the steering group will include; • Clinical group • Informatics group This will follow approval at Business Case Assurance Group **(30/09/2021)**

4.11	**Clinical Standards and Audit Performance**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
National Clinical Audit and Outcome Review Advisory Committee Programme Health Board Clinical Audit & Effectiveness Team in place.	• Midyear and annual reports received and scrutinised by the Audit Committee, together with an update report to the Quality & Safety Committee	✓	✓		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.	Unknown impact of NHS England's proposed withdrawal from the national clinical audit programme Scope identified to improve assurance reporting to the Q&SC	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.

HB Clinical Outcomes and Effectiveness Group (COEG) established. NICE Guidance	• COEG update reports to the Quality & Safety Governance Group • 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	✓ ✓		✓ ✓ ✓ ✓ ✓	(WHO Checklist) Monitoring of WHO checklist compliance not evident at corporate groups.	in respect of outcomes and action taken following mortality reviews.	**(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)** A local SBUHB Mortality Review Framework document will be produced, based around the National Learning from Deaths Framework. **(30/09/2021)** Content of reports to the Q&SC regarding morality reviews will be reviewed and revised following adoption of the local SBUHB Mortality Review Framework **(30/09/2021)** Service Group Medical Directors to ensure that the results of WHO checks are included at Unit/Group Quality & Safety meetings **(31/07/2021 and Ongoing)** Review of LocSSIP audits will be undertaken at Clinical Outcomes and Effectiveness Group (COEG), and both Group and Board Quality & Safety Groups. **(31/07/2021 and Ongoing)**

4.12	**Primary, Community & Therapy Services (PCCTS)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
COVID-19 Response plan for PCCTS in place based on service-level business continuity plans.	Integrated Performance Report contains statistical performance and trend data on key areas including: • Primary and community areas • Therapy wait times • Outpatient wait times	✓				Inconsistent use of action logs at cluster meetings, meaning that actions assigned were not always clearly trackable to completion.	Introduction of standardised reporting mechanisms and action logs. **(31/03/2021)** A standard approach to cluster monitoring including IMTP progress will

Reactivation of primary care, community and therapy services overseen by the Health Board Reset & Recovery Group. Monitoring of daily reporting of GP, GDS and Community Pharmacy pressures, facilitating early engagement and enhanced support to practices reporting at level 3 and 4. Plans in place to support primary care contractor professions in the implementation of nationally issued guidance as required: • Urgent Dental Care Centre • COVID-19 Cluster Hubs • Urgent Eye Centre HB Flu Plan developed, with emphasis on collaborative cluster working across GMS and Community Pharmacy. Acute Medical Services Redesign (AMSR) Group established, supported by four work streams. Agreed phased plan in place. Reset and restart the Cluster Wide System Transformation Programme. All primary care cluster annual plans support the continued roll-out of digital platforms, e.g.: • Ask My GP • Attend Anywhere • Consultant Connect. Support to encourage the uptake of the Care Home GMS Directed Enhanced Service (DES) included in primary care cluster annual plans Directed Enhanced Service (DES) regarding winter bank holiday opening offered to Health Board GMS practices. Development and use of Community Services Escalation Framework (2 per week) Enhanced OOH/IHA model for GDS. New model and pathway developed for paediatric dental Gas	• Flu Vaccine Uptake • Patient Experience Operational Plan performance tracker reports. Monthly reporting on utilisation of Consultant Connect service, which includes primary care. AMSR update reports received by Senior Leadership Team (project temporarily put on hold due to operational pressures). A&A Report SBU-2021-013 Primary Care Cluster Plans & Delivery Reasonable Assurance Weekly PCS Silver meeting to monitor progress against PCT COVID Response Plan. Highlight and progress reports at Community Silver meetings (Integrated with Swansea and NPTH Councils) meeting to monitor progress against joint plan reporting Monthly reporting to PCT Transformation Forum. PCT Performance update reports to Q&S and P&F Committees	 ✓ ✓ ✓ ✓ ✓	 ✓	 ✓ ✓ ✓		Scope identified to improve and standardise reporting on IMTP progress both within cluster meetings, and to the Primary and Community Services Board, thereby deriving greater assurance in respect of IMTP progress and delivery.	be developed and implemented during 2021/22. **(31/03/2021)** Dental representation at all 8 clusters from Q1 **(30/06/2021)**

13	Test, Trace and Protect (R COV Strategic 13)

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in 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.	 ✓ ✓ ✓	✓				

4.14	Mass Vaccination (R COV Strategic 15)

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in 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. 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.	The position in terms of vaccine of vaccine supply remains fluid. The potential delivery of a Booster programme in the Autumn has yet to be clarified.	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)**

4.15	Impact of COVID on HB Underlying Financial Position, and Capital Resource Limits and Planning

Key Controls	Forms of Assurance	Levels of Assurance			Gaps in Control	Gaps in Assurance	Agreed Action
		1st	2nd	3rd			
Financial plan reported to and approved by Board as part of the Annual/IMPT Plan. Risk-assessed savings plan in place, linked to opportunities pipeline developed	Regular reporting/monitoring of the financial position, movements and risks, notably at Performance & Finance Committee and the Board. Performance against savings targets	✓	✓		Issues regarding historic under-achievement of savings plans identified as part of Audit Wales Structured Assessment.	Scope identified to extend the information used in respect of benchmarking costs.	Review/Refresh planned savings programme utilising benchmarking, KPMG opportunities pipeline and the Efficiency framework. Develop detailed savings plans, with milestones, deliverables and timescales to ensure

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 Delivery Groups Regular reporting to and dialogue with WG regarding the financial plan and position Discretionary capital plan and subsequent revisions reported to and approved by Board. Review/Scrutiny via the Capital Prioritisation Group. Review/Scrutiny via the Investments and Benefits Group. Regular reporting to and dialogue with WG regarding capital position and requirements.	separately reported. Financial impact of COVID separately reported. Monthly monitoring returns to WG Regular reporting/monitoring of the capital position and risks, notably at Performance & Finance Committee and Capital Prioritisation Group. Operational Plan performance tracker reports.	 ✓ ✓ ✓		 ✓			the deliverability of the opportunities in 2021-22. Due to COVID, The Health Board has reverted to 2019-20 service and cost baselines to review efficiencies and benchmarking. Our approach for 2021/22 will be to assess the financial requirements of the plan across base plan, COVID response and COVID recovery.

4.16	**Mental Health and Learning Disabilities**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Service Group command and control system and COVID-19 response centre established Pathway reviews across Older Peoples Mental Health, Adult Mental Health, and Learning Disability Services to provide a	Update reports received at Quality & Safety Committee and Senior Leadership Team, as well as Operational Silver and Gold meetings.	✓ ✓	✓				Undertake demand and capacity modelling within Local Primary Mental Health Services (LPMHSS) utilising local and national data. Rapid review of LPMHSS in order to inform best use of additional recurrent

single point of admission for each service. Technology solutions in place across Community Services and Psychological Services Therapies Services. Utilisation of 'Attend Anywhere' and 'Teams' to offer virtual 1:1 and group psychological therapy interventions Psychological Therapies Stakeholder group established to identify and implement actions to reduce waiting times. Implementation Board in place, including WHSSC. Psychological Therapies Project Group established to plan a revised service model based on stepped care. Progressing the development of a permanent mother and baby unit at Tonna Hospital.	Single points of admission established in all services as reported to Operational Silver meetings. Integrated Performance Report contains statistical performance and trend data on key areas, including therapy wait times. Progress on psychological therapies reported to Reset & Recovery meetings. Operational issues addressed at Service Group Silver, Operational Silver and HB Gold meetings. Psychological therapies targets met in November and maintained. A&A Report (SBU-1920-034) ML&LD Unit Governance Review Reasonable Assurance Operational Plan performance tracker reports.	✓ ✓ ✓ ✓ ✓					funding secured from the WG's mental health service improvement fund. Commissioning of MABU – on target for April 2021

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	**External Partnerships**				
Key Controls	**Forms of Assurance**	**Levels of Assurance**	**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**

		1st	2nd	3rd			
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 Integrated Care Fund Written Agreement in place.	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. A&A Report SBU-2021-043 Integrated Care Fund: Banker Role No Assurance Rating Given	✓ ✓	 ✓	 ✓	No internal document detailing the process for managing the ICF Fund.		Priorities for the RPB are: - Stabilisation and Reconstruction - Remodelling Acute Health and Community Services - Transforming Complex Care - Transforming Mental Health Services A review of how ICT Funds are managed within the overall governance structure of the HB is being undertaken; the new process will be documented. This is being overseen by the Deputy Director of Finace. **(31/12/2021)**

5.2	Partnerships for Care						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
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	Progress reports and minutes of joint meetings are provided to and reviewed by the Board Operational Plan performance tracker reports. Regional & Specialised Services Provider Planning Partnership	 ✓	 ✓	✓			

• 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	ARCH National Endoscopy Group Cwm Taf & Swansea Bay UHB Joint Exec Group		✓	 ✓ ✓			

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**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding	Both the Staff Health and Wellbeing Service and Occupational Health Service have won national awards October 2020			✓	Imminent departure of OH Consultant and reduced medical capacity mitigated by agency support and the potential to work		Develop an overarching post COVID-19 Staff Health & Wellbeing Strategy **(30/06/2021)**

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. Established Workforce & Organisational Development Committee in place, with Terms of Reference which include matters relating to staff health and wellbeing services.	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.		✓ ✓ ✓ ✓		with AB and C&V UHB's on a joint procurement for medical support		Expand trauma management training and support (TRiM) to staff in identified priority areas **(31/03/2022)** Establish an Occupational Health staff support for Post COVID19 Syndrome – Long COVID19 Pathway. **(31/12/2021)** Continue to develop staff wellbeing service to ensure meets COVID-19 related health impacts, including mental health, trauma and bereavement. **(30/09/2021)**

6.2	**Workforce Efficiencies**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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	Operational Plan performance tracker reports. A&A Report SBU-1718-046 EWTD Limited Assurance		✓	✓	Lack of Health Board-wide policy or procedure which supports EWTD.	Need for bank and agency continues.	Review of Local bank/Agency booking processes, and introduce revised management controls to standardise usage. Completed in part – joint paper between Finance and Workforce submitted to COO. CE has written to SGs requesting they review their internal bank/agency controls. Review of remaining block booked Bank staff to be undertaken **(31/08/21)**

							Review HB WOVEN compliance **(30/09/21)** Action plan to address issues following the Review **(30/11/21)** WOVEN action plan reviewed by WF&ODC **(01/04/22)** Review existing standard KPI's for Nurse roster management across the Health Board. **(30/09/2021)** Procure the final part of the Allocate package for the medical workforce, and develop an interim project plan to implement the system. **(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. **(31/03/2022)** EWTD guidance will be issued by 31st July 2021. **(31/07/2021)**

6.3	**Staff Experience**						
Key Controls		**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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.		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	 ✓ ✓	✓ ✓		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%	Support Service Leaders to identify and develop local staff actions plans to improve the staff experience. **(30/09/2021)** Develop a cohort of practitioners to drive forward the cultural change required for the JUST culture. **(31/03/2022)** Update leadership and management programmes to take into consideration the effects of COVID on the workforce.

Staff Experience & Organisational Development Plan in Place Clearly articulated organisational values.	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.		✓				**(30/9/2021)** Identification and training of 'Resolution Champions' **(31/12/2021)**

6.4	**Recruitment & Retention –** Recruitment & retention strategy in place supporting widening access and enabling a sustainable workforce to be developed.						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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	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	 ✓	✓ ✓	 ✓	Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework.	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. **31/12/2021)** Extend opportunities for apprenticeships in both clinical and non-clinical functions. **(31/03/2022)**

	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			✓ ✓			In conjunction with professional heads, develop and implement a recruitment strategy to support the development of a sustainable workforce. **(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)** Content of reports to the Workforce & OD Committee will be reviewed and updated in respect of DBS checks undertaken.

6.5	**Workforce Planning (Supporting the Annual Plan)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in 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.	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	 ✓ ✓ ✓	 ✓	✓	Progress on adoption of draft guidance documents in respect of junior doctors' hours and handover procedures.		Facilitate the redesign and development of workforce plans for all staff groups to outline the required workforce design based on demand capacity modelling. **The annual plan has been submitted to WG. We are now starting the development of the sustainability plan. (31/12/2021)** Support the Engagement Plan at Health Board-wide and local service level. **Throughout 2021/22** Develop and support the roll-out of the Consultation Plan, in line with the all-Wales OCP

	Junior Doctor Bandings (Follow-Up) Reasonable Assurance						**30/09/2022** Draft guidance documents in respect of junior doctors will be reviewed to take account of recent legal rulings, and implemented. Monitoring of rotas will recommence in October 2021. Guidance will be issued in September 2021. This will not be in partnership as the BMA cannot agree the documents. **(31/09/2021)**

6.6	**Non Compliance with Nurse Staffing Levels Act (HBRR 51)**						
Key Controls	**Forms of Assurance**	**Levels of Assurance**			**Gaps in Control**	**Gaps in Assurance**	**Agreed Action**
		1st	**2nd**	**3rd**			
Monthly Nurse Staffing Act Steering Group established, which provides update and assurance elements of the NSA. Setting up of appropriate sub groups, including Paediatrics, Mental Health and Learning Disabilities. Bi-annual calculation and formal review undertaken across all Service Groups, (previously called Delivery Units) to ensure a consistent approach to reporting nurse staffing requirements. Nurse Staffing Act (Wales) guidance issued, and Welsh Levels of Care and Operational Handbook circulated	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 Three yearly caveat report to Welsh Government submitted 05.05.2021 Report to Board outlining action taken to ensure appropriate nurse staffing during the COVID-19 pandemic, and 'Once for Wales' approach to calculating and reporting nurse staffing levels (May 2020).	✓	✓ ✓	✓	'Safecare' acuity-based rostering tool not yet fully implemented across all relevant wards. IT systems, HIEW working to establish number of IT systems that are used across Wales to gather information pertinent to the Nurse Staffing Act. (SafeCare) HEIW withdrawing some support, particularly around provision of visualisers and feedback. Training to be provided to Health Board by HEIW, for Health Board to generate visualisers and provide own feedback	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.	Develop and implement a system which allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster (All Wales). Rollout of the 'Safecare' acuity-based rostering tool across all wards that report under the Nurse Staffing Act (Wales), due to start implementation September 2021- no date confirmed for All Wales Rollout. **(30/09/2021) – Start Implementation** Ongoing discussions with HEIW regarding support through 2021 and support and planning for possible training HEIW to SBUHB on how to generate

Enhanced Supervision Framework introduced in March 2020 in response to increased patient acuity levels. Paediatric Task & Finish Group established in preparation for the extension of the Act Unit Nurse Directors working with Service Group in the development of workforce plans to address COVID escalation. During the height of COVID-19, a Daily Silver Workforce Nurse Staffing Logistics Cell were in place, chaired by the Interim Director of Nursing & Patient Experience or nominated deputy to focus on any key issues (hot spots) regarding Nurse Staffing levels across all Delivery Groups and support any immediate measures and solutions required. Due to the improving availability of the nursing workforce, the meeting was reduced to twice a week. This twice weekly meeting was further decreased to weekly and now ceased in place of the re-introduction of the Nursing Efficiency Transformation program in February 2021, this is chaired by the Interim Director of Nursing & Patient Experience. This is a weekly rolling programme focusing on the grip and control for each Service Group. Compliance with the Nurse Staffing Act is on the HB Risk Register (Number 1759), discussed and HB Nurse Staffing Act meeting and updated monthly. Currently, has a score of 20. Corporate Nurse Staffing 7-day rota was introduced. Stood down end of January 2021 in response to the improving COVID position. Recently retired registered staff contacted with a view to returning to the Health Board. A number of registrants that are on the NMC COVID register remain employed within the HB at this time. Appropriate utilisation of student nurses, completed during the first phase of COVID, now stood down in response to the improved COVID position. Use of bank and agency staff continues as appropriate.	Reported improvement with quality indicators showing a reduction in falls, pressure damage, complaints, length of stay and medication errors on wards previously invested in under the remit of the Act. Audit & Assurance Report (SBU-1920-041) Reasonable Assurance Audit & Assurance Report Follow-up Review only (SBU-2021-040) Substantial Assurance Ongoing monitoring and reporting of clinical indicators as outlined in the annual Nurse Staffing Levels (2016) Act board report. Reports to Health Board Nurse Staffing Act Meeting and reports progress to All Wales Paediatric Nurse Staffing Act Group. Submission of HB internal position paper, June 2021 SBAR to HB reporting measures in place to support safe staffing Minutes recorded, RAID log, roster headline report, bank and agency report and financial report. Risk Register	✓ ✓ ✓ ✓		✓ ✓			visualisers and feedback to service groups effectively

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**	**Gaps in 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	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	✓		 ✓ ✓ ✓			Development of Innovation Hub and associated Multi-Disciplinary Team (MDT)

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.							