BOARD ASSURANCE FRAMEWORK (BAF)

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.

Levels of Assurance

VISION AND STRATGEIC PRIORITIES

First Line
Operational

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

Second Line
Risk and Compliance

Reports to Assurance and Oversight Committees

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

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

Third Line
Independent Assurance

- Inter Audit Plan
- Audit Wales
- External Audits
- Health Inspectorate Wales (HIW Inspections
- Visits By Royal Colleges
- External Visits and Accreditations
- Independent Reviews
- Patient/Staff/Public Surveys, Feedback etc.

REGULATORS

EXTERNAL AUDIT

BAF1: Promoting and Enabling Healthier Communities & Partnership Working				
1.1	A Focus on Population Health Needs	Associated HBRR Entries: None	Trend	
			Assurance Rating	

Vision	Outcomes
Primary Care Clusters Contribute to Sustainable Population Health & Wellbeing – There is integrated planning of services driven by prevention, early intervention and addressing health inequalities – There are place-based solutions to tackle issues that matter to local communities – SBUHB takes a wider determinants approach to a fairer society, tackling the causes of the causes of ill health – The population's health and wellbeing is co-created with communities and partners – SBUHB commissions and delivers services that put prevention first – SBUH is supported to take an evidence-based approach to health and care **Population Health Strategy for Swansea Bay** – A new Public Health Management Board overseas action to improve population health – Systems and partners take timely, informed and targeted action that promotes good health for all, and reduces inequalities – People with chronic diseases are supported through a holistic approach that recognises the importance of taking action early to prevent multi-morbidity **Tackling Population Health Challenges** – There is less of a gap in health and wellbeing between those living in areas of deprivation and those not – More people, especially those facing greatest disadvantages, are empowered to adopt health-promoting behaviours – There is a focus on prevention and treatment of mental ill-health – SBUHB supports a One Health approach to sustainable development in line with the CMO for Wales' special report.	SBUHB has access to population health intelligence to support planning and delivery of services SBUHB takes action across all six of the domains set out in the Marmot Review to improve the Health of the population. A Public Health Programme Board is established to co-ordinate our Health Board activities as a whole system The priorities of the population health work stream of the new National Clinical Framework are delivered locally Local Public Health Team staff are successfully transferred from Public Health Wales to SBUHB Local outcomes meet the expectations set by national Welsh Government funded programmes such as Health Weight Healthy Wales, the Tobacco Control Strategy for Wales, and Healthy Schools Public health initiatives are successfully delivered through primary care, such as implementation of the All Wales Diabetes Prevention programme, delivery of the Adult Weight Management service, and childhood immunisations A population health strategy to be produced with our partners across Swansea Bay

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Public Health strategy and work plan
- Strategic Immunisation Group (SIG) and immunisation action plan in place
- Childhood Immunisation Programme
- Primary Care Influenza Group and Vaccination Programme
- Support from Public Health Wales Health Protection Team
- Local Smoking Cessation Services
- Joint working with Regional Area Planning Board

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Lines of reporting assurance in respect of vaccination & immunisation systems, processes and performance are not clear.	Planned reconfiguration of arrangements to provide strategic direction to and operational oversight of vaccination activity within SBUHB. There is a proposal for a whole system Immunisation Group to be established as a sub-Group of the Population Health Group. Reporting would then be via the Management Board. **30/06/2022**
Key Population Health measures included in integrated performance reports (P&F Committee): • Childhood Vaccinations • Flu Vaccinations • Alcohol attributed hospital admissions • Hospital admission rates which mention intentional self-harm		x		Scope identified to enhance governance arrangements and oversight around the work of vaccination & immunisation subgroups.	Under new proposals for an Integrated Vaccination Programme, sub-groups will be established reporting through a whole health system Immunisation Group. There is an intention to align vaccination planning with an LHB annual planning / IMTP refresh process, and an expectation that there will be a clear business cycle with systematic reporting and scrutiny of vaccination activity. **30/09/2022**
A&A Report ABM-1819-012 Vaccination & Immunisation Limited Assurance			x		
A&A Report ABM-2021-014 Vaccination & Immunisation (F/Up) Reasonable Assurance			x	Previously identified resource issues in respect of maintaining vaccination & immunisation records for those aged 17-19	Enquiries are being made to ascertain whether this historical issue has been addressed through upgrades of the underlying digital systems. This work is related to reform of immunisation data records which is part of the national vaccination integration programme work. Clarity on the impact of the national approach on this issue within SBUHB is expected by end July 2022 and a local action plan (if required) will be set out following that. There remain resource implications which are not currently addressed in the SBUHB IMTP but a proposal for dealing with any residual issues will be available by 30 September 2022. **30/09/2022**
				Due to COVID-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed.	Action plan to outline recovery actions to be developed in tandem with Population Health Strategy.

BAF 2: Best Value Outcomes from High Quality Care			
2.1	Demonstrably Improved Safety, Quality and Reduced Harm	Trend	
		Assurance Rating	

Associated HBRR Entries: **HBRR 4 – Infection Prevention Control & Decontamination (20)** **HBRR 13 – Environment of Premises: H&S Regulations (12)** **HBRR 41 – Singleton Hospital Cladding (16)** **HBRR 51 – Non Compliance with Nurse Staffing Levels Act 2016 (20)** **HBRR 57 – Controlled Drugs: HO Licenses (16)**	**HBRR 64 – Health, Safety & Fire Function Resource (25)** **HBRR 78 – Nosocomial Transmission (20)** **HBRR 80 – Unable to Discharge Clinically Optimised Patients (20)** **HBRR 84 – Cardiac Surgery – Getting It Right First Time Review (16)**
Vision	**Outcomes**
Suicide preventions and early recognition of anxiety and depression – Remove ligature risks across the Health Board – Education in recognition and management of suicide prevention – Baseline Assessment – Multi-Agency Working **Falls prevention, reduce mortality and incidence of falls** – Increased scope of falls review – Established Health Board Strategic Falls Group **SEPSIS Prevention** – Increase in number of at risk patients screened for Sepsis. – Established SEPSIS Team – Improved compliance in SEPSIS risk recognition training – Improved compliance within Sepsis screening audits **Improve the recognition and compliance of End of Life Care** – Review findings of National Audit of care at End of Life – Training in recognition and management of patients approaching End of Life **Increase IPC Compliance** – Increase compliance with staff training – 100% Hand Hygiene IPC training of available staff – Achieve reduction in Tier 1 target infections across all service groups – Review and implement reduction targets monthly **Health & Safety** – Support service groups and undertake audits/surveys to obtain a baseline assessment of key Health & Safety areas – Comprehensive plans in place in all service groups to support delivery in improvements with IPC and reduce instances of infection. Tier 1 targets monitored monthly to chart progress with updates to Q&S and Quality Management Board.	Increase number of patients being recognised, assessed and treated for Sepsis All patients to be recognised and receive EOLC wherever they are being cared for/treated within the HB An overall reduction in the numbers of suicides across the HB A service which takes suicide seriously and embeds the knowledge of recognising and managing suicide and self-harm across the HB Health Board specific target reduction of tier 1 infections against WG set limits. Analysis of data via service group for monthly scrutiny. Q1 shows limited improvements as a trend. Training compliance for IPC and Hand Hygiene supported by additional training sessions and face to face assessments across the HB. Q2 expected to demonstrate improved compliance Reduce injurious falls and mortality levels, associated with injurious falls, across the HB (including within Primary, Community and Secondary Care)

– Support teams to provide a professional health & safety advisory service – Identify funds that will immediately prioritise health & safety resources	

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Clinical Audit & Effectiveness Policy, which sets out the hierarchy of audit reviews
- Clinical Audit & Effectiveness Team in place
- Clinical Outcomes & Effectiveness Group (COEG) established
- Audit Management and Tracking (AMaT) system in place to support Service Delivery Groups and departments with improved monitoring and reporting on clinical audit progress.
- Review of LocSSIP and WHO Surgical Checklist audits form standing agenda items at meetings of the Clinical Outcomes and Effectiveness Group (COEG)
- Approved local SBUHB Mortality Review Framework document and SOP in place.
- Health Board Policy to Determine the Requirements for Home Office CD Licenses in place
- National Infection Control Manual supplemented by local policies, procedures, protocols and guidelines.
- We have IPC action plans in place for all service groups with clear accountability lines for improvement
- BI support for quality improvements and quality outcomes supported with data required down to ward level with early warning of infection risks..
- Infection prevention and control related training programmes
- Documented Cleaning Strategy/Policy in place. Enhanced ward cleaning by domestic staff being considered to free nursing time for direct patient care
- Quality & Safety Committee in place with approved Terms of Reference, supported by a Quality & Safety Governance Group.
- Quality & Safety Process Framework in place, Approved by Q&SC and Executive Board
- Established Quality & Safety forums in place at Service Group level.
- Health & Safety Operational Group and Health & Safety Committee monitor compliance with Health & Safety legislation. Refreshed Fire Safety Group with additional controls in place.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
	1st	**2nd**	**3rd**		
All levels of clinical audit activity will be monitored by COEG and reported to the Quality Safety Governance Group, who in turn report to the Quality & Safety Committee.	x			Identified scope to improve oversite and reporting on the completion of WHO/LocSSIP checklists at both a Service Group and Corporate Level.	
Clinical Audit midyear and annual reports received and scrutinised by the Audit Committee		x		The HB currently has limited assurance regarding compliance with Home Office CD licensing requirements.	HB to discuss and agree a policy position on the requirements for HOCD licenses with the Home Office. Once agreed, this will be followed by a baseline assessment of current CD management, and implementation of a control system to ensure compliance. **01/09/2022**
Quarterly mortality review reports to the Quality & Safety Committee (commenced August 2021)		x			
A&A Report ABM-1819-022 Clinical Audit & Assurance – Limited Assurance			x	Improvement required in governance arrangements in order to allow the CD Accountable Officer to fully discharge their accountability as outlined in the Welsh Government Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008	Medicines Management colleagues to further progress work on the design and implementation of revised controlled drug governance systems and processes, in conjunction with Service Groups. **30/09/2022**
A&A Report ABM-1819-025 Mortality Reviews – Limited Assurance			x		
A&A Report SBU-2021-028 Mortality Reviews – Limited Assurance			x	HB incidence of key Tier 1 infections per 100,000 population above all-Wales rates. Please see graphs below.	Development of a Ward-to-Board Dashboard on key Tier 1 infections. **31/07/2022**
A&A Report SBU-1920-021 WHO Checklist – Limited Assurance			x		

A&A Report SBU-2021-026 WHO Surgical Safety Checklist (F/UP) – Limited Assurance			x	Quality & Safety Process Framework requires review/refresh in light of the impact of COVID, and development of an action plan to support its implementation.	In progress. This will form part of the quality workshops to design the quality management system. **30/09/2022**
A&A Briefing Paper SBU-2122-006 Controlled Drugs Governance – No Assurance Rating Given			x	Operational managers' approach to risk management is inconsistent, with risk registers often incomplete and missing mitigating actions.	Series of risk workshops was completed in NPTS Service Group in late summer. The training will be rolled out to other service groups during the next two quarters, with progress reported to the Risk Management Group and Management Board. **30/09/2022**
Clear corporate and Service Group IPC assurance framework in place, which reflects the HCAI quality priority actions.		x			
Infection Control Committee monitors infection rates, receives assurance reports from Service Groups and sub-groups to the Infection Control Committee, and identifies key actions to drive improvements.		x			A programme of service group risk register presentations for 2022 has been agreed. Service groups will report on processes in place to manage and scrutinise their registers, and present their registers with a focus on their top risks. This will commence from March 2022 and the programme will complete by the end of the calendar year. **31/12/2022**
A&A Report SBU-2021-025 Infection Control (Cleaning) – Reasonable Assurance			x		
A&A Report SBU-2122-002 Quality & Safety Framework – Limited Assurance			x	Staff are not always aware of the HB's values and behaviours, and do not always recognise a culture that promotes learning from errors.	Health Board culture programme underway which will include a culture audit. These issues will be addressed as part of this work. **31/12/2022**
Audit Wales 2714A2021-22 Review of Quality Governance Arrangements (SBUHB)			x		
Monitoring through the appropriate group/committees (H&S Committee) to receive assurance and/or identify gaps for key compliance and adherence to applicable legislation.		x		Compliance with Personal Appraisal and Development (PADR) reviews is low. A performance improvement plan should be put in place which sets out when full compliance can be achieved.	Progress will be monitored via local service group meetings and Management Board, and reported to the Workforce & OD Committee. **30/09/2022**
A&A Report SSU-SBUHB-2122-001 Singleton Cladding 2021/22 – Reasonable Assurance			x	Insufficient resource/capacity of the health, safety and fire function within SBUHB to maintain legislative and regulatory Health & Safety compliance.	Health & Safety Department structure reviewed – to be presented to the Health & Safety when funding has been agreed. **30/09/2022**
				Cladding applied to Singleton Hospital front flank is not compliant with fire regulations.	Replace the existing cladding and insulation applied to Singleton Hospital with alternative specifications **31/03/2024**

2.2	The Transformation of Primary & Community Care	Associated HBRR Entries: None	Trend	
			Assurance Rating	

Vision	Outcomes
Programme and Visions for Clusters – Strengthen the Multi-Disciplinary Team approach to Clusters – Implement the National Accelerated Cluster Development (ACD) Programme **Communication and Engagement** – Prioritise the Primary Care Communication Plan to support programmes of change – Continue to plan, development and implement service change through excellent partnership arrangements. **Workforce and Organisational Development** – Increase workforce from range of professionals recognising importance of OD framework to support people to work outside hospital environments and utilise skills to top of license. – Implement new contract reform across all contractor services. **Data and Digital Technology** – Progress the Welsh Community Care Information System platform to improve integrated working and patient care coordination – Maximise benefits of digital platforms to allow patient to access services in primary care and community, including therapy services.	Increased number of patients being treated in Urgent Primary Care settings and through Virtual Wards = Reduced Emergency Department Attendance/Emergency admissions Increased number of patients managed in the community through virtual wards leading to 10% reduction in bed days (reduction in LOS) for high risk adult cohort Palliative care improvements and community services expansion. 7 days services improved access to primary care Improved digital access to primary and community services Reduced number of patients referred from primary care to secondary care for specific planned care pathways e.g. MSK and chronic conditions (diabetes, atrial fibrillation, heart failure)

Key Controls:

– Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x			
A&A Report SBU-2122-023 General Dental Services (GDS) – Substantial Assurance			x		
A&A Report SBU-2021-013 Primary Care Cluster Plans & Delivery – Reasonable Assurance			x		

2.3	The Transformation of Mental Health & Learning Disabilities Care	Associated HBRR Entries: HBRR 43 – Deprivation of Liberties/Liberty Protection Safeguards (12)	Trend	
			Assurance Rating	

Visions	Outcomes
People's mental health and wellbeing is supported – Wellness centres – Social prescribers – Appropriate housing – Vocational opportunities – Community Resilience **Inpatient care is evidence based and provided in fit for purpose environments** – Redesigned older person's inpatient services – Perinatal inpatient unit – Improved adult mental health inpatient provision **People receive mental health treatment and support in the community wherever possible** – Specialist Midwives – Extended Sanctuary Service – MH link workers in clusters – Assessment hub and single point of contact – 111 Service **People with learning disabilities receive the best care and support to live fulfilled lives** – Expanded Community LD Provision and change in inpatient provision – Annual Health Checks – Specialist LD Inpatient Services	Improved % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral Improved % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS Reduced number of patients reliant on specialist MH beds Compliance with measure 95% of those admitted between 0900 2100 will received a gate keeping assessment by the CRHTS prior to admission Compliance with measure 100% of those admitted without a gate keeping assessment will receive a follow up assessment by CRHTS within 24hrs of admission Reduced % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health Reduced number of patients reliant on specialist older peoples MH beds

Key Controls:

- Established Mental Health Legislation Committee in place
- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Insufficient Best Interests Assessor (BIA) resource available. Limited rota uptake due to inability to release staff.	Business case for the revised service model to deliver Liberty Protection Safeguards is being developed. **30/09/2022**
A&A Report SBU2122-023 Mental Health Legislative Compliance – Reasonable Assurance			x	Scope identified to enhance reporting to the Mental Health Legislation Committee in respect of assurance on legislative compliance. Inconsistencies in reporting noted in respect of Mental Capacity Act and Deprivation of Liberty Safeguards training	An exercise to be undertaken to 'map' legislation and codes of practice to Mental Health Legislation Committee reports **Ongoing** A revised programme of training will be put in place. **Ongoing**

2.4	Networked Hospitals - A Systems Approach Urgent & Emergency Care	Associated HBRR Entries: HBRR 1 – Access to Unscheduled Care Services (25) HBRR 82 – Risk of Closure of Burns Service: Anaesthetic Consultant Cover (16)	Trend	
			Assurance Rating	

Vision	Outcomes
People are supported to remain healthy – Healthy lifestyle advice and support linked to high deprivation clusters – Patient Activation and Co-Production – Consultant Connect **Following an urgent care episode people receive the right care and support to return home swiftly** – Planned Investigation Unit – Hyper Acute Stroke Unit – Centralised Inpatient rehabilitation at Neath Port Talbot Hospital – Home first pathways – Palliative Care – Virtual Wards **When people need urgent care they are treated by the right person at the right time in the right place** – Centralised medical assessment and admissions at Morriston – Critical Care Capacity – Effective Ambulance Service – 7-Day Care – Improved Ambulatory Care – 111 Service – Urgent Primary Care Centre – Hot Clinics **People are supported to effectively manage their conditions at home and in the community** – Integrated care for older people – Virtual Wards for care of the elderly – Older Person's Assessment Service – Prioritised Chronic Conditions Pathway Improvements	Reduced number of Emergency Department Attendances and Emergency Admissions Reduced % patients spending more than 4 hours in ED (target = 95% seen under 4 hrs) Reduced number spending more than 12 hours in ED (target = 0 waiting more than 12hrs) Diversion of a minimum of an additional 6 patients a day from the Emergency Department into the acute hub Reduction in total estimated bed days, equating to increased admission avoidance Reduced Average Length of Stay for all emergency admissions Discharge rate of 85% via OPAS Virtual wards phase 1 (x4 clusters) = 8,000 bed days saved per year Virtual wards phase 2 (roll out to additional x4 clusters) circa 3,500 bed days saved 22/23 (implementation from month 6 onwards) / 8.000 bed days saved FYE Home First pathway 2 183 203 discharges per month (subject to RPB revision and SBUHB approval) Home First pathway 4 Reduce average length of stay for residents returning to, or moving to a care home (from 13 weeks to 3 weeks) for up to 56 individuals a month (subject to RPB revision and SBUHB approval) Heart failure Reduction in LoS from a 13 days median LOS to 7 days median; Reduce hospital re admissions by 38%

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, to offer leadership and support in addressing risks and issues within systems, and to create an enabling framework to allow care to be delivered appropriately.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Unscheduled Care reports received from the COO
- An integrated Unscheduled Care Plan has been developed with partners, based around the WG Six Goals for Urgent & Emergency Care, and approved by the West Glamorgan Regional Partnership Board.
- An Urgent and Emergency Care Network Board has been established to oversee the Health Board's Unscheduled Care Plan.
- Programme Management Office (PMO) in place to improve Unscheduled Care
- Health Board Representation on the National Unscheduled Care Board.
- Development of a 'Phone First for ED' model in conjunction with 111 to reduce demand
- Implementation of Consultant Connect for major referring specialties
- H2H implemented, developed into Rapid Discharge to Assess pathway in line with WG directive.
- SAFER – Patient Flow and Discharge Policy in place
- 24/7 Ambulance triage nurse in place.
- Patient level dashboard in place, which allows breakdown of clinically optimised patient numbers by delay type
- Direct Pathway to Older Person's Assessment Service (OPAS) implemented and operational hours extended.
- Establishment of virtual wards aligned to GP clusters.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control and/or Assurance**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Need for clear definitions for MFFD patients and SOP for MFFD meetings	Establish a group to work with the Local Authority on reducing numbers of Medically Fit For Discharge (MFFD) Patients with clear Terms of Reference for the Service Group Meetings **Ongoing**
Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board,		x			The Health Board's 'SAFER Patient Flow and Discharge Policy' is to be reviewed and updated. This will be followed by a comprehensive training and communication programme for staff. **Ongoing**
Monitoring of the implementation of the integrated Unscheduled Care Plan via the Unscheduled Care Board and Community Silver Command (Regional Partnership Board), and Quality & Safety Committee		x		Failure to adhere to, as well as inconsistent application of, elements of the SAFER Patient Flow and Discharge Policy. Scope to enhance the content of the policy, as well as systems and processes in respect of the setting of EDD and arrangements for patient discharge, were also highlighted as part of the NWSSP A&A review.	Development of new audit tools and SOP to accompany the revised SAFER Policy **Ongoing**
Rapid Discharge to Assess pathway performance monitored via H2H implementation group and reported to Community Silver.	x				SIGNAL User Group to consider further enhancements in phase 3 around clinical recording, including reasons for changes to EDD, a standardised approach to Board Rounds, and risks around limitations of storage capacity. **Ongoing**
A&A Report (SBU-1920-025) Discharge Planning Limited Assurance			x		Following engagement with Carers via Stakeholder Reference Group, a leaflet will be produced outlining patient and family communication and involvement in EDD planning. **Ongoing**
WAO Report 255A2017-18 Discharge Planning No Assurance Rating Given			x		Re-establish Short Stay unit on Ward D at Morriston Hospital. **31/07/2022** Review roles and service models in order to increase Same Day Emergency Care working hours and throughput sustainably. **30/09/2022**

2.5	Networked Hospitals – A Systems Approach Planned Care	Associated HBRR Entries: HBRR 16 – Access and Planned Care (20) HBRR 58 – Ophthalmology Follow-Up Clinic Capacity (20)	Trend	
			Assurance Rating	

Vision	Outcomes
Patients have access to appropriate care at the right time at the right place – Improved access to critical care – Regional solutions and services – World class Cellular Pathology – Centralised Elective surgery at Singleton – Orthopaedic Centre at Neath Port Talbot – New PACU developments at Morriston, Singleton and Neath Port Talbot Hospitals **People have access to high quality advice and guidance to enable informed decision making** – Consultant Connect – Improved access to eye care outpatient services – Structured advice and guidance **People receive effective referrals to the right place and receive swift diagnoses** – Extended 7-Day Working – Increased availability of cross-sectioned imaging and other diagnostics – Growth of Point of Care Testing – Mobile CT and MRI Scanner – Minor Basal Cell Carcinoma – Deliver MSK Pathways in Primary Care Clusters **We measure what's important, transforming care to better meet the clinical need of the patient** – Diabetes – COPD – Heart Failure and Atrial Fibrillation **Follow up care is prudent and individuals have more choice and control over their care** – Clearance of waiting list backlogs – Utilisation of virtual platforms – Validation and management of waiting lists – Supporting patient to remain active whilst waiting.	**Follow up WL** • Reduce 100% delayed follow ups by 55% • Remove 30% of FUWL through validation exercises • No patient to be on a FUWL who hasn't been reviewed/seen in last 2 years **Stage 1 WL** • No patient classed as urgent to wait over 52 weeks • No patient waiting over 104 weeks for a first appointment • All patients waiting over 52 weeks to be validated **Virtual activity** • 35% of all new appointments to be undertaken virtually in 2022/23 • 50% of all follow up appointments to be virtual in 2022/23 **Appointment outcomes** • 20% appt. outcomes to result in SOS or PIFU pathway • Reduction in DNAs • Reduce Hospital Initiated Cancellations by 50% by April 2023 **Diagnostics** • Eliminate >8 week waits for urgent endoscopy by March 2023 • Reduce waits in cardiac, neurophysiology, nuclear medicine and pathology • Eliminate >8 week waits in MRI • Reduce CT and NOUS waits to <6 weeks **Orthopaedics** • Ortho elective surgery insourcing 480 day cases and 240 inpatient cases by end of Mar 23 • Ortho elective surgery outsourcing 36 inpatient cases by end of Mar 23 • Opening centre of excellence at Neath Port Talbot Hospital **Diabetes** • Increased % patients (age 12 years+) with diabetes receive all 8 NICE recommended care processes • Increased % patients (age 12 years+) with diabetes achieve all 3 treatment targets (BP readings/ cholesterol values/ HbA1c) in preceding 15 months

Key Controls:

- Programme/Project structure in place to drive delivery of Annual Plan/Recovery & Sustainability Plan priorities
- Regular and frequent Executive-led meetings with Service Groups to monitor and discuss performance, to offer leadership and support in addressing risks and issues within systems, and to create an enabling framework to allow care to be delivered appropriately.
- Performance & Finance Committee in place, with an agreed work programme which includes the receipt and scrutiny of Planned Care reports received from the
- The Planned Care Recovery Programme Board has been established
- Plans based on specialty level capacity and demand models which set out baseline capacity and solutions to bridge the gap.
- Appropriate utilisation of the Independent Sector
- Focussed intervention to support the 10 specialties with the longest waits. Fortnightly performance reviews to track progress against delivery
- Quality Impact Assessment process set-up to manage the re-start of essential services
- Outpatients Clinical Redesign and Recovery Group established in June 2020.
- Use of Doctor Dr and Consultant Connect to prevent unnecessary referral and attendance
- Increased use of virtual appointments
- DNA monitoring and management
- Opthalmology Gold Command established and meeting on a monthly basis, chaired by Deputy COO, reporting to Q&S Committee
- Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on the follow-up list.
- Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow-up backlog.
- Outsourcing of cataract activity to reduce overall service pressure.
- Redesign of approaches to improve waiting list management. Rollout of See-On-Symptom and Patient Initiated Follow-Up principles and processes where clinically appropriate have been implemented.
- Following Royal College of Surgeons guidance for all surgical procedures; patients on waiting lists have been categorised and clinically prioritised accordingly.
- A live dashboard for all surgical demand has been developed, supplemented by a scheduling tool to ensure that available capacity can be used to maximum benefit.
- Developed monitoring tools using data from TOMS to improve monitoring and efficiency of theatre capacity utilisation and benchmark performance
- Implementation of WPAS update in order to enable reporting of planned care wait times using new deferred target dates based on clinical assessment.
- New care pathway implemented with Parkway Clinic for the provision of Paediatric DA dental Services, including revised SLA/Service Specification - no direct referrals to provider for GA

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Three serious incident reports were reported in Ophthalmology during 2021.	Overall Regional Ophthalmic Sustainability Plan to be delivered **31/03/2022**
Regular reporting on dashboards and detailed performance data to fora including Performance & Finance, Quality & Safety and Audit Committees, as well as the Board		x			Additional ophthalmology day case theatre will be operational at Singleton during 2022. **31/07/2022**
A&A Report SBU-2021-015: Adjusting Services: QIA Reasonable Assurance			x	Adequate Burns Anaesthetics cover may not be sustained, potentially resulting in closure to this regional service	Capital funding bid to Welsh Government for work required to co-locate the burns service with General ITU **31/05/2022**
Regular reports from Ophthalmic Gold Command received by Q&S Committee		x		There is no immediate access to crash team/ICU facilities in Parkway Clinic – the client group are undergoing G/A/sedation. Medical Safety risk GAs performed on children outside of an acute hospital setting.	Relocation of the paediatric GA service provided by Parkway Clinic to a hospital site. **31/05/2023**
Paediatric Dental GA referral and treatment outcome data collated and reviewed by Paediatric Specialist.		x			
Assurance documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients	x			There is currently a gap in assurance around our ability to deliver >52 and >104 day waits, and elimination of endoscopy waits.	
Parkway Clinic HIW Inspection Visit Documentation provided to HB			x		

2.6	Networked Hospital – A Systems Approach Cancer Care	Associated HBRR Entries: HBRR 50 – Access to Cancer Services (25) HBRR 66 – Access to Cancer Treatment SACT (20) HBRR 67 – Access to Radiotherapy Treatment (15)	Trend	
			Assurance Rating	

Vision	Outcomes
Prevention of Cancer is effectively supported where possible – Lung Health Checks – Increased uptake of breast, cervical and bowel screening – Mobile Screening Units **People are properly supported and able to coproduce their care** – Cancer Information Solution – Single Cancer Pathway Dashboard – Wales Cancer Patient Experience Survey – Person Centred Care Group **Excellent evidence based treatment** – Regional Oncology outpatients model – Modern equipment and environment at the SWWCC – Regional Radiotherapy Schemes in place – Expanded Acute Oncology Services – Expanded homecare treatment (SACT) and in–hospital capacity – National Peer Review Programme **Cases of cancer are detected earlier and outcomes are maximised** – Increased straight to test pathways – Expanded direct access for GPs to diagnostics – Expanded Rapid Diagnostics Centre – Prehabilitation and rehabilitation approaches embedded – National Optimal Pathways implemented	**Prevention** • Earlier detection of cancers • Greater proportion of patients going into to treatment pathways versus palliation • Increased survival following cancer diagnosis and treatment **Single Cancer Pathway (SCP)** • % of patients starting definitive treatment within 62 days from point of suspicion (regardless of the referral route) improved trajectory towards a national target of 75% • Reduced number of patients waiting over 63 days **Reduced radiotherapy wait times** • Scheduled --% within 21 days (80% target)/ % within 28 days (100% target) • Urgent SC --% within 7 days (80% target)/ % within 14 days (100% target) • Emergency --% within 1 day (80% target)/ % within 2 days (100% target) • Elective delay --% within 21 days (80% target)/ % within 28 days (100% target) **Reduced SACT wait times improved trajectory towards 100% compliance** • Priority 1 (Emergency within 48 hours) Urgent/Priority 2 within 14 days (for Curative, Palliative/Disease Control, Haematology remission and Neoadjuvant intent) • Routine/Priority 3 within 21 days (for adjuvant intent) **AOS (5-day service)** • Support pre hospital triage service for cancer patients, reducing admissions and positive impact of LoS • Provide expert advice for ambulatory areas and ensure timely access to oncology FU to facilitate this, increase oncology consultant reviews for those in non-oncology beds • More able to adapt to the need, more medical support • Improved recruitment and retention • Consistent presence on the 2 acute hospital sites • Flexibility to adapt according to greatest need on daily/weekly/monthly basis • Improved retention and productivity of non-medical posts **SACT (Home Care Expansion phase 1) Review, Sustain and Expand Treatment Capacity for Cancer Services** • Maximise supply through external medicines homecare services for current patients, where appropriate. • Fully utilise current CDU capacity before investing in alternatives. • Increase capacity for Pharmacist led clinics to monitor, review and prescribe on repeat basis. • Release consultant workforce to see new/ complex patients and thus reduce waiting times. • Improve patient experience and patient outcomes. **SABR (Lung) Regional RT: Deliver and embed sustainable SABR Lung Service commissioned from WHSSC** • SABR service provided from Singleton SWWCC (rather than VCC) • Improved patient experience due to reduced travel (particularly for Hywel Dda UHB patients) • Improved patient outcomes in contrast to conventional lung RT

Key Controls:

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

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance -**	**Agreed Action**
	1st	**2nd**	**3rd**		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		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)	Phased and sustainable solution to the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services **30/09/2022**
Cancer performance update reports are received and considered by the Performance & Finance Committee.		x		Performance and activity data monitored, but delays in treatment continue while sustainable solutions found. The current trajectories do not effectively link with D&C, and practical actions being undertaken at tumour site level.	Capacity increased within CT/MRI via recruitment and extended working hours. Further increase to 6 day working planned for 22/23, subject to funding. **31/03/2023 (Subject to Funding)**
Operational Plan performance tracker reports.		x			Business case for delivery of Acute Oncology Services (AOS) from Morriston Hospital approved by Business Case Advisory Group. Currently out to advert to recruit workforce. Implementation planned for end of Q2. **30/09/2022**
Backlog trajectory to be monitored in weekly enhanced monitoring meetings.	x			Capital and revenue assumptions and resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.	10-Year regional transformation and development plan for SWWCC in conjunction with Hywel Dda. Business case to presented by and of Q2 (ARCH) **30/09/2022**
Radiotherapy performance and activity data monitored and shared with radiotherapy management team and cancer board.		x		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.	Business Case for phase 2 home care expansion based on moving further treatments to community service. **30/05/2022** Relocation of CDU to vacant ward area which would increase chair capacity (linked to AMSR Programme and Phase 2 of Homecare expansion). **31/01/2023** Business plan for additional resources to implement hypo fractionated Prostate technique (Awaiting decision from Hywel Dda to support the case). **31/03/2022** Case agreed with Welsh Government for third Linear Accelerator **31/07/2022**

2.7	**The Transformation of Children, Young People & Maternity Services**	**Associated HBRR Entries:** **HBRR 63 – Screening for Fetal Growth Assessment in line with Gap-Grow (16)** **HBRR 65 – Misrepresentation of Abnormal Cardiotocography Readings: CTG (20)** **HBRR 69 – Adolescent Patients Admitted to Adult Mental Health Inpatient Wards (20)** **HBRR 74 – Delays in Induction/Augmentation of Labour (20)** **HBRR 81 - Critical Midwifery Staffing Levels (20)** **HBRR 85 – Non-Compliance with ALNET Act (20)**	**Trend**	
			Assurance Rating	

Vision	**Outcomes**
Child & adolescent mental health and wellbeing is supported, and treatment is accessible – Implement Additional Learning Needs Act – Psychological therapies in palliative care – CAMHS 24/7 crisis service – Implement the CAMHS emotional and wellbeing plan **When needed, children receive the right treatments and interventions in fit for purpose accommodation** – Established full CYP MDT to support children in acute care – Effective transition pathways between children and young people's and adult pathways – New fit for purpose General and surgical paediatric services – Increased routine and minor surgical procedures in a child friendly environment – Sustainable continuing care nursing services – Safe and sustainable community neurodevelopmental services **Babies are born healthy into families who can help them develop successfully and healthily** – Reduced smoking in pregnancy – Safe birthing environments – Increased breastfeeding rates – Effective maternal mental health support and services – Safe and sustainable neonatal care	Improved % Urgent Assessment by CAMHS undertaken within 48hrs Increased % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral Increased % of NDD assessment and intervention received within 26 weeks Reduced waiting list backlog (children waiting >26 weeks) in Community Paediatrics Improved waiting times (all RTT stages) in General Paediatrics Improved access to specialist paediatric services in South West Wales Reduced maternal smoking rates in line with All Wales targets Increased breastfeeding rates in line with All Wales targets

Key Controls:

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

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Annual Plan/Recovery & Sustainability Plan performance reporting to the Management Board, Performance & Finance Committee and the Health Board		x		Central monitoring system to store CTG recordings of fetal heart rate in electronic format not yet in place	Central monitoring system purchased. Awaiting installation and staff training. Expected gull use by October 2022. **31/10/2022**
A&A Report SBU-2122-018 CAMHS Commissioning Arrangements – Limited Assurance			x	Lack of SLA/Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS	Service Specification between SBUHB and CTMUHB regarding the commissioning of CAMHS to be developed. **30/06/2022**
CAMHS performance against local and WG targets included in Integrated Performance Reports		x			
Monthly monitoring of progress against waiting list improvement plan via the CAMHS Commissioning Group, with quarterly updates to the Management Board, and to Performance & Finance Committee when required.	x			The HB has not identified quality measures in respect of CAMHS being provided to the patients or the outcomes for those patients.	Through work to develop the Service Specification, the Health Board will identify further quality measures and outcomes for CAMHS patients. **31/07/2022**
				The Mental Health Legislative Committee felt the CAMHS governance report provided by CTMUHB did not provide sufficient assurance.	Issues around the content of reports provided to the Mental Health Legislative Committee will be followed up and addressed as the reporting arrangements restart following the pandemic. **30/06/2022**
				Delays in induction of labour are a frequent occurrence	
				Midwifery absence rates leading to difficulties in maintaining midwifery rotas in both hospital and community settings.	
				There is insufficient Ultrasound capacity to allow the Health Board to offer third trimester ultrasound scan screening in line with the UK Perinatal Institute Growth Assessment Programme.	

BAF3:	Excellent Staff	Associated HBRR Entries: HBRR 3 – Recruitment of Medical & Dental Staff (20) HBRR 76 – Partnership Working with Trade Unions (10) HBRR 77 – Impact of COVID on Staff Wellbeing (12)	Trend	
			Assurance Rating	

Vision	Outcome
Service leaders and clinicians can achieve efficiencies through use of effective workforce information and data – Reduction in agency spend – ESR Service Improvement Plan – Revised Management Controls to standardise Bank/Agency Usage – Roster Management KPIs Established – ALLOCATE Optimising Package for Medical Workforce – Responsibility for ESR transferred to Workforce	Improvements in workforce productivity through the use for accurate and timely workforce information and analytics
There is a recruitment and retention strategy which widens access and enables a sustainable workforce – Widening access and development of career pathways – Talent development – Extend opportunities for clinical and non-clinical apprenticeship – Develop Recruitment and Retention Strategy – Develop pastoral approach to recruitment	Reduction trend in bank and agency spend as a % of total pay bill. A workforce that is diverse and representative of the community we service Career progression and 'grow your own' talent pipeline % reduction in turnover % reduction in vacancy rate
Delivery of the recovery and sustainability plan is supported by effective resource design – Delivery of recruitment plans aligned to Changing for the Future – OD support to service areas – Redesign of nurse rosters and team job plans	Improved overall staff engagement score - % increase in engagement with people completing the survey and reflected in the engagement score
Staff have an improved staff experience and rate the Health Board as excellent – Improved overall staff engagement score – Exit interviews – Organisational Culture Programme – Culture Audit – Staff recognition and reward – Promotion of the 2022 NHS Wales Staff Survey	Improved % of staff who report their line manager takes a positive interest in their health and wellbeing Compliance to 85% for the completed Level 1 competencies of the Core Skills and Training Framework by organisation Reduction trend in % of sickness absence rate of staff Compliance to 85% of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training).
Staff are supported to be resilient, well and in work – Rapid Access to staff health and wellbeing services – Improved % of staff report their line manager takes a positive interest in their health and wellbeing – Staff Health and Wellbeing services retained – Delivered Health and Wellbeing Strategy – Long-COVID support	

Key Controls:

- Established Workforce & Organisational Development Committee in place
- Multi-disciplinary Occupational Health Service in place providing timely advice for managers and staff regarding management of health in the workplace
- Multi-disciplinary Staff Wellbeing Service in place providing staff with support for mild-moderate musculoskeletal and mental health problems, which also continues to support the needs of COVID-related health impacts
- The Health board has invested in the TRiM programme (Trauma Risk Management)
- Wellbeing Champions in place, supporting teams and services
- Post-COVID Staff Wellbeing Strategy has been developed to outline additional support available for staff
- Local bank/Agency booking processes have been reviewed, and revised management controls introduced (Feb 2022)
- Regular periodic review of block booked bank staff taking place (Feb 2022)
- KPI's for nurse roster management have been reviewed, and form part of the regular nurse staffing meetings (Feb 2022) – this includes EWTD controls
- Staff Experience and Organisational Development plan in place
- All areas have been allocated L&OD support for development of local staff action plans to improve the staff experience
- Clearly articulated organisational values
- Chief Executive and other Executive Directors attend HB Partnership Forum on a regular basis.
- Speciality based local workforce boards established
- Established partnership working and engagement initiatives with key stakeholders.
- Workforce Planning function in place which facilitates the design, redesign and development of workforce plans for all staff groups
- HB Home working and flexible working policies have been revised and reissued

Forms of Assurance	Levels of Assurance			Gaps in Control and/or Assurance	Agreed Action
	1st	2nd	3rd		
Reporting to and oversight by the Workforce and Organisational Development Committee		x		The OH Team do not typically receive feedback from stakeholders on the effectiveness of the service in order to identify areas for improvement or development.	The requirement to implement a robust evaluation mechanism for OH Services is included as part of service development. **30/06/2022**
Both Staff Health & Wellbeing Service and Occupational Health Service have won national awards October 2020, and again in January 2022 from Case-UK Limited Employers positive contribution to their workforce well-being Award.			x		
Monthly management data for Occupational Health and Staff wellbeing services regularly reviewed by Senior Occupational Health Management Team regarding capacity/demand and waiting times. This information is used to manage capacity and demand and reported to Workforce & OD Committee three times a year.		x		Lack of Evidence of collaborative working between OH, Staff member/TU rep and line manager to agree strategies to support return to work	OH to work with HR Ops team and Line managers to introduce case conferences **30/6/2022**
				Lack of timely sickness absence data	Project to review workforce informatics **31/12/22**
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)		x		Need for bank and agency staff continues.	Local bank/Agency booking processes have been reviewed, and revised management controls introduced. The position will be reviewed with the COO and DoN to address the post-COVID position. **01/09/2022**
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.		x			
A&A Report SBU-2122-024. Staff Wellbeing & Occ Health Reasonable Assurance			x	Lack of Health Board-wide policy or procedure which supports EWTD	EWTD guidance has been drafted, and and has been circulated for comment. Anticipated to be

Weekly reporting of Bank and Agency usage to service groups as well as monthly Corporate Nurse staffing meetings	x				presented to staff side by 30/6/22 **30/06/2022**
Each service group also have local reporting mechanisms for bank and agency spend	x			PADR completion performance is below the Welsh Government target of 85%. Gaps in assurance around recording of PADR due to delay in implementation of roll out of supervisor self-service.	The transfer of the ESR team to the WOD Directorate is now complete and the Service Improvement plan is in progress. The detail of the SSS roll out is currently being considered and worked through. Target date for the roll out to be confirmed at a later date.
Monthly Roster scrutiny meetings held across all service groups and Corporate Nurse staffing meetings KPI reports are sent to service groups weekly	x				
A&A Report SBU-1718-046. EWTD. Limited Assurance			x	Need to enhance clarity and detail of reports to the W&OD committee in respect of Disclosure and Barring Service (DBS) checks undertaken	Report to be produced for Workforce & OD Committee in respect of completion of DBS Clearance of staff currently employed but not previously checked, to include clear reporting of progress against milestones. **30/06/2022**
A&A Report SBU-1819-043. Staff Performance Mgmt. & Appraisal. Limited Assurance			x		
Service Groups are invited to Workforce & Organisational Development Committee to present local actions plans to improve the staff experience.		x			
Results from NHS Wales and LHB Staff Surveys			x	Lack of Workforce and OD Delivery Group to oversee operational delivery of workforce priorities	Workforce and OD Delivery Group set up with first meeting in July 2022 **31/07/2022**
Guardian Service Annual report received and reviewed by the Workforce & OD Committee and Audit Committee		x			
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.		x		Recruitment and retention plan(s) to be produced in support of the Workforce and Organisational Development Framework.	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.**
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.		x			In conjunction with professional heads, develop and implement a retention strategy to address retention issues. **31/03/2022**
Permanently funded central resourcing team from 2022/23 financial year	x				
Overseas nursing campaign for 200 Nurses funded for 2022/23	x			Progress the adoption of draft guidance documents in respect of junior doctors' hours and handover procedures.	Draft guidance documents in respect of junior doctors will be reviewed. This has slipped due to workforce pressures and priorities. Aim is that matters will progress during Q1/2 2022/23, pending exploration of new junior doctor contract. **31/06/2022**
Streamlined recruitment for medical staff including retrospective VCP and anticipatory recruitment for medical posts linked to major rotations.	x				
Working with head hunter agencies to recruit hard to fill medical posts	x				Contract with external company to develop branding and attraction campaign for HB. **31/10/2022**
Vacancy levels and turnover rates form part of the Integrated Performance Report received by the W&OD Committee. The report also sets out trends and planned action.		x		Delay of national staff survey which is commissioned by Welsh Government with no fixed role out date.	
A&A Report SBU-1920-039. WOD Framework. Substantial Assurance			x		
A&A Report SBU-1920-042. DBS Checks. Reasonable Assurance			x		
A&A Report SBU-1819-042. Junior Doctor Bandings (Follow-Up) Reasonable Assurance			x		

BAF 4	Digitally Enabled Health, Care and Wellbeing	Associated HBRR Entries: HBRR 27 – Digital Transformation (16) HBRR 36 – Paper Record Storage (16) HBRR 37 – Data Informed Decisions (12) HBRR 60 – Cyber Security (20)	Trend	
			Assurance Rating	

Vision	Outcomes
Patients empowered to manage their health and wellbeing – Structured advice and guidance – Ophthalmology digital record – Welsh Community Care Information System **Regional approach to efficient and effective Health and Social Care Services** – Single sign-on – Technology refresh – Remote monitoring – Modern devise management **Quick and highly resilient digital services based on the right digital tools and infrastructure** – Digital Champions – Digital engagement – User centred design and development **Data driven decision making and automation** – Real-time data and expertise – National Data Repository – Business Intelligence Business Partners – Business Intelligence Strategy **People have the right skills to support them to be highly effective in their roles** – Signal – E-Prescribing – Welsh Clinical Portal – Digitisation of Paper Records **Professionals can access a shared digital health record to support care** – Virtual consultations – Remote monitoring – Swansea Bay Clinical Portal	Self-management and a reduction in unnecessary contacts whilst maintaining high levels of Health and Wellbeing Increase in patient satisfaction and timeliness of access to services and support Improved utilisation of digital resources (NHS and non NHS) Increased use of data and modelling in design of patient services Increase in proactive rather than reactive decision making Reduction in use of paper and increase in electronic data capture Clinicians have access to information and decision aids at the right time at point of care Clinicians are supported in diagnosis assessments through automated processes releasing time to care Improved quality and safety of care provision Increased efficiency, releasing more time to care Improved efficiency and effectiveness of business processes Greater collaboration across teams Improved recruitment and retention of digital workforce Improved user satisfaction levels Increased adoption of digital technologies High availability and speed of Digital Services Increase in collaborative working and shared pathways to support citizens and increased collaboration and sharing with 3rd sector

Key Controls:

- Digital Strategy and Strategic Outline Plan
- Digital Leadership Group (DLG) in place, supported by a Digital Service Management Group and Digital Transformation Programme/Project Boards. The DLG provides governance and assurance for the delivery of the HB's Digital Strategic Plan, and has oversight of the Digital Transformation Programmes and their delivery plans.
- Information Governance Group (IGG) and Digital Service Management Group (DSMG) in place.
- Digital Risk Management Group and Risk Register in place.
- HB Capital Prioritisation Group considers digital risks for replacement technology, which is fed into the annual discretionary capital plan.
- HB Business Case Assurance Group process provides scrutiny to ensure digital resources are considered for all projects.
- Digital Services prioritisation process introduced to ensure that requests for digital solutions are considered in terms of alignment to the strategic objective, technical solutions and financial implications.
- Project Boards established for all significant projects.
- Clinical Reference Group established, providing a forum for engagement with and feedback from clinicians in respect of digital solutions and enhancements, and the strategic direction of digital services. Meetings recommenced in June 2021.
- Digital meetings with Service Delivery Groups to identify and prioritise requirements, monitor progress with implementation, and address issues with business-as-usual activities.
- Receipt, approval and recording of changes/updates made to all existing digital solutions via the Digital Services Change Advisory Board.
- Internal Digital Business meetings monitor performance of business-as-usual activities and achievement of internal objectives Joint Executive Team for Boundary Change provides oversight of the disaggregation process in respect of Digital Services (CTMUHB boundary change process).
- Business Intelligence Modelling Cell established to prioritise the delivery of BI requirements. Approved Business Intelligence Strategy in Place.
- The Health Board has representation on national groups such as Advanced Analytics Group (AAG), all Wales Business Intelligence & Data Warehousing Group and Welsh Modelling Collaborative.
- Records managed by medical records libraries are Radio Frequency Identification (RFID) tagged and location tracked.
- Medical records libraries are regularly risk assessed for fire by Health & Safety.
- Alternative offsite storage arrangements for paper records have been identified
- Requirement for all records to be documented on the Information Asset Register
- Creation of a Health Board Cyber Security Team. Firewalls in place at a local and national level, with national security tools in place to highlight vulnerabilities and provide warnings when potential attacks are occurring.
- Patching regime in place which ensures desktops, laptops and servers are protected against known security vulnerabilities.
- Digital Services Management Group ensures systems are compliant with security standards.
- Cyber Security training and phishing simulation in place to increase staff awareness.

Forms of Assurance	**Levels of Assurance**			**Gaps in Control/Assurance – Identified Areas for Improvement**	**Agreed Action**
	1st	**2nd**	**3rd**		
The DLG is accountable to the Executive Board and reports to the Senior Leadership Team		x		Issues identified in respect of the operation and functionality of the Theatre Operational Management System (TOMS)	Redevelopment of the TOMS system to be undertaken. **30/11/2022**
The SLT receive update reports on progress against digital transformation programmes	x			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.	Digital workforce plan currently being developed as part of the IMPT/annual planning process. SBUHB has also contributed to a national workforce review and are awaiting outcomes. **31/03/2022**
Update reports also provided to the Board and Audit Committee.		x			
Operational Plan performance tracker reports.		x			
Annual Cyber Security progress reports to Senior Leadership Team, Audit Committee and Board		x		Despite the rollout of digital solutions (e.g. Radio Frequency Identification (RFID)), significant volumes of paper records remain, exacerbated by the enforced halt of record destruction as part of the infected blood enquiry.	Continued rollout of digital solutions to reduce the volume of paper being used/added. Multi-faceted to include: • HEPMA (Singleton initially) • WNCR (NPTH initially) • SIGNAL V3
Monitoring of complaints and incident reporting in respect of paper records		x			

				Cyber security training in not currently mandatory within the Health Board.	**31/03/2026** Work is ongoing at a national level to put a joint mandatory Cyber and IG training solution in place across Wales. **TBC (all-Wales)**
A&A Report SBU-2021-029 Digital Technology Control & Risk Assessment. No Assurance Rating Given			x	Lack of a holistic review of current/future gaps in digital services staff expertise/knowledge	Complete National Digital Services skills assessment, and draw up a workforce plan based on the outcomes. **31/12/2022**
				Scope identified to enhance testing of BC/DR plans in conjunction with stakeholders	A Digital BC Planning Bronze group has been established. The Group are focussing on BC plans in Digital Services specifically. A BC table top exercise with the Head of Emergency Preparedness Resilience and Response is also planned. **31/08/2022**
A&A Report SBU-2021-021 Information Technology Infrastructure Library Service Management Review Reasonable Assurance			x	Scope to implement a more formal structure around problem management processes and recording and communicating known errors.	Subject to finding, a post will be recruited to and a formal structure developed, linked to the all-Wales Infrastructure Programme service desk replacement and associated process timescales. **31/12/2022**
A&A Report SBU-2122-005 Network & Information Systems (NIS) Directive Reasonable Assurance			x	Scope to improve the recording of information in respect of the completion of the Cyber Assessment Framework (CAS).	A suitable information recoding mechanism will be agreed with the Cyber Resilience Unit (CRU) for the next assessment cycle. **31/12/2022**
				No action plan has been produced following the Health Board's self-assessment against the CAS.	An action plan will be produced following the receipt of feedback from the CRU **31/05/2022**
A&A Report SBU-2122-019 Hospital Electronic Prescribing & Medicines Administration Application (HEPMA) Reasonable Assurance			x	Impact of national architecture and governance reviews not yet known. Operational impact of the requirements of the Network and Information Services Directive (NISD) have yet to be established.	
A&A Report SBU-1920-029 IT Application Systems (TOMS) Reasonable Assurance			x		
A&A Report SBU-1920-028 Discharge Summaries No Rating Given			x		