Follow-up Review

Final Internal Audit Report

June 2024

Swansea Bay University Health Board

Contents

Executive Summary 3
1. Introduction 4
2. Detailed Audit Findings 4
Appendix A: Assurance opinion and action plan risk rating 17

Review reference:	SBUHB-2324-23
Report status:	Final
Fieldwork commencement:	17 April 2024
Fieldwork completion:	16 May 2024
Debrief meeting:	09 May 2024
Draft report issued:	24 May 2024
Management response received:	7 June 2024
Final report issued:	10 June 2024
Auditors:	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit; Johanna Butt, Principal Auditor
Executive sign-off:	Hazel Lloyd, Director of Corporate Governance
Distribution:	Len Cozens, Head of Compliance; Kath Hart, Deputy Nurse Director (MHLD); Dermot Nolan, Joint Service Group Director (MHLD); Claire Parsons, Head of Information Governance; Matt John, Director of Digital; Mark Parsons, Assistant Director of Capital Planning; Darren Griffiths, Director of Finance & Performance; Sharon Ragbetli, Clinical Audit & Effectiveness Manager; Raj Krishnan, Acting Executive Medical Director; Kate Morgan, Head of Corporate Governance & FOIA Lead; Jennifer Nagle, Head of Health Records & Clinical Coding; Brian Owen, Group Director (Primary, Community & Therapies)
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

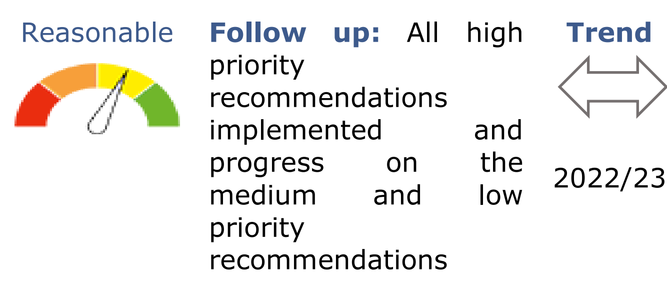
Disclaimer notice - please note:
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Swansea Bay University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Swansea Bay University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Follow-up Report Classification [1]



Reasonable	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations	**Trend** 2022/23

[1] The scope of this follow-up review provides assurance against the implementation of the agreed actions from prior years' audit reports. It does not provide assurance against the full scope and objectives of the original audits.

Recommendation Summary

	High	Medium	Low	Total
Closed	9	-	-	**9**
Partially implemented	1	-	-	**1**
Outstanding	-	-	-	**-**
	10	**-**	**-**	**0**

Purpose / Background

To provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the health board has in place to monitor progress with the implementation of actions.

Overview of findings

We have issued reasonable assurance on this area.

The health board has adequate arrangements in place to track progress in relation to internal audit findings, noting specifically the summary reports of overdue actions (and those due within the next three months), prepared by the Head of Compliance, presented to Executive Team meetings monthly; and the regular status reports presented to Audit Committee.

Our testing confirmed that nine of the ten recommendations tested at this review were appropriately classified as complete on the tracker.

However, we note that one of the recommendations was closed on the tracker when the management actions had not been fully implemented; this has since been re-opened on the tracker in the absence of the relevant supporting information.

We raised two recommendations in our prior year Follow Up report; one of which (ensuring appropriate oversight of recommendations raised by other external inspection and review bodies) remains open on the tracker; and we note the health board's statement regarding ongoing work and acknowledge a date has been set for a further update to be provided.

1. Introduction

1.1 We undertook a follow-up review of limited assurance internal audit reports issued during 2022/23, to provide assurance that the Swansea Bay University Health Board (the health board) has implemented the related recommendations appropriately and in a timely manner. We also considered high priority recommendations from reasonable assurance reports, and reviewed the systems and arrangements the health board has in place to monitor progress with the implementation of actions.

1.2 The potential risks associated with this review were:

- failure to implement agreed audit recommendations in a timely manner;
- increased financial, clinical, statutory and reputational risk for the health board; and
- inaccurate reporting of the Tracker within the health board.

1.3 The scope of this follow-up review does not provide assurance against the full scope and objectives of the original audits or that the matters arising to which they relate have been fully closed. The follow-up review opinion provides assurance against the level of implementation of the recommendations reviewed only.

2. Detailed Audit Findings

2.1 This section of the report captures a summary of our previous findings from our testing sample, along with progress made to implement associated recommendations.

2.2 Our review incorporates a sample of recommendations (high and medium priority that have been recorded as closed on the health board's Audit Recommendations Tracker (the tracker)) raised in the following Limited Assurance reports:

- Transition from Child and Adolescent to Adult Mental Health Services – to review the arrangements to manage and safeguard the transition from child and adolescent to adult mental health services.
- Continuing Healthcare – to review the governance arrangements in place to ensure that continuing healthcare is provided to the required standards with appropriate financial controls in operation.
- Information Governance – to review the arrangements in place for the resourcing, capacity and resilience of the Information Governance function to achieve compliance with GPDR in the future.
- Health and Safety – to review the health board's structures and arrangements for complying with the Health and Safety legislation.
- Clinical Audit – to consider how clinical audit links to strategic risks and objectives and assess the extent to which clinical audit is playing a full role for quality improvement and contributing to Board assurance.

2.3 We also sought to review the status of the recommendations included in the 2021/22 Limited Assurance report for Safety Notices & Alerts (which sought to review the arrangements in place, assess and provide assurance regarding compliance with safety notices and alerts) noting that all (13) recommendations remained open at our 2022/23 follow up review recognising work being undertaken to explore the development of an all-Wales alert module which would incorporate a central receipt and distribution process. All recommendations remain open at this review recognising that workload/resource issues have hampered the required progress. As per the tracker, a date of 30 June 2024 has been set for a further update to be provided.

2.4 We also included a sample of high priority recommendations that have been recorded as closed on the tracker from reasonable assurance reports issued during 2022/23, being:

- Freedom of Information Requests – to review the arrangements in place to ensure compliance with the requirements of the Freedom of Information Act.
- Infection Prevention & Control - to review the effectiveness of the governance arrangements in place within the Service Groups to manage the risks relating to Infection Prevention and Control.
- Access to Cancer Services – to review the health board's approach to manage the waiting list backlog within cancer services in order to ensure timely access to services for patients; and
- Management of Physical Health Records – to review the arrangements and processes for the management and storage of physical records, focusing on the management of the acute record.

2.5 As per paras 2.2 to 2.4, we selected a sample of closed recommendations from the tracker (as at 4 March 2024). These are detailed in table 1 below:

Table 1

As per original Internal Audit Report				As per Tracker Note 1	
Report title	**Assurance Rating**	**Matters arising raised**	**Number of recommendations**	**Number of management actions in tracker**	**Total Reported Closed**
Transition from CAMHS	Limited	8	11	10 **Note 2**	7
Continuing Healthcare	Limited	9	13	14	4 **Note 3**
Information Governance	Limited	4	5	5	5
Health & Safety	Limited	10	18	19	16
Clinical Audit	Limited	5	8	8	7
FOI Requests	Reasonable	4	4	4	4
Infection Prevention Control	Reasonable	4	8	8	8
Access to Cancer Services	Reasonable	8	9	10	5

As per original Internal Audit Report				As per Tracker Note 1	
Report title	**Assurance Rating**	**Matters arising raised**	**Number of recommendations**	**Number of management actions in tracker**	**Total Reported Closed**
Management of Physical Health Records	Reasonable	2	3	3	3

Note 1 For some recommendations raised, we note that there is more than one management action associated with their implementation and these are split out on the tracker. This accounts for the difference in the recommendations in this table.

Note 2 For Transition to CAMHS, we note that two recommendations (1.1 and 1.2) have been merged into one.

Note 3 We note that progress in addressing recommendations has been impacted by long term sickness of key senior management within the Commissioning team.

2.6 The audit excluded Estates Assurance recommendations which were subject to separate follow up arrangements (report issued March 2024; Reasonable Assurance). Our work also excluded the Swansea Wellness Centre (which sought to review the delivery and management arrangements in place to progress this project, and performance against its key delivery objectives i.e. time, cost and quality). Discussions remain ongoing with the external partner regarding the viability of this project to progress to Outline Business Case and will be subject to a separate audit once an appropriate way forward has been established.

Corporate approach to tracking recommendations

2.7 As previously reported, all final internal and external audit reports continue to be made available on the Finance Portal on SharePoint for managers and executives to access and update via an audit tracker, with training provided. We note that in September 2023, *Audit Tracker - User Guidance Notes* were produced and circulated by the Head of Compliance. Furthermore, summary reports of overdue actions are presented to Executive Team meetings monthly and note that such has recently (from April 2024) been extended to include a summary, by Executive, of those actions due within the next three months.

2.8 Reporting deadlines for each Audit Committee meeting are clearly set out within the file set up. The Audit Committee reviews the status of internal and external audit recommendations and refers audit reports to relevant Board Committees to support oversight and scrutiny of recommendations relating to their remit.

2.9 The health board has continued to enforce the requirement for Executive Directors to attend Audit Committee to provide assurance to members where 'Limited' or 'No Assurance' reports have been issued. Responsible officers have also been requested to attend Committee, where a concentration of overdue recommendations is highlighted.

2.10 Audit Wales' Structured Assessment for 2023 (issued October 2023) reported that performance management arrangements are generally good. It stated that *arrangements for tracking internal and external audit recommendations are strong,*

but opportunities remain to improve processes for tracking the recommendations of other regulators.

2.11 In our 2022/23 follow up report we recommended that the health board should ensure appropriate oversight of recommendations raised by other external inspection and review bodies. We note that this recommendation remains open on the tracker where it is stated that *the adoption/implementation of the AMaT system continues to be hampered by significant staffing/ resource issues within the department. Work is currently ongoing in order to identify additional appropriate resource to take this forward.* As per the tracker, a date of 30 June 2024 has been set for a further update to be provided, therefore we have not re-raised a recommendation at this report.

2.12 We do note, however, that the health board now prepares a separate External Inspections report, which monitors matters arising in respect of inspections and reviews from Healthcare Inspectorate Wales (HIW) and other external reviews; and provides assurance regarding action to address issues raised. The report has been presented to both Audit Committee and Quality and Safety Committee.

2.13 We also recommended that the health board should look to establish a process for the review and approval of changes made to audit recommendation implementation dates. This was recorded as complete at the date of issue of the final report noting the practices employed through the regular update to the tracker, reporting to Audit Committee and attendance at such by Executive Leads where additional assurance is required.

Transition from Child and Adolescent to Adult Mental Health Services

2.14 Eight matters arising which included 11 recommendations were raised in the original report. There are 10 management actions associated with these recommendations on the tracker (two recommendations, 1.1 and 1.2, have been merged as one management action) seven of these are recorded as closed. These included three high priority and three medium priority management actions. For the three recommendations that remained open, these had not met their original due date; and whilst a review date had been defined on the tracker, at the date of fieldwork, it had passed. We selected two closed recommendations from this report.

Recommendations 6.1a and 6.1b: Safeguarding Children Training (Operation) – High priority

2.15 Our previous audit reported that the admissions policy details that *'All staff on Ward F will receive Safeguarding Children training - Level 2. Ward Manager, Clinical Leads will undergo Safeguarding Children level 3'.* Our review of records and discussion with the Ward Manager confirmed that staff were only undertaking Level 1 training. Further, the Mandatory and Statutory training reports distributed within the Service Group to managers for information indicated training compliance, but not the date of expiry.

2.16 It was recommended that (6.1a) management should ensure that Ward F Staff undertake Safeguarding Children Training Level 2 to ensure compliance with the

admissions policy; and (6.1b) to assist in ongoing monitoring training, compliance reports should include expiration dates to assist in addressing those areas longest overdue.

2.17 An ESR report was provided detailing the compliance rates Level 2 training for Ward F. The report shows the Ward has an assignment count of 35: 16 Qualified Nursing staff and 19 Health Care Support staff. 15/16 (93.75%) of Qualified Nursing staff had completed the Level 2 training; however, Health Care Support staff compliance is only 8/19 (42.1%). The health board recognises that this is low and we understand that training is due to be completed over the next eight weeks. We also note that 13/16 (81.25%) of the Qualified Nursing staff had also completed Level 3 training. Health Care Support staff are not required to complete Level 3 training.

2.18 With regard to the inclusion of expiration dates, we note the update provided within the Audit Tracker and Status of Agreed Actions report as presented to the November 2023 Audit Committee, which stated that '*whilst it has not been possible to deliver all elements referred to in the original response, management feel it is reasonable to close the recommendation at this time given the action taken to date and all other circumstances'.* We have reviewed the email communication from the ESR team which indicates that the inclusion of an expiry date is not possible and would require a national response/review of ESR to be achieved.

Conclusion:

2.19 Recommendation 6.1a is considered **partially implemented**. Whilst we acknowledge there is high compliance for Level 2 training amongst Qualified Nursing staff, the compliance rates for Health Care Support staff is low. We have therefore concluded that the recommendation remains **open**; and note that this concurs with the view of the Head of Compliance who re-opened the recommendation on the tracker during the course of fieldwork in the absence of updated training compliance rates.

2.20 We acknowledge the health board's conclusion for regarding the recording of an expiry date and therefore consider recommendation 6.1b as **closed**.

Continuing Healthcare

2.21 Nine matters arising which included 13 recommendations were raised in the original report. There are 14 management actions associated with these recommendations on the tracker. Four of these management actions, including three high priority, are recorded as closed. For the ten recommendations that remained open, these had not met their original due date; and whilst a review date had been defined on the tracker, at the date of fieldwork, it had passed. We selected one closed recommendation from this report.

Recommendation 7.1: Reviews of Continuing Healthcare Packages (Operation) – High priority

2.22 Our previous audit reported that once a CHC package has been approved, it is initially reviewed after 3 months, and at least annually thereafter (as required by

the Framework). Typically, the review should follow the format of an assessment, consider all the services received by the individual; and focus on whether these plans remain appropriate to meet the person's needs. Further, if an individual's needs change, a review is initiated in order to establish current care needs and appropriate funding stream.

2.23 Key dates and metrics associated with care packages are recorded within the National Complex Care Database (NCCD) and updated to reflect any changes to the package structure. However, our sample testing noted a number of reviews were overdue; and noting issues with time stamp / audit trail of changes on NCCD we were unable to determine that all changes sampled had been processed in a timely manner. With regard to monitoring of reviews, we were advised that that in some instances, details of the reviews are only reported to the scrutiny and complex care panels by exception i.e. when the review results in changes to the package.

2.24 It was recommended that routine monitoring of reviews should be undertaken by service groups to ensure they are undertaken in a timely manner.

2.25 The health board has split this recommendation, on the tracker, into two management actions - one for Primary, Community and Therapies Service Group (PCTG) and one for Mental Health and Learning Disabilities (MHLD).

2.26 For PCTG, we reviewed the agendas for the Continuing Healthcare (CHC) monthly meetings. This confirmed that the status of reviews is a standard agenda, reporting on the number of reviews due and completed.

2.27 Review of the report presented at the March 2024 meeting (for the period up to February) noted that the percentage of due reviews completed had an average of 73.8%, with 73.25% having been completed in February. For those reviews due in 3 months, the average percentage of those completed was 69.8%, with 67.1% having been completed in February. Management advised that workforce pressures and a staff vacancy had impacted the achievement of 100% compliance; but note the vacancy has now been filled, and this should help improve performance going forward.

2.28 For MHLD, we understand that reviews commenced in November 2023 and that the National Collaborative Commissioning Unit (NCCU), as part of a Welsh Government review process on Complex Care, are also completing reviews on the top 50 cases for all health boards across Wales. Review of the Mental Health and Learning Disabilities, Complex Care Monthly Update Report (April 2024), which is presented to the Service Group's Weekly Business & Board Meeting, includes a section on the performance activity as at 31 March 2024.

2.29 For Mental Health (MH), 163 (76.2%) reviews have been completed, five (2.3%) have been booked and 46 (21.5%) are outstanding. For Learning Disabilities (LD), 172 (73.8%) reviews have been completed, 9 (3.9%) have been booked and 52 (22.3%) are outstanding. The report also details that NCCU have undertaken 50 reviews of MHLD cases (23 MH and 27 LD) - work is ongoing to validate any comments / recommendations outlined by NCCU and then enact if the findings are agreed.

Conclusion:

2.30 Recognising reviews are being undertaken (with compliance being above 70%) and monitoring of the same, this recommendation is considered **fully implemented** and is therefore **closed**.

Information Governance

2.31 Four matters arising which included five recommendations (two high priority and three medium priority) were raised in the original report. There are five management actions associated with these recommendations on the tracker, all of which are recorded as closed. We selected one closed recommendation from this report.

Recommendation 2.1: Subject Access Request Process (Design) – High priority

2.32 Our previous audit reported that whilst there was a process for handling Subject Access Requests (SARs), in relation to the acute health record, and that the health board was complying with the requirement to provide information in a timely manner, review of Information Governance (IG) update papers to the Information Governance Group (IGG) highlighted inconsistent application of this process. There was no formal health-board wide policy or process for effectively managing SARs.

2.33 We reported that the team had seen a 2000% increase in hours spent on SAR support over a period of 2 years, with both volume and complexity of requests increasing. In the same timeframe, there had been a rise in the number of breaches and complaints regarding the health board's SAR management, including four Information Commissioner's Officer (ICO) reportable breaches, 12 non-ICO reportable breaches; and 18 complaints (of which 10 were reported to the ICO by the complainant).

2.34 It was recommended that management should ensure that the work is progressed urgently to develop a robust health-board wide policy on handling SARs, to mitigate the current high risk of ICO breaches and serious incidents.

2.35 The SAR Policy (Policy ID 177) has been developed, and was presented and approved by the Workforce and Digital Committee in October 2023; and is readily available on the health board's intranet site. The purpose of the Policy, and any associated procedures, is to ensure that staff are able to meet the health board's legal obligations when processing requests received from applicants. Review of the Policy confirms that it sets out the roles and responsibilities of individuals, covers requests to access identifiable data of a living or deceased individual by data subjects or their representatives; and it also provides both internal and external e-mail links, for support or getting help.

Conclusion:

2.36 This recommendation is considered **fully implemented** and is therefore **closed**.

Health and Safety

2.37 Ten matters arising which included 18 recommendations were raised in the original report. There are 19 management actions associated with these recommendations on the tracker; and 16 of these (one high priority and 15 medium priority) are recorded as closed. For the three recommendations that remained open, these had not met their original due date; and whilst a review date had been defined on the tracker, at the date of fieldwork, it had passed. We selected one closed recommendation from this report.

Recommendation 8.1: Reporting against Key Performance Indicators (Operation) – High priority

2.38 Our previous audit reported that Key Performance Indicators (KPIs) are not reported as a dedicated item within Health & Safety Operational Group (HSOG) papers. Therefore, we reviewed exception reports from Service Groups, Estates and the reporting of the Health and Safety Team to the HSOG, to confirm if they were in use. We identified little evidence to support their ongoing use with only information on health and safety training compliance being regularly reported by Service Groups. Updates on fire risk assessments were provided through circulation of the Fire Group minutes as part of the HSOG agenda.

2.39 We noted that the sources of information which make up the KPIs would need to be collated from across Service Groups, Estates and the Health and Safety Team, and so it was unclear if reporting by individual groups or through one specific report is intended.

2.40 It was recommended that the health board should establish the responsible leads for collating and reporting the agreed KPIs. The frequency and forum at which the KPI's will be reported should also be confirmed.

2.41 Health and Safety representatives have been identified for each Service Group. Exception reports from Service Groups are expected to be presented quarterly to the HSOG. Review of the papers for the November 2023 HSOG confirms that the standard template exception reports were presented and these include KPIs such as, but not limited to, reporting of RIDDOR incidents within agreed timeframes, health and safety training completion in line with health board policy frequencies and Welsh Government targets, completion of fire risk assessments and completion of legionella risk assessments. .

2.42 The terms of reference for the HSOG states that '*the Health and Safety Operational* Group *must submit a written report quarterly to the Quality and Safety Committee meeting in the business cycle following the operational group'*. Review of the 'Health and Safety Operational Group Key Issues Report' presented to the Quality and Safety Committee (QSC) (19 December 2023) confirmed that these summarise information contained within each of the exception reports presented at the November 2023 HSOG. The narrative within the report presented stated that '*following on from the audit by NWSSP covering health and safety, the exception report template has been updated and circulated to the service groups and other departments who submit reports to the HSOG, in addition to the Service Group*

exception reports, an estates specific exception report was submitted to the HSOG in November and was well received'.

2.43 The QSC also received the equivalent update in March 2024 for the February 2024 HSOG meeting.

Conclusion:

2.44 This recommendation is considered **fully implemented** and is therefore **closed**.

Clinical Audit

2.45 Five matters arising which included eight recommendations were raised in the original report. There are eight management actions associated with these recommendations on the tracker, seven of these (four high priority and three medium priority) are recorded as closed. For the recommendation that remained open, this had not met its original due date; and there is no review date defined on the tracker. We selected one closed recommendation from this report.

Recommendation 4.1: Progress of Service Delivery Group Clinical Audit Plans (Operation) – High priority

2.46 Our previous audit reported that at the monthly Clinical Outcomes and Effectiveness Group (COEG) meetings, the status of Service Delivery Group (SDG) clinical audit plans had been provided, with poor progress reported. At the end of the financial year, COEG reported that only 19% of the SDG level audits had been completed. We noted that there was no evidence of escalation, from COEG, within the wider health board governance structure regarding this poor progress.

2.47 It was recommended that a lessons learned exercise should be undertaken to 'support' the low completion rate of the 2022/23 SDG clinical audit plans.

2.48 Review of the agendas and papers presented to COEG confirms that the Clinical Audit Plans are a standard agenda item at these meetings, and that lessons learnt from the 2022-23 plans have also been included.

2.49 The 'Clinical Outcomes and Effectiveness Group Mid-Year Report' presented to COEG in June 2023, and the 'Clinical Outcomes and Effectiveness Group Report' presented to the January 2024 COEG provided updates on progress against the plans.

2.50 The lessons learnt from monitoring and reporting, has resulted in a reduction in the number of clinical audits on the plan. The 2024/25 plan has 103 topics listed compared with the 212 topics listed in the 2022/23 plan (although we note this was amended to 102 topics during the course of the year); and 117 topics listed in the 2023/24 plan.

2.51 As at the date of reporting, the completion rate of the amended 2022/23 plan is currently at 87% (noting that it was only 19% complete at 31 March 2023); and the 2023/24 plan at 41.5%. Evidence was provided confirming that e-mails are sent to audit leads to ensure that progress updates against the remaining audits is provided, and to understand the circumstances behind each of the delayed topics. Noting the fluid nature of the plans, these updates can provide details of

topics to be deferred which are deemed unnecessary at this time; as well as removal of topics as they are being progressed outside of audit work or deemed as no longer clinically relevant.

Conclusion:

2.52 This recommendation is considered **fully implemented** and is therefore **closed**.

Access to Cancer Services

2.53 Eight matters arising, which included nine recommendations, were raised in the original report. There are 10 associated management actions associated on the tracker, of which five, including one high priority, are recorded as closed. For the five recommendations that remained open, these had not met their original due date; and whilst a review date had been defined on the tracker, at the date of fieldwork, it had passed. We selected one closed recommendation from this report.

Recommendation 1.1a: Cancer Delivery Structure (Design) – High priority

2.54 Our previous audit reported that whilst we noted the health board had established a Cancer Programme Board (CPB), a number of meetings had been cancelled, and there had been concerns raised relating to its remit by its Chair, and the wider responsibilities relating to management of cancer within the health board. The supporting structure of the Programme Board had also not been taken forward as originally outlined and whilst alternative arrangements had been made, we noted a lack of formal governance or documentary trail. We acknowledged, however, that as the fieldwork was concluding, there had been the re-establishment of the outlined Cancer Performance Group (CPG).

2.55 It was recommended that noting performance arrangement had recently been amended, terms of reference are refreshed to reflect the roles of each group within the health board's cancer delivery structure and associated reporting needs.

2.56 The CPB has been replaced by the Cancer Programme Improvement Group (CPIG). The terms of reference for this new group were prepared and reviewed by CPIG in January 2024 for final comments; and ratified at the March 2024 meeting.

2.57 As defined in the terms of reference, the purpose of the CPIG is to develop the framework to provide direction to the clinical reference groups / project groups supporting the programme and oversight of the performance monitoring of recovery. The reporting structure is detailed, within which is the CPG and below that Performance Scrutiny meetings. The reporting structure expects that the monthly CPG will include '*review and oversight of key pathway metrics against SCP/NOPs, benchmarking against other HBs*; *SACT and Radiotherapy Performance oversight*; and *monitoring of Service/Tumour Site Improvement Plans*.'

2.58 We note that the terms of reference for the CPG were updated and agreed its May 2023 meeting, with a next review date within 12 months. Given that the terms of reference for the CPIG has recently been ratified, the health board should ensure that it explicitly details the expectation of CPG as set out in the CPIG terms of reference and that these arrangements now need time to embed to become effective.

Conclusion:

2.59 This recommendation is considered **fully implemented** and is therefore **closed**.

Freedom of Information (FoI) Requests

2.60 Four matters arising which included four recommendations were raised in the original report. There are four management actions associated with these recommendations on the tracker, all of which, including one high priority, are recorded as closed. We selected one closed recommendation from this report.

Recommendation 1.1: Disclosure Log (Operation) – High priority

2.61 Our previous audit reported that the health board had a disclosure log in place, designed to help the public access information that has been published by the health board. The disclosure log was intended to give a brief outline of previous requests received by the organisation, together with the relevant responses issued under the Freedom of Information Act 2000. A review of the health board's disclosure logs for 2021 and 2022 identified omissions in uploading information. Management advised that updating the log was a time consuming exercise and consideration was being given to implementing a more effective process.

2.62 It was recommended that the health board should ensure that the published disclosure log is updated to include the correct information as soon as practicable and is maintained in a timely manner.

2.63 A new process has been developed which makes it easier to upload the requests without the need for redaction; which was considered the main cause of the previous backlog. We noted that some disclosures were missing from the latter part of 2023 and early 2024. However, the health board advised that this was due to staffing issues / changes in the team since October 2023. We have since re-reviewed the disclosure log and confirmed the omissions have been uploaded.

Conclusion:

2.64 This recommendation is considered **fully implemented** and is therefore **closed**.

Management of Physical Health Records

2.65 Two matters arising which included three recommendations were raised in the original report. There are three associated management actions on the tracker, all of which, including two high priority, are recorded as closed. We selected one closed recommendation from this report.

Recommendation 1.2: Lack of fire Suppression (Operation) – High priority

2.66 Our previous audit reported that physical health records are stored across the health board's Health Records Departments, held at three locations within Neath Port Talbot, Morriston and Singleton hospitals. The records storage areas do not have fire suppression (sprinklers) in place. Medical record libraries are regularly risk assessed for fire, and the Fire Safety Manager is aware of the lack of fire suppression. However, it was not held on the departmental risk register as we were informed that, due to the age and types of the buildings, there is no requirement

to have fire suppression installed. We were also advised that it would require a major renovation project at significant cost to install this.

2.67 We recommended that the fire risk to patient records should be included within the departmental risk register, with appropriate mitigation defined and any residual risk being clearly accepted.

2.68 A risk 'Lack of Fire Suppression across the Acute Health Records Libraries' (Datix ID 3439) has been raised and escalated onto the Digital Services Risk Register (May 2023). Review of the Datix record confirms that this has a score of 10, in line with its target score. The controls in place include:

a. Regular Health & Safety and Fire risk assessments are undertaken across all the Health Records Libraries to assess the risks and provide recommendations; and

b. There are dedicated Fire Wardens across each of the hospital sites and fire inspections are undertaken by the health board's Fire Officer.

It is also noted that the Estates Strategy (approved November 2023) recognises the fire risks within its wider backlog maintenance risks.

2.69 Management advised that the service is looking at the centralisation of medical records and all fire measures (including use of sprinklers) will be assessed in the new facility; and with any future fire risk assessments going forward where medical records are retained on the current sites.

2.70 We understand that in the July 2023 risk meeting it was agreed to close the action to request escalation to the Health Board Risk Register (HBRR). The risk has been shared with the Service Groups for them to consider whether to include on their individual risk registers.

Conclusion:

2.71 This recommendation is considered **fully implemented** and is therefore **closed**.

Infection Prevention & Control: Service Group Governance Arrangements

2.72 Four matters arising which included eight recommendations were raised in the original report. There are eight associated management actions on the tracker, all of which, including four rated as high priority, are recorded as closed. We selected one closed recommendation from this report.

Recommendation 3.1: Work Programme Implementation (Design) – High priority

2.73 Our previous audit reported that the health board have created work programmes to help improve Infection Prevention and Control at both Corporate and Service Group levels. However, review of the progress made against the implementation of the work programmes showed that a number of actions at Service Group Level are yet to be implemented or are off target.

2.74 It was recommended that the work programme target dates, and associated resource requirements, should be reviewed; with changes approved, and

monitored at Infection Control Committee (ICC) and Quality and Safety Committee (QSC) meetings.

2.75 The health board has developed the 'Infection Prevention Improvement Plan 2023-24' which includes the Infection Prevention and Control (IPC) related outcome measures and incorporates all Service Groups. Review of the Improvement Plan confirms that it includes the baseline position for 2022/23 for each of these outcome measures (where appropriate), the target quarterly cumulative totals, the target outcome, responsibility; and the quarterly progress against the targets – colour coded to highlight when a target has been met or not met.

2.76 Review of the Infection Prevention and Control Group agenda and papers confirms that the group has received assurance updates on progress against the plan. Quarterly updates have been provided to the Quality and Safety Committee (QSC), the most recent being in May 2024, which provided the end of year position citing the health board had failed to achieve the 2023/24 Welsh Government infection reduction expectations and had been escalated to Targeted Intervention for healthcare associated infections (HCAI). The paper also included the 2024/25 improvement plan.

Conclusion:

2.77 This recommendation is considered **fully implemented** and is therefore **closed**.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

Rating	Definition
Substantial assurance	**Follow Up**: All recommendations implemented and operating as expected.
Reasonable assurance	**Follow Up**: All high priority recommendations implemented and progress on the medium and low priority recommendations.
Limited assurance	**Follow Up**: No high priority recommendations implemented but progress on most of the medium and low priority recommendations
Unsatisfactory assurance	**Follow Up**: No action taken to implement recommendations.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership