

Urgent & Emergency Care: Delivery Governance Final Internal Audit Report 2025/26

Swansea Bay University Health Board



Limited Assurance

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Review Reference

SBU-2526-16

Fieldwork

January 2026 – March 2026

Executive Sign Off

Deb Lewis, Chief Operating Officer 30th April 2026 / 11th May 2026

Audit Committee

21 May 2026

Executive Lead

Deb Lewis, Chief Operating Officer

Audit Team

Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To assess whether governance arrangements for the delivery of Urgent and Emergency Care (UEC) across Swansea Bay University Health Board (the health board) are sufficiently robust, clearly aligned, and supported by appropriate decision-making, escalation, and oversight processes. This review focused on the governance interfaces between the health board and regional partners; it did not assess the performance of partner organisations.

Recent external reviews reinforce the contextual pressures underpinning UEC delivery. Reports issued by Audit Wales including *West Glamorgan Region - Urgent and Emergency Care: Flow Out of Hospital* (February 2026) and *Urgent and Emergency Care: Arrangements for Managing Demand – Swansea Bay University Health Board* (September 2025) identified that while partners demonstrate clear commitment to improving system flow, performance remains extremely challenging. While these external reviews were broader in scope, our work focused specifically on governance arrangements rather than operational performance.

Overview

Performance within UEC remains a critical area of focus and a source of sustained operational pressure for the health board and its regional partners. Effective governance is therefore essential to ensure coordinated delivery, clear oversight and accountability. Our review found strong collective commitment to improving UEC pathways and clear alignment between health board and regional plans.

However, despite consistent strategic direction across the UEC Plan, the Regional Partnership Board (RPB) Area Plan, and associated workstreams, delivery is hindered by limited visibility of partner capacity, overlapping responsibilities between the UEC Programme Board (UECPB) and the Communities & Older People Board (COPB), and the absence of a formalised decision-making interface to address delays and blockages. In addition, inconsistent application of the Pathways of Care Delays Escalation Framework weakens the effectiveness of operational escalation arrangements.

We also note the learning arising from the NHS Wales System Reset Initiative (“Winter Sprint”), a Welsh Government-mandated programme undertaken by the health board during December 2025 and January 2026. The initiative demonstrated that targeted system leadership, strengthened joint decision-making, and enhanced escalation can temporarily improve visibility and patient flow.

Overall, while partners demonstrated clear commitment, weaknesses remain in governance clarity, boundaries, and escalation mechanisms. On this basis, we have concluded **limited assurance**. Key matters requiring management attention include:

- Limited visibility of partner capacity and external dependencies restricts the robustness of health board UEC planning and delivery.
- The governance relationship between UECPB and COPB is defined within a memorandum of understanding, however, this does not clearly distinguish strategic and operational responsibilities, resulting in overlapping agendas and unclear accountability.
- The absence of a formal decision interface contributes to duplication and unclear escalation routes.
- The Pathway of Care Delays Escalation Framework outlines tiers and timescales associated for escalating patient delays but is not consistently embedded or applied.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. During our fieldwork, we also noted that the UECPB terms of reference do not adequately define the core membership for quoracy (see objective 2). It is considered best practice to ensure quoracy to be recorded within meeting minutes. This has not impacted the audit opinion and assurance rating.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

| | | Related Findings | Assurance |
|---|--|------------------|-------------------|
| 1 | The health board's Urgent and Emergency Care plans align with regional priorities, with clear ownership of actions and mechanisms for managing dependencies | 1 | Reasonable |
| 2 | Roles, responsibilities, and decision-making arrangements for Urgent and Emergency Care delivery are clearly defined, documented, and understood, including escalation routes. | 2 | Limited |
| 3 | Governance structures and reporting flows enable effective oversight of Urgent and Emergency Care and support timely, informed decision-making. | 3, 4 | Limited |

Management Actions

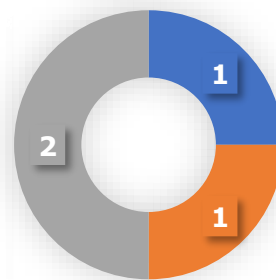


High Priority



Medium Priority

Themes



- Governance
- Performance Monitoring
- Planning, Delivery & Deadline Management

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Choose an item.

Choose an item.

Findings & Agreed Action Plan

Objective 1: The health board's Urgent and Emergency Care plans align with regional priorities, with clear ownership of actions and mechanisms for managing dependencies.

Reasonable

The health board's Annual Plan 2025/26 identifies UEC as a core transformation priority and reflects ministerial expectations set through the national Six Goals UEC programme¹. The wider context for delivering UEC improvement continues to be shaped by significant operational and financial pressures across the health and social care system. Reducing reliance on unfunded surge capacity remains a priority for the health board, noting that progress is dependent on increasing the timeliness and capacity of discharge pathways. External national reviews, including the Ministerial Advisory Group NHS Performance and Productivity review and Getting It Right First Time (GIRFT), have also highlighted that overcrowding and poor flow contribute to delay-related harms, including increased mortality.

These factors create a complex operational environment requiring the health board to balance its statutory responsibilities for UEC (see *objective 2*) with its dependencies on local authorities, who are responsible for community social care provision that materially affects patient flow and discharge performance.

In May 2025, an interim Community and Older Peoples Board (COPB) was established within the West Glamorgan Regional Partnership Board (RPB) structure, with UEC included within as a workstream. This followed externally facilitated discussions between the partner organisations leading to a shared purpose memorandum of understanding (MOU) for integrated health and social care. The approach also aligns with Welsh Government's Integrated Community Care System (ICCS²) model, which aims to bring together existing national programmes and funding streams within RPB governance.

Our review of the Annual Plan, the health board's UEC 2025/26 plan ('the UEC plan'), the West Glamorgan RPB Area Plan ('the RPB area plan') and the 2025/26 regional Winter Plan found strong thematic alignment. Key actions to improve admission avoidance, frailty management, community and intermediate care, and discharge pathways feature consistently across all documents.

The COPB has established six workstreams to deliver its elements of the RPB area plan, each with a designated lead and defined goal. Project briefs for the Discharge to Recover and Assess (D2RA) programme, the Pathway of Care Delays (POCD) action plan and the development of an Integrated Discharge Hub (IDH) demonstrate multi-agency involvement, with representation from the health board's Service Groups, local authorities, the RPB programme office and third-sector partners. Intended tasks are clearly defined. Progress is monitored at COPB through standardised highlight reports (introduced from July 2025), which include task descriptions, owners and target completion dates.

Our review of these project briefs and highlight reports (July 2025 – January 2026) confirmed that many key components of the D2RA programme and wider UEC improvements rely on multi-agency contributions and cross workstream dependencies. Discussion with UEC senior management also indicated that the health board does not have full visibility of local authority capacity and resourcing, which affects its ability to develop fully aligned UEC plans and understand the wider system conditions necessary for delivery (see **Key Finding 1**). Prolonged hospital stays for clinically optimised patients (COP) also drive significant financial pressure, with the health board currently funding both unfunded surge capacity and the bed-day consumption associated with delayed discharge.

¹ The Six Goals for Urgent and Emergency Care National Programme has been established to support local health boards and their partners to transform and improve delivery of urgent and emergency care services to the people in Wales. <https://performanceandimprovement.nhs.wales/functions/six-goals-uec/>

² The Integrated Community Care System for Wales integrates national funding streams and programmes including housing, social care, primary care and UEC initiatives. [Towards An Integrated Community Care System](#)

| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|--|
| <p>1 Dependency and external capacity visibility</p> <p>The health board's UEC plan is clearly aligned to national, ministerial, and regional priorities; however, planning is constrained by limited visibility of partner-side capacity, funding decisions, and operational readiness across the regional system.</p> <p>The health board does not have access to detailed local authority resourcing plans. Although Welsh Government announced additional funding for local authorities in August 2025 (Swansea £3m; Neath Port Talbot £1.3m) intended to support discharge, community services, and preventative / early intervention initiatives, UECPB discussions in February 2026 confirmed that the health board was not sighted on how these allocations were deployed. These factors have a significant impact on UEC flow and overall service delivery.</p> | <p>Limited visibility of partner capacity and external dependencies increases the risk of delays to key UEC actions, reduces the robustness of health board planning, and negatively impacts patient flow, discharge performance and operational delivery.</p> | <p>Agreed Action:</p> <p><i>SBUHB Executive & senior management officers have reviewed (as part of the national UEC Summit) the UEC work programme moving into 26/ 27 in conjunction with senior West Glamorgan Regional Partnership Board colleagues.</i></p> <p><i>It was concluded that closer co-ordination across the work programme will be undertaken and the Governance of activity will be aligned so as those Responsible and Accountable have direct line of sight of works and enabling actions.</i></p> <p><i>As such to set a baseline a RACI review will be undertaken. This including confirmation on the four core roles for UEC works that sit across organisation boundaries. As such to include:</i></p> <p>Responsible (R): <i>The person/ people who perform the work to compete the task/ project.</i></p> <p>Accountable (A): <i>The individual (e.g. Exec. Director) answerable for the task(s)/ project(s). Ensures prerequisites are met and approves work completed</i></p> <p>Consulted (C): <i>Stakeholders or experts who provide input/ advice or feedback</i></p> <p>Informed (I): <i>Those who need to be kept updated on progress and decisions</i></p> <p><i>Furthermore, agreed that there will be a review of Membership across existing structures (UEC Board & RPB). Specifically, this will include consistent West Glamorgan RPB representation at the UEC Board and consistent attendance and input at RPB forums (e.g. Communities & Older Persons Board) by SBUHB senior representatives.</i></p> <p><i>Updates provided will include all areas that relate to any dependencies on a different part of UEC system functioning (e.g. POCD consistently reported at UEC Board to show key themes and present opportunities for change – aim to reduce delays and increase timely discharges).</i></p> <p><i>To support this will be standing items at UEC Board relevant to the entire UEC pathway and similarly project/ programme reporting reports reinstated to flag any key risks (and updated by leads).</i></p> |

| | | |
|---|-------------------------------|---|
| | | <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • <i>RACI review – May 26</i> • <i>Updated Governance structure and updated UEC Board documentation (e.g. TOR, monitoring templates) – May 26</i> • <i>Roll-out of new structure and reporting mechanism – June 26</i> |
| | <p>Medium Priority</p> | <p>Officer: Deb Lewis, Chief Operating Officer, in conjunction with UEC Pillar leads:</p> <p>Pillar 1: Pre-Hospital & Community – Dr Claire Dieppe, UEC Clinical Lead</p> <p>Pillar 2: Front Door & first 72 hours – Dr Rhodri Edwards, Associate Medical Director, Morriston Service Group</p> <p>Pillar 3: Ward based flow & Discharge – Alison Gallagher, Associate Director of UEC, Emily Davies Associate Service Group Director, Primary Community and Therapies Service Group</p> |
| <p>Theme: Planning, Delivery & Deadline Management</p> | <p>Control Design</p> | |

Objective 2: Roles, responsibilities, and decision-making arrangements for Urgent and Emergency Care delivery are clearly defined, documented, and understood, including escalation routes.

Limited

Governance arrangements for UEC sit within a complex statutory framework where the health board and local authorities retain distinct responsibilities. The health board is accountable for hospital-based urgent and emergency care, safe discharge processes, and stewardship of NHS resources; while local authorities remain responsible for social care assessment, support provision, safeguarding, and commissioning.

The ICCS model (see *objective 1*) strengthens Welsh Government expectations around joint planning and coordination but does not alter statutory accountabilities. Amendments made in 2024 to the Part 9 Partnership Arrangements Regulations, under the Social Services and Well-being (Wales) Act 2014, increased expectations for regional coordination and strengthened requirements for RPB monitoring and reporting. The current West Glamorgan RPB Governance Framework (2023) reflects previous arrangements and will need updating once revised RPB structures are agreed, to ensure alignment with the ICCS programme.

Our review of UECPB and COPB terms of reference found roles and responsibilities are not consistently articulated. While both UECPB and COPB have established terms of reference (ToR), testing identified significant overlap in the scope of issues considered by each forum. Papers presented to both groups included items relating to D2RA pathway development, discharge delays, long-stay reviews, and community capacity. This duplication suggests that the boundaries between operational oversight (UECPB) and strategic oversight of older people's and community pathways (COPB) are not yet clearly defined (see **Key Finding 2**).

UECPB minutes reviewed did not consistently record quoracy, and because the ToR does not adequately define the extent of core membership, it was not possible to confirm whether meetings met quorum requirements for decision-making purposes. For COPB, however, testing confirmed that meetings were quorate, noting the seniority of attendees varied across sessions.

Welsh Government's *Optimal Hospital Patient Flow Framework* sets out system-wide expectations for coordinated working across health and social care, including timely discharge once a patient is clinically optimised and the requirement to escalate and record delays beyond 48 hours. In line with these principles, partners have developed an 'Our Shared Purpose' outline, which includes commitments such as avoiding long-term care assessments within acute settings and strengthening access to D2RA pathways. We were advised that local authority leaders had indicated support for reducing the number of COP to circa 100 by March 2026; however, we were unable to confirm that this commitment has been formalised within the COPB. At the date of fieldwork concluding the number of COP exceeded 250. Findings under Objective 3 further indicate that, while escalation activity does occur, it is not applied in a sufficiently structured or consistently evidenced way to provide assurance of alignment with national expectations.

The Pathways of Care Delays Escalation Framework ('the Framework') introduces a tiered escalation methodology with timelines for key discharge activities. Originally agreed in February 2025, it was subject to draft revision at the time of audit fieldwork. The Framework categorises delay types, including social work assessments, brokerage, care-home placements, housing interventions, and equipment provision, with expected completion timescales ranging from two to fifteen working days depending on the activity. It also identifies initial and secondary contacts for escalation when delays occur.

While the Framework improves internal health board clarity and operational consistency, it does not yet establish a shared regional escalation process (see **Key Finding 4**). Whilst local authority contacts are identified, the absence of defined response obligations limits the development of a fully integrated approach across statutory partners.

| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|--|
| <p>2 Clarity of Governance Interface</p> <p>The 'Memorandum of Understanding 2025 Communities and Older People including 6 Goals Programme' states that UEC-related work will be incorporated within the interim COPB governance arrangements. While this provides a documented governance connection, it does not establish a clear operational interface between the health board's UECPB and COPB.</p> <p>Review of ToRs, minutes, and governance papers shows substantial overlap in responsibilities relating to patient flow, discharge, pathway design, and UEC-related transformation. However, there is an absence of accompanying definitions setting out:</p> <ul style="list-style-type: none"> • which forum holds primary decision-making authority, • how issues should escalate between forums, • the division between strategic and operational oversight, or • how disagreements or conflicting interpretations should be resolved. <p>In absence of a clear interface mechanism, such as a RACI (Responsible, Accountable, Consulted and Informed) model or a decision matrix, decisions are at risk of being stalled, duplicated, or inconsistently routed. This creates gaps in accountability and reduced governance efficiency.</p> <p>Theme: Governance</p> | <p>The absence of a defined governance interface increases the likelihood that UEC decisions will be delayed, duplicated, or inconsistent, undermining clear accountability across statutory partners.</p> <p>High Priority</p> <p>Control Design</p> | <p>Agreed Action:</p> <p><i>As noted above review of UEC and RPB Governance (and associated interface) undertaken at national UEC Summit. RACI review to be undertaken to confirm roles and responsibilities per organisation in delivery of improvement activity.</i></p> <p><i>Specifically agreed that all activity under UEC banner be aligned and to match with national key pillars of:</i></p> <ul style="list-style-type: none"> • Pillar 1: Pre-Hospital & Community • Pillar 2: Front Door & First 72 Hours • Pillar 3: Ward based flow & discharge <p><i>Noted that all this activity be monitored/ driven by SBUHB UEC Board. Any escalations from said UEC Board to SBUHB Executive Team and to Communities & Older Persons Board (RPB). Ask from UEC Board for 'whole system' solutions to take place within UEC Board (in-meeting to RPB representatives) and furthermore within Communities and Older Persons Board (RPB) e.g. potential activity relating to D2RA/ POCD.</i></p> <p><i>Updated TOR to highlight interface and escalation routes to be developed and this will include reference/ alignment to the RACI review. Furthermore, post-implementation of new governance model, action notes/ minutes of meeting(s) will be able to be shared to evidence the operation of escalation mechanism in practice.</i></p> <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • RACI review – May 26 • Updated Governance structure and updated UEC Board documentation (e.g. TOR, monitoring templates) – May 26 • Roll-out of new structure and reporting mechanism – June 26 <p>Officer: Deb Lewis, Chief Operating Officer Target Implementation Date: 30 June 2026</p> |

Group alignment

We reviewed agendas and minutes from the UECPB and COPB for the period May 2025 to January 2026. Both forums demonstrated clear recognition of shared system pressures and strong alignment in their priorities, with consistent focus on key workstreams such as D2RA, POCD, Pathway 2, community capacity, and falls. While agenda overlap is evident, the forums approach these issues from complementary perspectives: the UECPB emphasises acute operational pressures, ambulance handover performance and tests of change; whereas the COPB concentrates on the community-based enablers required to sustain flow, including reablement capacity, workforce and intermediate care pathways.

While UEC-related workstreams now progress through the COPB under regional ICCS arrangements, the health board still requires its own UEC governance mechanism to maintain oversight of delivery and ensure a direct organisational link to the national Six Goals programme. The UECPB fulfils this role by bringing together senior clinical, nursing, operational and national system representatives to review acute pressures, monitor performance indicators, oversee tests of change and ensure national expectations and funding requirements are embedded within local arrangements.

During December 2025 and January 2026, Welsh Government mandated two fortnightly national Winter Sprints introduced intensive, short-term operational focus on managing long-stay patients and improving flow across acute and community settings. COPB minutes and health board analyses show increased multidisciplinary attendance, with 38 complex cases reviewed, 21 discharged, 3 further discharge plans agreed and over 1,300 delay-days removed. However, while the Winter Sprints achieved progress in its targeted long-stay focus, some wider flow and discharge indicators (ambulance handover compliance, morning bed waits, midday discharges and Discharge Lounge activity) deteriorated during and immediately after the Winter Sprints, indicating that underlying operational pressures did not improve in parallel.

Progress against workstream goals

Progress across key UEC workstreams has been affected by their interdependent nature, with delays in one area inevitably impacting the pace of others. Evidence from minutes, highlight reports and discussions indicates that operational pressures, workforce constraints, differing digital capabilities, and variations in organisational prioritisation have all contributed to slippage against initial timelines for completion between May–September 2025, with several elements continuing into 2026. While some areas are now approaching resolution, such as development of an overarching discharge policy (targeted for August 2025 ratification, now expected to be presented for approval to COPB in April 2026), others, including the Trusted Assessor model and resourcing for the IDH, remain subject to more significant and unresolved delays (**see Key Finding 3**).

Notwithstanding these challenges, there has been notable progress within specific elements, for example, the operational use of the front-door Trusted Assessor form, ongoing development and application of an operational standard operating procedure for the IDH, active modelling and workshop activity within Pathway 2, and continued advancement of a regional Falls Response programme.

POCD Escalation Framework compliance

The health board operates a well-established bronze-to-silver huddle structure to provide oversight of patient flow, including capacity, staffing pressures and discharge activity across acute and community services. Our observations confirmed linkage from these huddles into the twice-weekly multi-agency POCD reviews. Escalations to address discharge delays are frequent and often driven by operational pressures due to the high number of COP on acute sites.

However, review of a sample of patient record on SIGNAL (the health board's patient flow system) identified adherence to the POCD Escalation Framework was inconsistent. Examples included bypassing early escalation tiers (issues directed immediately to senior officers rather than operational leads), and missed opportunities to flag delays in allocations and assessments (see **Key Finding 4**). Although enhanced reporting within the IDH, assisted by refinement of its reporting dashboard, could strengthen proactive oversight, longstanding resourcing constraints limit the extent to which this functionality can currently be utilised.

Health board reporting

The Planning & Partnerships report has improved Board-level visibility of RPB developments and regional transformation activity, but its focus remains on collaborative work rather than providing health-board-specific operational assurance. Although the UECPB does not report directly to the Board, updates on performance, service pressures and key initiatives are routinely presented to the Performance and Finance Committee, which provides a route for escalation of significant issues where required.






| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|
| <p>3 Absence of Workstream Escalation</p> <p>Progress across several priority UEC workstreams has stalled because no formal decision-making or escalation mechanism exists for partnership-dependent matters. As a result, workstreams have experienced repeated slippage, with minutes and highlight reports showing ongoing discussion but limited movement to agreed actions or timelines.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Policy and Procedure Framework: Originally intended for ratification in August 2025, but repeatedly delayed due to operational pressures within the health board. Revised dates have been pushed back several times, and we are advised that it is expected to be presented for approval in April 2026. • Trusted Assessor Model: Targeted for completion between June–September 2025 but remains ongoing. While the approach has been adopted at the health boards 'front door', its full impact is limited due to non-adoption by some local authorities and private care homes, alongside the absence of a fully resourced IDH to embed its wider use. <p>IDH Model & Resourcing: A resourcing paper was submitted to the COPB in July 2025; however, COPB minutes for July, September and October show no agreed outcome. A recent</p> | <p>Without a clear decision route or escalation mechanism, system-critical changes are at risk of delay, duplication, or non-delivery, reducing assurance of timely and coordinated implementation.</p> | <p>Agreed Action:</p> <p><i>All activity to be monitored / driven by SBUHB UEC Board. Any escalations from said UEC Board to SBUHB Executive Team and to Communities & Older Persons Board (RPB). Ask from UEC Board for 'whole system' solutions to take place within UEC Board (in-meeting to RPB representatives) and furthermore within Communities and Older Persons Board (RPB) e.g. potential activity relating to D2RA/ POCD.</i></p> <p><i>An updated TOR to highlight interface and escalation routes. will be developed. It is anticipated that if milestones or timescales are repeatedly missed (e.g. for 3 consecutive months) an escalation report / communication will be carried out e.g. to Executive Team</i></p> <p><i>Named leads have been agreed for each 'pillar'/ programme. Escalation regarding stalled progress of projects under a strategic pillar / programmes will be to Pillar/ Programme lead and (if unable to be resolved by said lead) to UEC Board and RPB structures (as required).</i></p> |

| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|--|
| <p>external assessment of the IDH has highlighted significant workforce gaps, an unstable staffing model, lack of administrative and therapy support, and its potential effectiveness constrained by the number of services unable to access the IDH.</p> <p>Where progress has stalled, it remains unclear how blockages will be resolved, creating ongoing risk of prolonged delay and inconsistent system coordination across partners.</p> | <p style="text-align: center; background-color: red; color: white; font-weight: bold;">High Priority</p> | <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • RACI review – May 26 • Updated Governance structure and updated UEC Board documentation (e.g. TOR, monitoring templates) – May 26 • Roll-out of new structure and reporting mechanism – June 26 • Roll-out of named leads – May 26 <p>Officer: Deb Lewis, Chief Operating Officer, in conjunction with UEC Pillar leads:</p> <p>Pillar 1: Pre-Hospital & Community – Dr Claire Dieppe, UEC Clinical Lead</p> <p>Pillar 2: Front Door & first 72 hours – Dr Rhodri Edwards, Associate Medical Director, Morriston Service Group</p> <p>Pillar 3: Ward based flow & Discharge – Alison Gallagher, Associate Director of UEC, Emily Davies Associate Service Group Director, Primary Community and Therapies Service Group</p> |
| <p>Theme: Planning, Delivery & Deadline Management</p> | <p>Control Operation</p> | <p>Target Implementation Date: 30 June 2026</p> |
| <p>4 Non-compliance with the POCD Escalation Framework</p> <p>Testing of ten clinically optimised patients (COP) found multiple instances of non-compliance with the POCD Escalation Framework, including:</p> <ul style="list-style-type: none"> • Escalations raised prematurely: two of 10 cases were escalated before COP status had been confirmed. • Escalation without IDH involvement: two of 10 cases were escalated without reference to the IDH. • Tier 1 steps bypassed: five of 10 cases progressed directly to Tier 2 without required Tier 1 contact or time-bound attempts. • Missed escalation opportunities: we noted seven of ten cases did not meet expected timescales but received no escalation, including one case where a social worker | <p>Non-compliance with the escalation framework increases the risk of delayed discharge, reduced patient flow, and inconsistent application of statutory responsibilities across partners.</p> | <p>Agreed Action:</p> <p><i>POCD to be reviewed consistently via UEC Board. National dashboard (monthly census) to be used as primary tool for reviewing progress. Key metrics to be reviewed to include:</i></p> <ul style="list-style-type: none"> • Total number of delays • Total days delayed • Delay code reasons • Assessment delays <p><i>All the above to be monitored month on month (and cumulatively across year for trends)</i></p> <p><i>Monthly the operational lead regarding POCD brings relevant materials (see earlier reference to pillar/ programme/ project reporting template) to each UEC Board meeting for routine reporting (and escalation if appropriate). Anticipated a fuller review take place at year end (i.e. 12-month trend) while the</i></p> |

| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|--|
| <p>allocation was outstanding for a month with no visible escalation within SIGNAL.</p> <p>Multiple communication routes (email, MS Teams, SIGNAL) make escalation activity difficult to track reliably. Additionally, the escalation monitoring spreadsheet referenced in the Framework is not in use due to limited administrative support.</p> | <p style="text-align: center;">High Priority</p> | <p><i>option of a deep dive on a particular 'problematic area' could be taken forward in-year. Important to note though that any actions to resolve a challenging area (i.e. assessment capacity to match period of high demand) may involve additional resource to implement.</i></p> <p><i>Monthly the operational lead regarding POCD brings relevant materials (see earlier reference to pillar/ programme/ project reporting template) to each UEC Board meeting for routine reporting (and escalation if appropriate).</i></p> <p>Expected Evidence of Implementation:</p> <p><i>Routine reporting of POCD to UECPB highlighting key metrics.</i></p> <p><i>UECPB minutes including evidence of management monitoring and escalation (if appropriate).</i></p> <p>Officer: Deb Lewis, Chief Operating Officer, in conjunction with UEC Pillar leads:</p> <p>Pillar 3: Ward based flow & Discharge – Alison Gallagher, Associate Director of UEC, Emily Davies Associate Service Group Director, Primary Community and Therapies Service Group</p> <p>Target Implementation Date: 30 June 2026</p> |
| <p>Theme: Performance Monitoring</p> | <p>Control Operation</p> | |

Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

| | | |
|--|-----------------------|--|
|  | Substantial | Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. |
|  | Reasonable | Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. |
|  | Limited | More significant matters require management attention. Moderate impact on residual risk exposure until resolved. |
|  | Unsatisfactory | Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. |
|  | Advisory | 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 Findings

| Priority | Explanation |
|---------------|--|
| High | Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance. |
| Medium | Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance. |

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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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.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the 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.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

