Bundle Audit & Risk Assurance Committee 25 August 2020

7.1 Audit Tracker

Presenter: Joanne Wilson

SBAR Audit Tracker ARAC August 2020

Appendix 1 - High Priority Recommendations

Appendix 2 - In Progress and Overdue Recommendations

Appendix 3 - Reports Opened & Closed Since June 2020

Appendix 4 - Strategic Log

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 August 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	UHB Central Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Williams, Assurance and Risk Administrator Claire Bird, Assurance and Risk Officer Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit and Risk Assurance Committee (ARAC) with progress in respect of the implementation of recommendations from audits and inspections.

Cefndir / Background

Audits, inspections and reviews play an important independent role in providing the Board with assurance on internal controls and that systems and processes are sufficiently comprehensive and operating effectively. Therefore it is essential that recommendations from audits, inspections and reviews are implemented in a timely way.

All reports from audits, reviews and inspections carried out across the UHB are logged onto the UHB central tracker and prior to COVID-19, progress on implementing recommendations was collated from services on a quarterly basis in preparation for the Executive Performance Reviews (EPRs) (these were suspended in March 2020).

At the Board in April 2020, the Board considered how outstanding recommendations from auditors, inspectorates and regulators should be managed by the Health Board during the pandemic. The Board agreed that as a minimum, the following recommendations must be progressed, as planned or in line with revised timescales:

- Immediate improvement recommendations from Healthcare Inspectorate Wales (HIW).
- Enforcement notices from the Mid and West Wales Fire and Rescue Service (MWWFRS)
- Improvement Notices and material breaches from Health and Safety Executive (HSE).
- High priority recommendations from Internal Audit (IA) and Audit Wales (AW)

In addition to the above, services were asked to review all other outstanding recommendations to assess whether they can be implemented within planned timescales taking into account the current and ongoing impact of COVID-19. The outcome of this work was reported to the Committee at its previous meeting.

Asesiad / Assessment

Management of outstanding recommendations during COVID-19

At the previous meeting, the assurance and risk team advised that they would:

- Escalate non-responses to relevant Executive Director – *services have provided a response on all recommendations and an escalation process is in place.*
- In the absence of the Executive Performance Reviews, implement a rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Committee – *this was implemented from the first week of July therefore the Tracker will only reflect the responses from services that have been contacted up to end of July 2020. An escalation process is in place for non-responses from services.*
- Work with services to establish how risks relating to delayed recommendations will be managed in the interim and ensuring these are added onto the Datix risk module (as appropriate) – *further work to do in this area, as agreed actions do not always materialise following discussions.*

The table below sets out a summary of the current status of the high priority recommendations. Appendix 1 provides an individual breakdown.

External Body	High Priority Recommendations	Update summary
HIW Immediate Assurance	3 Immediate improvement recommendations	2 of the 3 immediate improvement recommendations have gone beyond their original timescales. These recommendations relate to the update of the Venous Thromboembolism (VTE) policy and Disclosure and Barring Service (DBS) certificates. No change since last meeting.
HSE	32 recommendations from 8 improvement notices and 13 material breaches.	26 of the 32 recommendations have revised timescales that now exceed the HSE revised compliance date of 31/07/20. The remaining 6 recommendations were due to be completed by the end of July 2020. Confirmation of this will be sought with the service through the rolling programme and through updates provided to the Health and Safety Assurance Committee (next meeting 07/09/20). The UHB responded to HSE on 28/07/2020 with regards to questions they had raised on specific improvement notices and material breaches. A response has not yet been received.
MWWFRS	28 recommendations	MWWFRS have issued new dates for compliance for the following enforcement notices: KS/890/02 WGH (revised timescale 16/01/21) KS/890/03 WGH (revised timescale 31/12/21)

		KS/890/05 St Caradogs (revised timescale 16/02/21) KS/890/06 WGH (revised timescale 16/02/21) The extensions provided by MWWFRS do not correspond to the programme of work the Estates team provided to MWWFRS therefore 6 of the recommendations do not seem to be included within extended timescales provided by MWWFRS. The Estates team are currently liaising with MWWFRS for clarification. 1 enforcement notice KS/890/04 (WGH) and the 3 Letters of Fire Safety Matters have not been issued with new dates for compliance by MWWFRS. 11 recommendations against these are behind schedule. The Director of Estates, Facilities and Capital Management will provide a detailed report to the Health and Safety Assurance Committee on 07/09/2020 following clarification with the MWWFRS.
Audit Wales (AW) and Internal Audit (IA)	All 'high' priority recommendations AW – 12 IA - 35	All 12 AW recommendations are red RAG status. 7 of these do not have a revised date and these will be updated through the rolling programme. 18 of the 35 IA recommendations are red RAG status. The revised timescales for 6 recommendations will be clarified with the appropriate services through rolling programme.

Appendix 2 provides a list of other recommendations that still need to be implemented (these are RAG rated amber (in progress and on schedule) or red (behind schedule)). It does not include recommendations from HIW and CHC reports relating to inspections of independent contractors (i.e. GP and dental practice not managed by the UHB). The practices remain directly accountable for implementing these recommendations.

There are 39 recommendations that do not have revised timescales (45 reported at previous meeting). This may be due to the service not providing a clear enough response, which is currently being followed up, staffing pressures from responding to COVID-19 or staff have been redeployed, or due to COVID-19 the service may not be in a position to provide a revised timescale at this point in time. The unpredictability of the pandemic makes it difficult to predict when some services will resume and restarting services can bring capacity challenges.

UHB Central Tracker

Since June 2020, a further 27 reports have been closed or superseded, with 16 new reports received by the UHB. These are listed in Appendix 3.

As of 10 August, there are 124 reports currently open, 95 of which have recommendations that have exceeded their original completion date. The number of recommendations where the original implementation date has passed has increased from 182 to 202. Of the 202 recommendations that are overdue, 80 have gone beyond six months of the original completion date.

Of the 202 overdue recommendations 9 have been highlighted on the tracker as an 'external recommendation' whereby the recommendation is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

Below is a summary of activity on the audit tracker since it was last reported to ARAC in June 2020.

	No of reports open at ARAC Jun-20	**No of reports received since ARAC Jun-20**	**No of reports closed since ARAC Jun-20**	**No of reports open at ARAC Aug-20**	**No of reports that have passed their original implement-ation date**	**No of red recommend -dations i.e., Original implementat-ion date has passed or will not be met**	**No of red recommend -ations beyond 6 months of original completion date**
AW	15	0	1	14	12	22	14
CHC	7	0	1	6	5	9	6
CHC / HIW Contractors	10	1	6	5	5	8	0
Coroner Reg 28	1	0	1	0	0	0	0
DU	6	0	0	6	6	15	7
HEIW	0	0	0	0	0	0	0
HSE	21	0	0	21	19	32	0
HIW (Acute & Community)	9	1	1	9	7	15	5
HIW (MH&LD)	6	0	0	6	6	17	15
IA	34	10	11	33	21	45	25
MWWFRS	8	0	0	8	4	11	1
Peer Reviews	3	0	0	3	3	10	7
PSOW - S16	0	0	0	0	0	0	0
PSOW - S21	11	4	6	9	1	1	0
Royal Colleges	1	0	0	1	0	0	0
Other	1	0	0	1	1	5	0
WLC	2	0	0	2	2	6	0
TOTAL	**135**	**16**	**27**	**124**	**95**	**202**	**80**

Strategic log - progress of recommendations

The strategic log including current progress is attached in Appendix 4. Since the last report to the Committee in September 2019, there have been the following changes:

- 1 recommendation has been added following approval by the Executive Team in November 2019 which related to WHC 002-16 - Principles, Framework and National Indicators: Adult In-Patient Falls.
- 4 recommendations have been closed as per below

Consultant Radiologist recruitment (Breast Cancer Peer Review)
The breast service is now fully supported with two breast radiologist and a consultant mammographer. Substantive and Locum Consultants recruited over the last 12 months. Global Fellows, a Royal College initiative has resulted in two appointees (specialty doctors) who are now going through the on-boarding process.

Consultant Radiologist recruitment (Haematology Cancer Peer Review)
The UHB has employed one further Consultant Radiologist who commenced employment on 19/08/19.

Staff support structure for GP services (Internal Audit GP Practices serving contractual notice 2017)
Two vacancies were filled from December 2019 resulting in the full complement of Primary Care Services Managers required by the Organisational Change Process. There have been subsequent resignations (June 2020) and these are now back out to recruitment for that post, however the service is not expecting a gap in the workforce.

Lack of Glaucoma Nurse Specialist posts (specific recommendation relating to DU Focus on Ophthalmology: Assurance Reviews)
Following a successful bid for eye care sustainability funding, the Glaucoma nurse specialist post was no longer required once the Community Data Capture project commenced.

Argymhelliad / Recommendation

The Committee is asked to take an assurance on the following:

- Executive Directors and lead Officers understand that there is still the expectation that outstanding recommendations from auditors, inspectorates and regulators should continue to be implemented during COVID-19, to ensure services are safe and the risk of harm to patients and staff is managed and minimised
- The rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Committee.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW- Audit Wales (previously WAO (Wales Audit Office)) CHC- Community Health Council CIW – Care Inspectorate Wales DU- Delivery Unit HEIW-Health Education and Improvement Wales HIW- Health Inspectorate Wales HSE- Health and Safety Executive IA- Internal Audit MWWFRS – Mid & West Wales Fire & Rescue Service NWIS – NHS Wales Informatics Service PSOW- Public Services Ombudsman for Wales SSU – Specialist Services Unit UHB – University Health Board WLC- Welsh Language Commissioner
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.

Gweithlu: **Workforce:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: **Risk:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and identified risks are not being managed.
Cyfreithiol: **Legal:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: **Reputational:**	As above.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	No direct impacts from this report

Appendix 1: High Priority Recommendations

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_001	High	R3a. Calculate a baseline position for its current investment and resource use in primary and community care.	The Health Board need to set the baseline for expenditure in primary and community care based on the information used to produce its audited annual accounts. A plan for implementation of the baseline needs to be compiled and implemented to reflect services at 31st March 2019. Changes will then be measured relative to this baseline annually.	Apr-19	N/K	Red	Assurance and Risk Officer requested update from Finance Senior Business Partner on behalf of reporting officer. Finance Senior Business Partner confirmed he will need to discuss with reporting officer when she returns from leave.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_002	High	R3b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	The shift of resources into primary and community care can be monitored on an annual basis using the information that forms the basis of the Health Board's audited accounts. The shift of resources needs to be measured in accordance with the national paper dealing with the transfer of services and resources to primary care.	Apr-19	May-20	Red	Assurance and Risk Officer requested update from Finance Senior Business Partner on behalf of reporting officer. Finance Senior Business Partner confirmed he will need to discuss with reporting officer when she returns from leave.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_003	High	R5b. Revisit its primary care workforce plans to ensure they take account of the issues arising from the Transforming Clinical Services programme.	Work is ongoing to understand the current staffing within primary care across the contractor professions to ensure that the Primary Care Model for Wales is implemented.	Oct-19	N/K	Red	Response from Director of Primary Care, Community and Long Term Care- it should ultimately align to our strategy and what we want to see from Practices in that context. However where it becomes challenging is that whether or not we were linking nationally or locally, we still need to access the data and the only way in which we can get the accurate workforce data is through the national reporting tool which will then allow us to align our plans with our local Strategy. No revised timescale provided.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_004	High	R7b. Subject to positive evaluation, begin to fund new models from mainstream funding rather than the Primary Care Development Fund.	To be considered in line with the Primary Care Model for Wales, the IMTP and the shift of funding within the system to support service change and remodelling.	Oct-19	N/K	Red	No update provided. Reporting officer responded due to other pressures she may not be able to respond with update before commencing leave.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_005	High	R7c. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments	Public engagement plan regarding access to all primary care services to be developed and implemented.	Oct-19	N/K	Red	No update provided. Reporting officer responded due to other pressures she may not be able to respond with update before commencing leave.
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Nursing	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual001	High	R1. To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.	Options for standardising the approach to quality and safety arrangements have been agreed. This includes templates for terms of reference, agendas for meetings and standardised reporting. Templates will be developed in collaboration with the Corporate Governance Team. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Quality and safety matters are included in the county directors meetings and this will be monitored.	Apr-20	Sep-20	Red	Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements to ensure agreed core agenda items are discussed. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Monthly focused QSEAC meetings have been scheduled during the COVID-19 pandemic to deal with urgent Q&S issues/risks. As a result OQSESC meetings are temporarily on hold to reduce the burden on operational staff dealing with the pandemic. This will be monitored through the standardised reporting arrangements put in place. Revised timescale of September 2020.
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Nursing	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual003	High	R3c. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should align all directorate level governance committees, so they report directly to the Operational QSESC.	R3c. Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC.	Apr-20	Sep-20	Red	R3c - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements to ensure all directorate level governance committees report in a standardised way to OQSESC. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Revised timescales of Sept 2020 provided.
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Nursing	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual003	High	R3d. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC	R3d. Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1).	Apr-20	Sep-20	Red	R3d - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Standardised reporting templates will be introduced for all Directorates to submit to the Operational QSESC, with a summarised version submitted to QSEAC. Revised timescales of Sept 2020 provided.
1033A2019-20	Jan-19	Audit Wales	Structured Assessment 2018	Open	N/A	Governance	Director of Planning, Performance & Commissioning / Director of Operations	Board Secretary	WAO_SA_2018_003	High	R3a. Recommendation - Operational meetings To free up capacity for both executive and operational teams, and to enable a more joined up focus on the use of resources, the Health Board should streamline the number of holding to account (HTA) or performance review meetings with operational teams by: (a) reviewing the frequency and timing of these meetings;	~~Ensure the Holding To Account (HTA) meetings merge with the Executive Team Performance Reviews (ETPR) from April 2020 as this will reduce the burden on service leads and will make it more feasible for medical leads to attend (see R3c below for further details);~~ ~~Consideration to be given to the scheduling of the new meetings. ETPR meetings are currently held on Wednesday mornings to protect Wednesdays as a corporate day, with Executive Team meetings scheduled on Wednesday afternoons. However, Clinical Directors have since advised their attendance at the ETPRs will be increased if the reviews are scheduled for Thursday mornings to coincide with their protected time for managerial meetings (see R3c below).~~ ~~The Executive to continue to have ongoing discussions relating to performance management arrangements as part of the Board governance review and review of managerial arrangements in the Operations Directorate. A new Performance Management Assurance Framework will be presented to Board for approval on 26th March 2020. A schedule and agenda outline will be developed for the new combined meetings by 31st March 2020. The Principal Project Manager for Turnaround and the Performance Manager will lead on developing the new performance review schedule and agenda.~~ The previous intention was to merge the Holding To Account (HTA) meetings with the Executive Team Performance Reviews (ETPR) in quarter one 2020/21, with the aim to reduce the burden on service leads and make it more feasible for medical leads to attend. However, the COVID-19 pandemic has seen a shift from a parent-to-child relationship to adult-to-adult across the organisation with increased engagement from staff which we want to build on. Performance management is most effective when an organisation has agreed goals that all staff are aware of and can contribute to. During 2020/21 we will: • Through the Transformation Steering Group, scope and agree organisational goals which will be embedded into our Integrated Medium Term Plan (IMTP) and communicated to staff. • Identify key performance indicators to monitor progress and determine success. • Build corporate performance dashboards to provide service leads with all relevant information in one place to identify issues and improve performance. The dashboards will cover a wide variety of areas e.g. sickness, PADR, core skills, finance, risk management, incidents, concerns, NHS delivery framework. • Develop a new mechanism for performance managing areas against the new organisational goals and corporate priorities. • Revise our Performance Management Assurance Framework to capture the new arrangements. Consideration to be given to the scheduling of new meetings to allow Clinical Directors to attend (Thursday morning are preferable for this).	Jun-19	~~Apr-20~~ Mar-21	Red	~~• On 17 February 2020, the CEO led a workshop with Executive Team members/nominated deputies and presented a proposed new operating model for 2020/21. The new model was structured around our three year plan actions, organisational risks and performance management. The new model looked to merge HTA and EPR meetings into the same process to reduce the burden on service leads. Executive Directors would be given greater responsibility for performance management within their directorate. Service areas would only be seen by the CEO twice a year (ahead of JET meetings) or if a performance trigger was met. Following the workshop, work began on scoping performance triggers and what groups were already in place and new ones needed to oversee the key elements of the new operating model i.e. plan actions, risks and performance management.~~ ~~• In early March the scoping work for the new operating model was put on hold to allow staff time to prepare for and manage the COVID pandemic.~~ ~~• Alongside this, the EPR meetings were also stood down to give staff more time to focus on COVID related tasks. At present, there are no plans to resume the EPR meetings.~~ ~~• A new Transformation Steering Group has been established, with the first meeting held on 8 June 2020. This group will refresh our thinking and determine what our priorities will now be for the new operating model, in light of COVID.~~ • On 15 and 17 July the Transformation Steering Group held design sessions to seek opinions on what the organisational goals should be for Hywel Dda. Alongside this the Transformation Programme Office (TPO) also sought opinions from clinical leads across the organisation through staff interviews. Combined these flagged the need to concentrate on actions to improve: o Joy at work o Digitally enabled working o Social model for health o Decision making, empowerment and leadership o Care pathway - prevention o Care pathway - treatment o Care pathway - access and coordination o Care pathway – transfer / discharge and ongoing support • The Director of Finance has established a Corporate Performance Dashboard Steering Group to oversee the development of the corporate dashboards. The group met on 9 and 21 July; it is chaired by the Director of Finance and the project is being managed by the Performance Manager. Phase 1 of the project aims to build dashboards for workforce, finance and risk management with close links from the relevant corporate leads, Informatics and the Performance Team. On 22 July a workshop was held to discuss performance management and alignment to priorities. The session was arranged by the Director of Finance and facilitated by KPMG. Some key findings of the session were the need to identify common objectives/goals and align performance management accordingly.
1033A2019-20	Jan-19	Audit Wales	Structured Assessment 2018	Open	N/A	Governance	Medical Director / Director of Operations	Board Secretary	WAO_SA_2018_003	High	R3c. Recommendation - Operational meetings To free up capacity for both executive and operational teams, and to enable a more joined up focus on the use of resources, the Health Board should streamline the number of holding to account (HTA) or performance review meetings with operational teams by: (c) aligning these meetings with management sessions contained within job plans for clinical directors to enable them to participate fully.	The Deputy Medical Director for Acute Hospital Services is now in post and has been working to fill vacancies within the clinical leadership structure, which will help to strengthen medical representation at operational meetings. The Deputy Medical Director for Acute Hospital Services will communicate the need for job plans for those clinicians holding managerial and leadership positions to be robust and for protected time to be allocated to enable clinical director engagement with relevant executive and operational meetings. The job plans of clinical leads need to ensure that leadership responsibilities can be managed and prioritised accordingly. Details of meetings requiring attendance need to be regular and consistent with sufficient advance communication to be provided of any changes to meeting arrangements (at least 6 weeks if the change results in a clash with clinical commitments) to enable clinicians/medical leads to attend without the risk of any disruption to service provision.	Apr-20	~~Sep-20~~ Dec-20	Red	The review of all job plans in the current and post-CV19 period is being agreed with Clinical Leads/Hospital Directors. The allocation of time to allow Clinical Directors and Senior leaders to attend management meetings (including ETPR's) will be included within this process. Assurance on the process of job planning, and the evolving amendments of job plans within revised operational plans, has been provided to ARAC; and a revised compliance plan, including timescales for completion in-line with GMC expectations for revalidation.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_002	High	R2. We found that the Executive Performance Reviews (EPRs) do not apply to corporate directorates, with the exception of Estates. The Health Board should apply EPRs to corporate directorates not already covered within the process.	The Health Board agrees corporate directorates should also be included in the EPRs. ~~The Executive continue to have discussions relating to performance management arrangements as part of the Board governance review and review of managerial arrangements in the Operations Directorate. A new Performance Management Assurance Framework will be presented to Board for approval on 26th March 2020, this will include the merger of the existing EPRs and Holding To Account meetings as well as the inclusion of corporate teams in the performance review process. A schedule and agenda outline will be developed for the new meetings by 31st March 2020. The Principal Project Manager for Turnaround and the Performance Manager will lead on developing the new performance review schedule and agenda.~~ A new Performance Management Assurance Framework will be developed and will focus on agreed organisational goals with supporting key performance indicators. These will cut across both operational and corporate teams for which a new mechanism will be developed to performance manage effectively. See the 2018 R3a response for further details.	Apr-20	Mar-21	Red	~~• On 17 February 2020 the CEO led a workshop with Executive Team members / nominated deputies and presented a proposed new operating model for 2020/21. The new model was structured around our three year plan actions, organisational risks and performance management. The model was health board wide i.e. included corporate directorates. Following the workshop, work began on scoping performance triggers plus what groups were already in place and what new groups were needed to oversee the key elements of the new operating model i.e. plan actions, risks and performance management.~~ ~~• In early March the scoping work for the new operating model was put on hold to allow staff time to prepare for and manage the COVID pandemic. Alongside this, the EPR meetings were also stood down to give staff more time to focus on COVID related tasks. At present there are no plans to resume the EPR meetings.~~ ~~A new Transformation Steering Group has been established, with the first meeting scheduled for 8 June 2020. This group will refresh our thinking and determine what our priorities will now be for the new operating model, in light of COVID.~~ • On 15 and 17 July the Transformation Steering Group held design sessions to seek opinions on what the organisational goals should be for Hywel Dda. Alongside this the Transformation Programme Office (TPO) also sought opinions from clinical leads across the organisation through staff interviews. Combined these flagged the need to concentrate on actions to improve: o Joy at work o Digitally enabled working o Social model for health o Decision making, empowerment and leadership o Care pathway - prevention o Care pathway - treatment o Care pathway - access and coordination o Care pathway – transfer / discharge and ongoing support • The Director of Finance has established a Corporate Performance Dashboard Steering Group to oversee the development of the corporate dashboards. The group met on 9 and 21 July; it is chaired by the Director of Finance and the project is being managed by the Performance Manager. Phase 1 of the project aims to build dashboards for workforce, finance and risk management with close links from the relevant corporate leads, Informatics and the Performance Team. • On 22 July a workshop was held to discuss performance management and alignment to priorities. The session was arranged by the Director of Finance and facilitated by KPMG. Some key findings of the session were the need to identify common objectives/goals and align performance management accordingly.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Through the appointment of the clinical team within the TPO there is a focused direction of reaching the workforce to become engaged in delivering the Strategy. Leads are attending meetings within service areas to increase awareness, understanding and help staff to become involved.	Apr-20	Oct-20	Red	Prior to the COVID-19 pandemic, leads had been attending meetings and holding workshops within service areas to increase awareness, understanding and help staff to become involved. Since March 2020, the clinical leads have been required to focus on operational service delivery. However, they continue to support colleagues to link the developments during the Health Board response to delivery of the Strategy. The clinical team will support colleagues with the priorities and pathway developments.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Formation of a core clinical group, comprising of the Associate Medical Director of Acute Services, Associate Medical Director of Primary Care, Associate Medical Director Transformation, Lead for Therapies & Health Sciences, Lead for Nursing, Medicines Management Lead.	Feb-20	Oct-20	Red	Group developed however, the members focus has been on operational clinical delivery since the pandemic. Discussions will be required to determine support for the Transformation Steering Group ~~and following the multi-stakeholder Design workshop.~~
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	•Use a Continuous discovery approach where information will be gathered and analysed on a continuous basis, and fed to staff to support our ongoing work to deliver the strategy. This approach includes detailed engagement with our staff during the 'discover' phase for individual projects. ~~Re-introduce workplace champions (developed during the Transforming Clinical Services programme Discover and Design phases) in 2020 for delivery of the Strategy.~~	Jul-20	Oct-20	Red	Planning is underway following agreement of priorities and pathway transformation required to be undertaken following the Design workshop and direction from Transformation Steering Group. Following the agreement of priorities, we will agree the methods for broad engagement with the wider population and staff. ~~This development has been impacted by the pandemic but planning is underway that will be informed following agreement of priorities and pathway transformation required to be undertaken following the Design workshop. An Engagement Strategy will be developed by end of July 2020.~~
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	•Development of a Communications strategy to share developments and to engage with wider staff to empower them to become involved in transformation projects. ~~Development of the use of a newsletter to engage with wider staff to empower them to contact clinical and project leads and become involved transformation projects and in champion roles.~~	Jun-20	Sep-20	Red	The transformation programme office are working with the communication team in the development of a communication strategy including the use of intranet pages, a newsletter and blogs to engage with wider staff. ~~This has been delayed due to COVID. However, the transformation programme office are working with communication team in the development of a communication strategy including the use of a newsletter and blogs to engage with wider staff.~~
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Cohort 2 of the EQIip programme have ensured projects identified are supportive of teams delivering change projects in line with the Strategic direction.	Apr-20	N/K	Red	Cohort 2 of EQIIP has been placed on hold due to COVID. The projects initially chosen by selected teams will now need to be reviewed to ensure their continued relevance in light of service changes associated with the operational response to COVID and how services will be 'reset'. Team projects will align to improvements which reflect the UHB Risk Register and/or the strategic priorities. The start date for cohort 2 will be determined by the level of COVID related service activity.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Development of the "Hywel Dda Way", a single gateway-managed process, standardised for all change programmes, large and small, that wraps governance and control around delivery whilst supporting all staff to be involved and lead in change; Providing project buddy system to advise and guide change projects, alongside appropriate project management skills development and training.	Jul-20	Oct-20	Red	This has been impacted by COVID and the requirement to focus on supporting operational delivery. Discussions are required to align the process with new governance arrangements that are being phased in. Clear guidance and templates will be utilised and support will be provided to empower staff with transformation projects.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Development of social media platform for the strategy delivery programmes and Transformation Programme Office to celebrate success and share updates and strategy delivery news.	Jul-20	N/K	Red	No update received.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Medical Director/Director of Planning, Performance and Commissioning	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Continuation of leadership development programme delivery for: System Level Leadership for Improvement (SLLIP, Aspiring Medical Leaders Programme (AMLP), Medical Leadership Forum (MLF), Senior Nurse Leadership Development (STAR), with alignment to strategy direction and feeding in programme cohort graduates into involvement on priority change projects	Apr-20	N/K	Red	All leadership programmes continue to be delivered and expanded. A workshop was held with all participants on the leadership programmes to discuss how they could become more involved in shaping the delivery of the strategy moving forward. Regrettably COVID-19 has impacted on these programmes. However regular contact and support has been provided to participants as well as coaching provision to enable them to continue on their leadership journey. Discussions are underway to establish new ways of connectivity to enable group learning to be reviewed later this year.
JHET/HD/04102019/01	04/10/2019	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19 IN1	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/01_001	High	R1. Establish a management system to monitor and review the implementation of your Violence and Aggression Policy number 285. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	Outstanding action- Further improvements are being made to the Datix recording system in terms of V&A, with a Case Management module currently being developed.	May-20 Jul-20	Jul-20 Oct-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Due to COVID-19 rec won't be full implemented until October 2020.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experiences	JHET/HD/04102019/02_001	High	R1. Establish a management system to monitor and review the implementation of your Manual Handling Policy number 273. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	Critically review the Manual Handling Policy to ensure that it is fit for purpose. Request assistance of General Managers in achieving aims. Increase moving and handling risk assessments where required. Introduction of new Moving & Handling risk assessment paperwork to standardise nursing documentation across Wales. Link to Incident Investigation Control Group.	May-20 Jul-20	Oct-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_002	High	R2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	May-20 Jul-20	Oct-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_004	High	R4. Identify how the findings from monitoring, auditing and review will be considered and consulted on, and responsibilities allocated to ensure that suitable and timely action is taken and completed.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	May-20 Jul-20	Dec-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.

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JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_005	High	R5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	May-20 Jul-20	Apr-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.
JHET/HD/04102019/03	04/10/2019	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19 IN3	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/03_001	High	R1. In consultation with employees or their representatives, and with the assistance of a competent person, assess the risk from violence and aggression in the Accident and Emergency Department. In order to be suitable and sufficient the risk assessment should include consideration of the following: a. Information on the number and nature of recent previous incidents and near misses, and learning from these. b. The physical layout and design of the department, and how it is currently used at different times of day and night. c. Different groups who may be harmed e.g. agency staff, porters, students, visitors. d. Alarm systems and the response to these e. Sharing of risk information between agencies and between employees, e.g. patient history f. Lone working or isolation within the department g. Information, instruction and training for employees h. Communication with patients and relatives	Various actions notes under this recommendation.	May-20 Jul-20	Jan-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer. One action under 'Consideration of g). Information, instruction and training for employees' has a timescale of 2021. Clarity is being sought from the reporting officer if this revised timescale has been agreed with the HSE. Due to COVID-19 it is unclear when these actions will be achieved.
JHET/HD/04102019/03	04/10/2019	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19 IN3	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/03_002	High	AND R2. Identify and prioritise the measures you need to take as a result of the risk assessment in order to comply with health and safety law.	Various actions notes under this recommendation.	May-20 Jul-20	Jan-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer is unclear if this recommendation will be implemented by July 2020, or if the HSE have agreed to an extension to January 2021. Clarity is being sought from the reporting officer. Due to COVID-19 it is unclear when these actions will be achieved.
JHET/HD/04102019/04	04/10/2019	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19 IN4	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/04_001	High	R1. In consultation with employees or their representatives, and with the assistance of a competent person, assess the risk to employees of musculoskeletal disorders from moving and handling health records. In order to be suitable and sufficient the risk assessment should be done using the MAC, ART and RAPP tools or other similar relevant risk assessment systems. The assessment of each task should include but may not be limited to: a. Weight and size of notes, boxes, crates and trolleys b. The number of times employees have to pick up, carry, push or pull c. The route and distance they are carrying or moving it, including steps, ladders, floor surfaces etc d. Where they are picking it up from or putting it down (e.g. emptying the bottom of a trolley, putting it on a shelf above shoulder level) e. Any twisting, bending, stretching or other awkward postures	Risk assessments have commenced on all moving and handling activities involving health records. A company was engaged to monitor push/pull force for manual trolleys and link to Health & Safety limits for the NHS. It was discovered that it was more to do with how the trolleys were handled rather than the weight so training was identified as more the issue. However if the trolleys were to be powered then the issue would be eliminated	May-20 Jul-20	Jul-20 Sept-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Rec delayed to September 2020.
JHET/HD/04102019/04	04/10/2019	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19 IN4	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/04_002	High	AND R2. Identify and prioritise the measures you need to take as a result of the risk assessment in order to reduce the risk and comply with health and safety law, for example by making changes to the task, the load, providing suitable equipment and changing the working environment	Various actions notes under this measure.	May-20 Jul-20	Jul-20 Sept-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Rec delayed to September 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experiences	JHET/HD/04102019/05_001	High	R1. With the assistance of a competent person assess all risks that involve manual handling of loads with the Laundry at Glangwili Hospital.	Main issues identified by the report and the M&H Team were the weight of the load on the cages / trolleys and the impaired vision caused by overloading. Risk assessments have commenced for key moving and handling tasks. A company was engaged to monitor push/pull force for manual trolleys and link to Health & Safety limits for the NHS.	May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/05_002	High	From the findings of your assessment; R2. Consider avoiding hazardous manual handling operations 'so far as is reasonably practicable', by redesigning the tasks to avoid moving the load or by automating or mechanising the process and produce a timetabled schedule for implementation of the chosen automated / mechanised process.	Various actions noted under this measure.	May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/05_003	High	R3. Where mechanical assistance is not reasonably practicable to achieve then initiate changes to the tasks, the load and the working environment and produce a timetabled schedule for implementation of the identified control measures.	Various actions noted under this measure.	May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/05_004	High	R4. When looking at an individual operation, consider in turn the task, the load, the working environment and individual capability as well as other factors and the relationship between them. Try to fit the operations to the individual, rather than the other way round. OR Implement any other equally effective measures to comply with the said contravention.	Various actions noted under this measure.	May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_002	High	R2. Having reviewed your arrangements, develop an effective system for investigating incidents to determine their immediate and underlying causes to ensure lessons are learnt. This system should enable the identification of any necessary remedial action and its implementation.	Various actions noted under this measure.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_003	High	R3. Design the system to effectively capture the accurate recording of incident details including the clear setting out of responsibilities for those expected to use this system.	Various actions noted under this measure.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_004	High	R4. Determine how the system will be monitored by senior managers to ensure that follow-up action is carried out, and how it will be audited and reviewed.	Various actions noted under this measure.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_005	High	R5. Implement a programme for making available the relevant information, instruction and training to those required to investigate and record incidents. OR Implement any other equally effective measures to remedy the said contravention	Various actions noted under this measure.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021.

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LPJ/HD/04102019/07	04/10/2019	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19 IN7	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/07_002	High	R2. Where such manual handling operations cannot be avoided you should in consultation with the Health Board's health & safety competent persons, and with their employee representatives, assess the risks and identify additional controls for all manual handling activities in theatres: You should take into consideration the following: a) Identifying all of those activities which pose a risk to employees' health and are not included in the All Wales Manual Handling Passport including: static support of patients' limbs, moving and handling patients into the prone position, repositioning patients during surgery. b) Developing systems to carry out suitable and sufficient risk assessments c) Identifying changes in processes to avoid manual handling or additional controls to reduce the risk to employees' health. d) Providing suitable and sufficient information, instruction and training to those who will be carrying out the patient handling e) Providing suitable and sufficient information, instruction and training to those who will be carrying out inanimate load risk assessments including wheeled operations. f) Developing a system to communicate the findings of the assessments and controls identified to eliminate or reduce the risk.	Various actions noted under this measure.	May-20 Jul-20	Jul-20 Oct-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Delayed to October 2020. Some of the delays are due to the impact of COVID-19 and the required re-directing of resource to manage the evolving Health Board response to the situation. Others, such as the contractor compliance work, are based on a phased approach to compliance.
LPJ/HD/04102019/07	04/10/2019	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19 IN7	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/07_003	High	R3. From the findings of your assessment provide a timetabled programme for implementing the necessary controls identified to reduce the risk of injury so far as is reasonably practicable. OR R4. Implement any other equally effective measures to remedy the said contraventions.	Various actions noted under this measure.	May-20 Jul-20	Jul-20 Oct-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Delayed to October 2020. Some of the delays are due to the impact of COVID-19 and the required re-directing of resource to manage the evolving Health Board response to the situation. Others, such as the contractor compliance work, are based on a phased approach to compliance.
LPJ/HD/04102019/08	04/10/2019	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_001	High	EITHER R1. Implement an effective management system to ensure all incidents where employees and others (such as Agency staff) have suffered an injury from a medical sharp are fully recorded and investigated. This system should also be used to manage any remedial actions required to ensure ongoing risks are mitigated.	Action plan not shared with Assurance and Risk Officer.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.
LPJ/HD/04102019/08	04/10/2019	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_002	High	AND R2. Implement a suitable follow up monitoring system for managing employees and others (e.g. Agency workers) post injury (caused by a medical sharp) that exposed, or may have exposed, the person to a biological agent, to ensure they receive appropriate medical advice, treatment and counselling. OR Implement any other equally effective measures to remedy the said contraventions.	Action plan not shared with Assurance and Risk Officer.	May-20 Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020.
MB1	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Estates	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB1	High	You should undertake a suitable and sufficient assessment of the risks to Estates employees who are required to work alone across all UHB estates (including Secure Mental Health Units) and implement a system whereby the identified risks (that include exposure to violence where reasonably foreseeable) are minimised and managed.		May-20 Jul-20	Dec-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB2	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Switchboard	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB2	High	You should undertake a suitable and sufficient assessment for all Switchboard employees required to work alone at all UHB estates and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Jun-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB3	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Bronglais Hospital	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB3	High	You should undertake a suitable and sufficient assessment for all employees (e.g. Agency staff) required to work alone at Bronglais Hospital and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB4	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Prince Phillip Hospital MIU / AMAU	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB4	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g. Agency staff) within Prince Phillip Hospital MIU / AMAU who are required to work alone and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB5	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Prince Phillip Hospital Mortuary and Bereavement Services	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB5	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g. Agency staff) within Prince Phillip Hospital Mortuary and Bereavement Services (including lone workers) and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB6	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Bronglais Hospital A&E/CDU	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB6	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g. Agency staff) in working within Bronglais Hospital A&E/CDU (including lone workers) and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB7	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Glangwili Hospital A&E (inc. reception)	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB7	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g. Agency staff) within Glangwili Hospital A&E (inc. reception) and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB8	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Community Mental Health Teams	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB8	High	You should undertake a suitable and sufficient assessment of the risks to all employees and others (e.g. Agency staff) working within the Community Mental Health Teams (including lone workers) and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB9	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Mental Health	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB9	High	You should undertake a suitable and sufficient assessment of the risks to all employees and others (e.g. Agency staff) within the Mental Health teams involved with the transportation of patients and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.		May-20 Jul-20	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
MB12	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Control of Asbestos Regulations 2012, Regulation 10	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB12	High	You should implement a system to ensure that any work where there is the potential to disturb Asbestos Containing Materials is effectively communicated to both internal staff and external contractors to ensure they comply with HDUHB policy and procedures.		May-20 Jul-20	Dec-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.

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MB13	Oct-19	Health and Safety Executive	Material breaches- The Control of Substances Hazardous to Health Regulations 2002, Regulation 7. Prince Phillip Hospital	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB13	High	Confined Spaces Regulations 1997, Regulation 4 If it is not reasonably practicable to clean the refrigerated body stores within the mortuary of Prince Phillip Hospital without the need for staff to enter these stores, you should implement the necessary control measures to ensure employees and others (e.g. Agency Staff) are not exposed or overcome by chemicals used whilst in confined spaces. You should also consider similar cleaning activities that are undertaken at other mortuaries within Hywel Dda UHB.		May-20 Jul-20	Jul-20	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020.
19102	Aug-19	HIW	Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Open	N/A	Community & Primary Care (Pembrokeshire)	Sonia Hay / Ceri Griffith	Director of Operations	19102i1_001	High	R7. The health board policy for the management and prevention of VTE finalised and disseminated to all appropriate staff.	The Health Board VTE policy will be disseminated once approved by MMSC, to be completed and distributed to all appropriate staff.	Sep-19	Sep-20	Red	The HB is to adopt the All Wales policy once this has been approved at the All Wales level., delays due to Covid 19. An All Wales meeting is planned June 16th. 03/08/2020 Emailed request, response received All wales Policy has been approved. Accepted at HB, Pharmacy Lead to disseminate to relevant staff.07/08/2020 Confirmed delayed due to risk assessment being updated, and will be issued withthe Policy new date for completion Sept 2020.
19097		HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	19097IA_004	High	R4. The Health Board is required to provide HIW with details of the action it will take to ensure that: Fire doors are fitted to the entrance of ward 7 in line with the requirements of the Enforcement notice issued by the Mid and West Wales Fire and Rescue Service to ensure the Health Board adequately protects patients, staff and the general public in the event of fire. We were informed that the doors to the entrance of ward 7 were not fire doors. An Enforcement Notice was issued by the Mid and West Wales Fire and Rescue Service requiring action to fit fire doors by the 30th November 2019. We were informed the doors were due to be replaced in September 2020 at the earliest as part of phase 2 of improvement work.	The Health Board has a fully structured plan for fire safety at WGH developed in response to the Mid and West Wales Fire and Rescue Service Enforcement Notice (MWWFRS). The plan presented to MWWFRS is a staged approach allowing us to undertake advance works very promptly with the substantive element of work progressed via a Business Case process. Within this plan all fire requirements to escape routes identified within the above Enforcement Notice will be undertaken at WGH between May 2020 and August of 2021. This programme is currently being considered by the MWWFRS and we are awaiting further clarity from them on the agreed timelines on this work. The Welsh Government are also fully engaged in this process and are supportive of the approach being taken by the Health Board. This work will include doors at the entrance to Ward 7 and any other Fire Doors necessary within the escape routes in this Hospital. The MWWFRS have recommended that the remaining works within Wards and Departments will be undertaken as a second stage to the above. 	Aug-21	Aug-21	Amber	
19106		HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Director MH&LD	Director of Operations	19106IA001	High	During the inspection, we found that three members of staff employed by the health board, and working at the Brynmair Clinic, did not have a current Disclosure and Barring Service (DBS) certificates in place. This meant that we could not be assured that the staff members were suitable to work with vulnerable adults .We consider the above practice to be unsafe and increases the risk of harm to patients. Improvement needed The Health board must ensure all staff (where applicable), have DBS checks completed with a record of completion kept on file.	With advice and input from the central Resourcing Team, to undertake an audit of the DBS status of all staff within the MH&LD Directorate	Jan-20	Jul-20	Red	Delayed to Covid-19. Work is being undertaken by New Manager and awaiting a response
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_001	High	R1. Bronglais General Hospital Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are considered for inclusion on the directorate registers.	We are also undertaking a review to ascertain if any other corporate or Scheduled Care risks exist which relate to BGH theatres which should be admitted and referenced to a generic theatres risk on the BGH Directorate Risk Register (but will remain the property of the Scheduled Care Directorate).	Feb-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Initial assessment of management finding found this recommendation to be partially addressed, however this is subject to change during the QA process and receipt of additional evidence. Tracker to be updated once follow up report submitted to ARAC.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_002	High	R2. Department managers and leads should ensure that the management of all periods of sickness complies with the NHS Wales Managing Attendance at Work Policy.	The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including sickness management.	Mar-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Internal Audit awaiting evidence against this recommendation. Tracker to be updated once follow up report submitted to ARAC.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_003	High	R3. Bronglais General Hospital Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy; and all employees on the Ystwyth Stroke Ward receive an annual personal development appraisal review that should be documented and retained on file.	The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including PADRs. BGH also has three inexperienced development Band 7 Ward Managers who are receiving support and are also cohorted on to the STAR leadership programme to aid in the development of their management skills.	Mar-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Initial assessment of management finding found this recommendation to not be addressed, however this is subject to change during the QA process and receipt of additional evidence. Tracker to be updated once follow up report submitted to ARAC.
HDUHB 1920-20	Feb-20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Paul Solloway/ Anthony Tracey	Director of Planning, Performance & Commissioning	HDUHB 1920-20_002	High	R2. The Health Board ICT department should formally define the cyber security tasks that cannot be undertaken within the current resource envelope and the associated risks. This should be reported through the organisational governance structure so that a decision on risks and priorities can be made.	Management response to be agreed at ARAC June 2020: Agreed In conjunction with Recommendation 1, a more detailed assessment of the gaps / tasks from the Stratia report action plan will be undertaken by the Band 6 Cyber Security once they are in post. It is envisaged that the Stratia report action plan will be fully implemented by March 2021, providing the post holder will be in place by September 2020. In the meantime the UHB are still undertaking all the necessary patching on the Desktops / Laptops and Server Infrastructure as previously agreed, as well as prioritising the removal of legacy equipment and systems to further reduce our exposure to cyber-attacks. The majority of the remaining actions from the Stratia report relate to the need to implement the nationally available products which will be undertaken by the Band 6 Cyber Security once in post. These products will allow at a national and local view to investigate any specific issues that arise from a cyber-attack. A cyber security risk is already included Corporate Risk Register (Risk Ref. 451). This risk is reviewed on a monthly basis and any additional mitigations or actions are updated accordingly. As required any new risks identified through the gap analysis will be added to the ICT Risk Register and assessed for escalation.	Mar-21	Mar-21	Amber	ARAC raised concerns at the June 2020 meeting that the date had changed from June 2020 to March 2021 for rec 2, and queried whether this significant deferment in a high priority recommendation was acceptable from a risk perspective. Director of Finance advised that he has discussed this with the Assistant Director of Informatics and the statement reflects the reality being dealt with by the IM&T team currently. It has been agreed that support for Cyber Security will be strengthened; however, recruitment is likely to be a challenge and will take time. The revised deadline is probably a realistic timescale. An update would be provided to the next ARAC meeting in August 2020.
HDUHB-1920-25	Oct-19	Internal Audit - HDUHB	Estates Directorate Governance Review	Open	Limited	Estates	Rob Elliott	Director of Operations	HDUHB-1920-25_004	High	R4: Estates Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are included on the directorate registers.	A full review is underway of all Directorate, Corporate and Service Risks within the FM team. It is planned to do this review in line with the agreed work plan by the end of Jan 2020. We intend to work closely with the Governance Team and Internal Audit within this review to ensure clarity on the recommendation.	Jan-20	Oct-20	Red	27/05/2020- Follow up report HDUHB-1920-39 shows this recommendation as only partially addressed; 'We noted the positive steps taken by the directorate to address the original finding, whilst acknowledging that continued actions are needed to be undertaken to ensure the risk register allows for the effective and robust management of risks'. Recommendation changed back to red on the audit tracker, to be confirmed when final report is agreed by ARAC. Recommendation being tracked by this original report. Revised timescale of Oct 2020 provided by service

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HDUHB-1920-25	Oct-19	Internal Audit - HDUHB	Estates Directorate Governance Review	Open	Limited	Estates	Rob Elliott	Director of Operations	HDUHB-1920-25_005	High	R7: Estate Directorate Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy.	Agreed. The FM team have made substantial efforts in delivering a formal PADR process to significant staff numbers (circa 86% of staff). This has been well received by the staff involved and acknowledged internally by members of the Executive team. A review will be needed to ensure the PADR process is consistently applied across all staff. We will work to identify exemplar examples within our workforce and ensure that there is learning delivered throughout our supervisory team to improve standards. This review will be undertaken on each PADR as it becomes due for each member of staff.	Oct-20	Oct-20	Amber	27/05/2020. Due to COVID-19 constraints this recommendation was not included in the HDUHB - 1920-39 follow up report, therefore this recommendation remains open on the tracker. Still on track for October 2020 as of May 2020.
HDUHB_1920_40	Mar-20	Internal Audit - HDUHB	IM&T Assurance – Follow Up	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Sara Brain	Director of Planning, Performance & Commissioning	HDUHB_1920_40_001	High	The Health Board should consider a wider security awareness programme. To facilitate this the Assistant Director of Informatics should identify individuals with jurisdiction to implement the recommendation fully, drawing on their expertise and services, coordinating a programme of work to improve the security arrangements surrounding the Health Boards IT assets. The programme should include a communications plan to better publicise good practices and individuals responsibilities in relation to the physical and environmental security for IT assets such as PCs laptops and server equipment. Specialist assistance should be sought from the Health, Safety & Security team to identify site leads and empower them with the knowledge and responsibility for IT physical and environmental security self-assessment. These self assessments should be reviewed and followed up by visits from the Health, Safety & Security team at an appropriate frequency. This was queried but no clarification or additional documentation was provided. For this reason we cannot provide assurance as to whether this work has been carried out.	In terms of the wider awareness program and physical environmental security, initial conversations took place with stakeholders (security, estates, etc.) the intention was to set up a virtual group to carry this forward. This progress was reported to the Health Board governance team as being on schedule for completion, however these initial conversations did not progress any further. Now the intention is to incorporate these tasks into the new Welsh IG toolkit work stream, the rationale for this is that section 6 of the toolkit submission relates to the physical and environmental security of information and IT assets, with requirements to capture and evidence and report the Health Board's arrangements. Categories will include polices, staff awareness, technical arrangements for security etc. If this is completed properly it will adequately address the recommendation made by us.	Feb-20	May-21	Red	This was put on hold due to COVID, but will be picked up again and progressed with estates colleagues. Estimated completion of May 2021
HDUHB_1920_40	Mar-20	Internal Audit - HDUHB	IM&T Assurance – Follow Up	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Sara Brain	Director of Planning, Performance & Commissioning	HDUHB_1920_40_002	High	Accurate records of stores should be maintained and regularly verified with physical checks.	Verbal updates from IM&T indicate that these registers are now in place for the sites which hold stocks of assets, however the evidence provided was not sufficient to support these statements. Instead of local stores asset registers one Kace network report was provided which showed all Health Board assets connected to the network. This report did not account for assets that were yet to be commissioned and did not evidence regular verification with physical checks.	May-19	Oct-20	Red	This follow up report did not include revised timescale for this recommendation. Reporting officer has provided revised date of October 2020. This recommendation was on track but due to COVID-19 this has been delayed as no checks have been able to take place.
HDUHB 1819-11	May-19	Internal Audit - HDUHB	Integrated Care Fund – Follow Up	Open	Reasonable	Community & Primary Care (Carmarthenshire)	Peter Skitt / Martyn Palfreman	Director of Operations	HDUHN 181-11_001	High	R2. Management must ensure that quarterly ICF reports are submitted to Welsh Government no later than the designated submission dates set out in the Written Agreement.	Late submissions of quarterly reports have been due largely to delays in receiving activity and financial data from partners. Welsh Government has been fully informed of anticipated delays and the reasons for them on all occasions. The Written Agreement will be updated by the end of June 2019 and will provide an opportunity for re-emphasising quarterly reporting deadlines in advance. Increased capacity within the Regional Collaboration Unit will be deployed to support partners in the retrieval and collation of data for inclusion in the reports.	Jul-19	N/K	Red	WG reduced the requirements in response to C-19, so only financial reporting was essential however, there was still impact across the board in terms of timely financial reporting. 03/08/2020 Request for update issued, to the Regional Programme and Change Manager Co-ordination officer, out of office received, copied in County Directors of Service.
HDUHB 1920-16	Jan-20	Internal Audit - HDUHB	Medical Devices	Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_001	High	R1: Management should put in place safeguards to ensure alerts and safety notices for all Health Board medical devices are fully captured.	To review current procedure for the management of safety notices and alerts and issue for consultation (Complete) To present the revised procedure to the appropriate committee for ratification (June 2020)	Jun-20	Aug-20	Red	Procedure reported to QSEAC June 2020 but further amendments are required. Final approval to take place at QSEAC in August 2020.
HDUHB 1920-16	Jan-20	Internal Audit - HDUHB	Medical Devices	Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_002	High	R2: Management should review the current approach to medical devices training for clinical and nursing staff to ensure: if all training is coordinated through a central point; if training provided by external parties can be quality assessed; and if training records can be accurately maintained.	Undertake mapping exercise to prioritise the training in accordance to high medium and low risk devices. (complete) To map the high risk devices across acute and community areas to identify which devices are used in each area and the number of staff in each area that will require training. (August 2020). To complete training needs analysis. The training needs analysis when completed will identify the initial training resource to deliver training on the high risk devices. (October 2020) Business case to be prepared for training resources. (November 2020). To transfer historical medical devices training records on to ESR (Temporary administrative support has been provided to start the transfer process. The admin support is on loan from the audit department and may have to return to her substantive duties at an unknown time. If the loan period continues at 2 days per week the data transfer should be complete by the 30th September 2020. However should the loan period end prior to this, the date will need to be pushed back indefinitely until further admin support can be found). (September 2020) To identify what admin duties are Learning Development functions as opposed to duties to specifically support the medical device work stream (with support from Health Board Learning and Development manager). (June 2020). A mapping of medical device specific duties will identify admin resources required. (July 2020) Business case to be prepared for administrative support. (Aug 2020)	Nov-20	Nov-20	Amber	Revised management response reported to ARAC June 2020.
HDUHB-1920-17	Jun-20	Internal Audit - HDUHB	Mortality Rates	Open	Reasonable	Medical	John Evans / Subhamay Ghosh / Ian Bebb	Medical Director & Director of Clinical Strategy	HDUHB-1920-17_001	High	R1: Management should introduce a mechanism of central oversight and implement processes that collate, monitor and report the accuracy and quality of completed Stage 2 reviews, ensuring lessons learned and outcomes are reported to the Mortality Scrutiny Group.	A Health Board Wide Stage 2 process has already been agreed by MSG, ECPSC & QSEAC. The new system is designed to increase local ownership. In addition to this, the new Quality Improvement Leads for each site in conjunction with the Hospital Directors will provide exception reports to MSG regarding Stage 2 concerns/lessons. Whilst we acknowledge that previously there was no standardised approach we would like to point out that Stage 2 outcomes are already discussed in a number of forums including, but not limited too; WHAM, M&M, Grand Round and Anaesthetic Forums.	Nov-20	Nov-20	Amber	
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_001	High	R1: Management should ensure wards maintain a Pharmacy agreed stock list of controlled drugs that are either used regularly on that ward or are required in case of an emergency.	Historically controlled drugs have not been part of the stock list controls and therefore have not routinely been included. However, it is accepted that the policy does not differentiate between CDs and non-CDs and it is good practice to have an agreed stock list for CDs for reference. In response to this recommendation: CD stock lists agreed for all wards. Reconfiguration of wards due to COVID has delayed implementation	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	Ward Sisters to provide up to date Signature lists and copies forwarded to the Pharmacy Department. Pharmacy department secretary to maintain a log of signature list received.	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	A programme of Medicines Management workshops to be developed to re-enforce the procedures within the Medicines Management Policy (to be included in the medication safety days).	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	Issues to be discussed with ward sisters at professional meetings and scrutiny reviews	Sep-20	Sep-20	Amber	

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
HDUHB 1819-32	Oct-19	Internal Audit - HDUHB	Radiology Directorate	Open	Reasonable	Radiology	Amanda Evans	Director of Operations	HDUHB1819-32-001	High	R3: A review of on-call arrangements across the Health Board sites would be beneficial in order to ensure standardised procedures to enable efficient and economic working practices and staffing arrangements. The benefits and cost savings of introducing a shift system should be considered.	On call arrangements within the Health Board are complex and historic, appearing to have evolved with demands of service and staffing levels. Furthermore the 'on call' has been seen as a recruitment incentive as it is financially lucrative and may attract new staff to the Health Board. In addition some arrangements and rotas have been in place since prior to the merger and have not been updated. It has been difficult to obtain written signed off documentation to support the current agreements but there is uniformity across the Health board in the amounts that are paid. There is in place an All Wales On Call agreement which staff have utilised to draw up the agreements. The interpretation of this agreement seems to vary from site to site in particular to the suggested 'compensatory rest'. The on call agreements have not been reviewed since this agreement was drafted in 2012. The on call arrangements review are part of the workforce IMTP of the directorate for 2019-20. As described due to the complexity and variety of all the arrangements changes will need time to implement .This will allow for uniformity across all sites. There will need to be staff side involvement and engagement. If it is agreed that an arrangement for a dedicated shift system is to be implemented a notice period and consultation for staff will need to take place. Workforce and Organisational Development have already been contacted for support and a task and finish group is being set up in December 2018 with the aim to consult with staff by February 2019 and the review to be completed by April 2019.	Apr-19	Aug-20	Red	A transformation project team has been established between the Head of Radiology, Workforce and OD and the Project Management Office (PMO) which met in February 2020 and devised a transformation project plan in relation to Radiology staffing levels including on-call arrangements. A second meeting was due to take place in March 2020 but was suspended due to COVID-19. The project plan was discussed with the executive team in the March 2020 Holding to Account meeting for Radiology where it was agreed Radiology would present new costings for improved staffing levels to the Executive Team. A model was developed and costed although due to COVID-19 this has not been presented to the Executive Team. Currently, during the pandemic, staff have been working differently to accommodate the patient flow and it is anticipated that some of the adjustments will continue when returning to what will be a new normal. The transformation project plan is currently a minimum of 3 months behind schedule. It is anticipated for a further meeting to be arranged in June 2020 to establish revised timescales against the remaining actions.
HDUHB 1819-32	Oct-19	Internal Audit - HDUHB	Radiology Directorate	Open	Reasonable	Radiology	Amanda Evans	Director of Operations	HDUHB1819-32-002	High	R8: It should be ensured that staff work on call or overtime hours in addition to their basic hours and not instead of. The full number of basic hours should be worked prior to receiving any payments for additional hours.	As per previous response, the on call arrangements are historic with the reasoning for this being the need to sustain out of hours services with the levels of staff available. However it is noted key staff are often away from the department on rest days and this is acknowledged as a significant issue with efficiency. Compensatory rest days count towards the basic hours with the current on call arrangements and as per previous response the system is to be reviewed with the task and finish group and staff consultation. Please note any staff member that works less than full time hours does not receive overtime payments until they reach normal working hours.	Apr-19	Aug-20	Red	A transformation project team has been established between the Head of Radiology, Workforce and OD and the Project Management Office (PMO) which met in February 2020 and devised a transformation project plan in relation to Radiology staffing levels including on-call arrangements. A second meeting was due to take place in March 2020 but was suspended due to COVID-19. The project plan was discussed with the executive team in the March 2020 Holding to Account meeting for Radiology where it was agreed Radiology would present new costings for improved staffing levels to the Executive Team. A model was developed and costed although due to COVID-19 this has not been presented to the Executive Team. Currently, during the pandemic, staff have been working differently to accommodate the patient flow and it is anticipated that some of the adjustments will continue when returning to what will be a new normal. The transformation project plan is currently a minimum of 3 months behind schedule. It is anticipated for a further meeting to be arranged in June 2020 to establish revised timescales against the remaining actions.
HDUHB1819-33	Feb-19	Internal Audit - HDUHB	Records Management	Open	Limited	Health Records/ Planning, Performance & Commissioning (Informatics)	Sarah Brain	Director of Planning, Performance & Commissioning/ Director of Partnerships and Corporate Services	HDUHB1819-33_002	High	R2. Identified Service and Departmental Managers should ensure a Paper Health Records Inventory Form is completed, regularly reviewed and forwarded to the Head of Health Records as set out in the Health Records Management Policy.	(a)All Information Asset Owners (IAO's) have been identified via the Information Asset Owners Group which is organised by the Health Boards Information Governance Team. The IAO's have clear responsibility for completing an Information Audit Template. Some of the information requested on the template includes: •Type of information held •Where the information is held •Legal requirements and classification of the information •How is the information shared •How is the information distributed Effectively over time the information gathered will support or potentially replace the inventory form as the list will be a Health Board wide database containing all IAO's and the relevant information. The Information Governance Manager is working directly with Directorates and lead IAO's to ensure the information is completed as quickly as possible. To date approximately 50% of responses have been received and the IG Manager will continue to work with individual leads to ensure those currently outstanding are completed as soon as possible. (b)This work is being supported by the Electronic Records Group which is being led by the Deputy Director of Operations. This group is looking at the potential to implement a scanned patient record within the Health Board and as part of the remit is developing a questionnaire which will again be completed by all relevant IAO's and will again cover records management arrangements within department and services but in addition will also identify any use of private storage companies and the costs. The questionnaire will be circulated to IAO's in January.	May-19	Nov-20	Red	Recommendation had previously been closed but is now re-opened after being reported to ARAC in April 2020 as outstanding with the progress below: In order to better track and monitor progress with the individual IARs and put more responsibility on the IAOs to drive this work, a template IAO Work Plan was circulated. Based on the most recent RAG update, 70% of IAOs have engaged in the process and are working towards compliance (31/44). The Information Governance Sub-Committee (IGSC) requested that the 13 IAO that have not engaged is escalated to the Executive Team. The compliance has now been included within the Executive Performance Reviews, and a number of IAOs have already begun to engage following the recent round of performance meetings A programme of in-depth refresher training is being rolled out for all IAO/IAAs to ensure they fully understand their information assets and the responsibilities that entails, including records management. This is being carried out in conjunction with ongoing work between IG and IAOs in developing a GDPR compliant Information Asset Register for each service area of responsibility. At the time of writing this update 65% of all IAO/IAAs (62/97) have undertaken the training It is anticipated that there will be a delay of 3-4 months and a revised date will be November 2020
HDUHB-1920-32	Mar-20	Internal Audit - HDUHB	Rostering	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_001	High	The required staffing skill mix should be maintained at all times. When a shift cannot be suitably filled, ward staff should ensure that senior management are fully informed as per policy.	Reinforce through senior nurse management structure the importance of maintaining the required staffing skill mix, unfilled shifts to be recorded and reported through risk assessment for regular review. Roll out of allocate E-Roster system will improve real-time visibility of skill mix, this will enable managers to intervene in a timely manner.	Jun-20	Mar-21	Red	(a)Nursing Workforce Management group was temporarily stood down to support COVID 19 response however discussions about rostering and shift management have continued through the following: Senior Nurse & Midwifery Team meetings- monthly. Heads of Nursing calls with the Director of Nursing- weekly Staffing calculation work in line with COVID staffing planning (b)Discussions have taken place at an all-Wales level regarding development of the HCSM system to enable enhanced capture of any reasons for variation in rosters. It is expected that this work will commence in July 2020 and be available to implement in the UHB during 20/21. (c)A decision was taken to pause the work on the introduction of Allocate (new e-rostering system) due to the requirements fors for our Covid-19 responses. A response is awaited from the company to confirm the approach and timescales.
HDUHB1718-35	Apr-18	Internal Audit - HDUHB	Theatres Directorate	Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_001	High	R4. The practice of claiming enhanced hours for the whole period of an on-call shift should be officially reviewed, as a matter of urgency, with appropriate personnel involved in the process. Any decision made on the future payment of enhanced provision should be made in line with the Agenda For Change On-Call Agreement. The decision should be fully documented and appropriately approved for sure.	This relates to current practice of the resident on-call shift for ODPs at GGH. Recent review of on-call has produced an SBAR with recommendations to address the anomalies as stated above. *Meeting with Workforce to follow by 31 Jan 2018 – completed. Significant pay costing implications to place in night shift and pay compensatory pay for 12 months. To undertake roster review and costings through finance and complete further SBAR. As of 13 Feb 2018, HoN Scheduled Care assumes responsibility with SNMs for all elements of workforce management.	Jun-18	N/K	Red	The recommendations cannot be addressed until grievance process is complete
HDUHB-1920-33	Jun-20	Internal Audit - HDUHB	Variable Pay	Open	Reasonable	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	HDUHB-1920-33_001	High	R1(a). The Blood Sciences Service should introduce an electronic rostering system to ensure an accurate audit trail of contracted hours, pay enhancements, on-call and overtime payments are captured. In the interim, Management should ensure: ☑ A standardised claims form is agreed and implemented across all department sites to ensure a key information is recorded and captured; ☑ Pay enhancements, on-call and overtime figures submitted on their claims forms accurately reconcile to work undertaken by Blood Sciences employees; ☑ All submitted claim forms are signed and dated by employees prior to any commitment to expenditure; and ☑ Summary recording spreadsheets are countersigned by another lead/manager where certifying leads are signing-off their own pay enhancements and overtime.	Pathology Blood Sciences will review the current record keeping practices across all four hospital sites with an aim to ensure standardisation and clarity in relation to the capture of enhancements and overtime. Practice in relation to the requirements for signing certification will be raised with managers and staff. Pathology Blood Sciences to explore if "RosterPro" has the functionality to support the Blood Science rosters. Pathology recognises that its rostering system, which was agreed as a partnership approach with Health Board Senior Managers and staff side representatives, is complex especially when we have to factor in "ghost shifts" when rosters fall below the required 1:9 level	Nov-20	Nov-20	Amber	22/07/2020 update received from Andrea Stiens - The findings of the audit were raised and discussed at the last Blood Science Leads meeting held June 25th 2020. The production of a standardised claim form will be progressed via e-mail following on from this meeting. Blood Science Leads have informed staff making claims that personal claim forms must be dated and signed and that monthly summary recording spreadsheets must be countersigned by another lead/manager if certifying leads are claiming enhancements and overtime for themselves. Payroll have been contacted to ask about suitability of current monthly summary recording spreadsheet. An alternative form has been supplied that they are trying implement across the Health Board. This waiting to be reviewed to assess suitability for use - any comments will be forwarded to payroll. Andrea Stiens - R1 (a) is currently being progressed as a priority. It is envisaged that RosterPro will be investigated and assessed from mid-August onwards.

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HDUHB-1920-38	May-20	Internal Audit - HDUHB	Review of PADR Process (Follow Up)	Open	Reasonable	Workforce & OD	Robert Blake	Director of Workforce & OD	HDUHB-1020-38_001	High	R1. Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy. Personal Appraisal Development Review - Follow Up Comments A review of personal appraisal development reviews (PADRs) undertaken since June 2019 were tested within six departments (three new departments and three revisited departments) to ensure the quality of reviews complied with the SMART principles set out in the PADR Policy. Concluding our review of the revisited departments, we noted the positive impact of objectives meeting the SMART principles since the introduction of the new PADR form – see Table A for breakdown. Whilst noting the improvement in the quality of PADRs within the revisited departments, instances of objectives not meeting the SMART principles (explicitly the Specific, Measureable and Timely principles) were evident in a sample of PADR forms tested within three new departments were evident in a sample of PADR forms tested within three new departments.	Management response from original report: Following receipt of this audit, the Director of Workforce and OD has reviewed and inspected all 56 PADRs audited as part of this review. In response, the Organisational Development team has already begun to review the PADR Policy, process and training provision. Specifically the layout of the documentation will be reviewed as reflecting on the audit findings the layout is not conducive to the recording of SMART objectives as per the Policy. Having reviewed all PADRs 89% are of very good quality with a high level of detail around objectives however to comply with the policy they must be documented differently.	Nov-19	Dec-20	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales. Christine Davies 16/07/2020- Update provided by Senior Organisational Development Manager. Quarterly reviews in place with sites to highlight areas of poor compliance however these have been temporarily stood down due to COVID-19. It is hopeful to have these reviews back up and running soon and in addition the service is looking into extra resource to drive this forward. Revised deadline of December 2020 provided for review process to be back up and running and for further work to take place to embed this into the normal culture of the UHB.
HDUHB-1920-04	Jun-20	Internal Audit - HDUHB	Health & Safety	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_001a	High	R1: Management should ensure all members of the Health & Safety and Emergency Planning Sub-Committee (and future Health & Safety Committee) regularly attend to ensure health and safety issues identified within directorates and services are reported and lessons learned are shared with other representatives.	The first meeting of the newly established Health & Safety Assurance Committee took place on the 14th May 2020. This is now a Committee directly reporting to the Board and the inaugural meeting was well attended. Attendance to be monitored at all future meetings and reported through the annual Health & Safety Report.	Jun-20	Jun-20	Red	
HDUHB-1920-04	Jun-20	Internal Audit - HDUHB	Health & Safety	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_001b	High	R1: Management should ensure all members of the Health & Safety and Emergency Planning Sub-Committee (and future Health & Safety Committee) regularly attend to ensure health and safety issues identified within directorates and services are reported and lessons learned are shared with other representatives.	Further consideration of membership will be undertaken post COVID-19 arrangements in line with other committee meetings. It is expected that issues identified at service/directorate level will be escalated where necessary to the Committee via the local quality governance arrangements. These arrangements will be further developed and confirmed at the September 2020 Health and Safety Assurance Committee.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07		Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_002	High	R2: Management should request, and retain in a centralised location, the required data providing assurance of the competency of appointed contractors. A 'valid for' period should be included to ensure that, upon expiration, up to date information is requested rather than reliance placed on historic data.	Accepted. The data will be obtained through completion of the pre-qualification questionnaires [as per the new policy]. Initially, it will be logged on a centrally maintained spreadsheet with a view to investigate databases available to the UHB. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07		Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_005	High	R5a: Formal inductions should be completed by all contractors engaged by the UHB and attendance recorded and reviewed appropriately on a centralised UHB database.	Agreed. Plans had been made for all current contractors to receive the induction by 31 March 2020 with a log of attendance maintained. However, in light of the current unique times the country is faced with, these plans have been postponed. Appropriate arrangements will be made to roll out the induction through an appropriate means for existing contractors and any new appointments. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07		Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_005	High	R5b: Job and location specific risks should be discussed and formally documented by relevant competent staff in addition to the induction via the new Job Registration and Authorisation form.	Agreed. Plans had been made for all current contractors to receive the induction by 31 March 2020 with a log of attendance maintained. However, in light of the current unique times the country is faced with, these plans have been postponed. Appropriate arrangements will be made to roll out the induction through an appropriate means for existing contractors and any new appointments. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07		Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_007	High	R7a: A permit to work procedure should be developed, ratified and communicated to all relevant officers.	Agreed. A procedure will be drafted to address the different types of permits that may require issue for work on UHB sites. As noted through a recent CDM course attended, when Estates Officers are signing the RAMS, they are accepting that the content appears reasonable. They do not have the expertise to confirm that the content is correct. This will be addressed accordingly. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07		Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_007	High	R7b: Appropriate permits to work for different high risk types of work must be High issued by Estates staff in line with HSE guidance and the new Control of Contractors policy.	Agreed. A procedure will be drafted to address the different types of permits that may require issue for work on UHB sites. As noted through a recent CDM course attended, when Estates Officers are signing the RAMS, they are accepting that the content appears reasonable. They do not have the expertise to confirm that the content is correct. This will be addressed accordingly. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_001	High	R1. Forecasting should be undertaken for each contract by the Finance Business Partners as the identified (Finance) Contract Leads to ensure the financial needs of the Health Board are met.	The Contracting Team will work closely with Finance Business Partners to support this work. As this recommendation is accepted, the contracting team have identified a resource to undertake this work with Business Partners moving forward.	Jan-21	Jan-21	Amber	
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_002	High	R2. SLA Contract monitoring and budget reviews of services both provided and accessed, need to be undertaken by management to ensure the standards of service meet the requirements of the Health Board.	The Contracting Team have identified a full time resource to support this work.	Nov-20	Nov-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_003	High	R3. Management need to ensure that LTA contracts are signed by the appropriate authorised signatory, in accordance with the agreed Health Board Scheme of Delegation.	All LTAs will now follow the scheme of delegation, with all contracts over £10m being reported to the Board following CEO approval, and those below £10m being reported for information.	Jul-20	Jul-20	Red	
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_004	High	R4. Management should ensure that the terms and conditions set out in SLA contracts are adhered to at all times.	All contract meetings involving the contracts team will be documented moving forward. These will of course include any actions arising. This will demonstrate the requisite compliance around roles and responsibilities as set out in the contact.	Jun-20	Jun-20	Red	At ARAC 27/05/2020 where report was approved, members noted the management response doesn't answer the question around the quality of the SLAs. The Director of Finance responded that Finance is doing a piece of work with the Value Based Outcomes team.
BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	04/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_ 001	High	R1. Fire Risk Assessment According to your action plan dated 02 December 2019 V2 there are still a small number of significant findings of your Fire Risk Assessment that need to be completed. These need to be confirmed once completed.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Dec-21	Amber	Some fire risk assessments have been completed with the exception of those assessments which is part of stage 2 WGH Fire Enforcement Programme. This recommendation is currently ragged as red as the original date of October 2020 is sited on the enforcement notice from Mid and West Wales Fire and Rescue Service (MWWFRS). Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Revised completion date issued on 21/07/2020 by MWWFRS of 16/02/2021
BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	04/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_ 002	High	R2. Fire Resisting Doors Ensure that door-sets that can resist fire and smoke for 30 minutes are provided in the following locations: • All identified fire resisting doors throughout St Caradogs Unit and Waldo Suite (Mental Health Department) Any self-closing device fitted to doors and must not compromise the effectiveness of any intumescent strips and smoke seals forming part of the door set. As stated in your action plan dated 02 December 2019 V2 the works are on schedule to be completed by 04 September 2020.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Dec-21	Amber	The priority doors have been verbally agreed with MWWFRS to be be completed by December 2020 (rapid progress has been made, with the remaining items to be completed by December 2021 (delayed by 4 months due to impact of COVID-19). Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). Revised completion date issued on 21/07/2020 by MWWFRS of 16/02/2021

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BFS/KS/SJM/ 00113573- KS/890/05 (supersedes EN/262/08)	04/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001135 73_ 003	High	R3. Compartmentation / Dampers Reinstate the fire resistance in the following location: • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devices are functioning in line with its design specifications and manufacturer's instructions. According to the action plan dated 02 December 2019 V2 these ongoing works are to be completed in the timescale of this Enforcement Notice	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Dec-21	Amber	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). Revised completion date issued on 21/07/2020 by MWWFRS of 16/02/2021
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_001	High	R1. Compartmentation - All Horizontal and Vertical Breaches and / or Penetrations. •To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the wards, theatres, plant rooms, offices, surgeries, specialist units and any other compartmented spaces within the Glangwili Hospital site are addressed. • Any contractual work undertaken to install services through a fire resisting barrier should be quality assured to ensure that the fire resistance is reinstated on completion. • Any room that is made into a hazard room / area should comply	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	May-21	Amber	Vertical escapes to be completed by May 2021, horizontal escape routes by April 2022. Business Case for final stage of work will be undertaken by May 2022, with all work to be completed by approximately May 2025 (unable to determine exact date at this time). MWWFRS have been informed. This is multi-faced approached which will be reflected in re-issued fire notices from the MWWFRS in the next few weeks. 21/07/2020- MWWFRS has provided extension to 16/02/2021.
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_003	High	R3. Fire Resisting Corridors and Doors Ensure that the escape routes are kept free from fire and smoke by making sure all fire doors are fit for purpose and protect the means of escape as they are intended to do so. 1. A number of fire resisting doors throughout the premises were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm. Any damaged fire resisting glazing needs to be replaced. 2. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position, if this is a requirement then the doors should be linked into the fire alarm system to allow them to positively close fully into their frame on the activation of the fire alarm. 3. Ensure that all doors on exit routes are available and can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency. 4. Doors to rooms that have no public access should be locked when not in use. 5. All fire doors should have identification showing the fire-rating of the door. 6. All transom lights above all doors and enclosures within the hospital should have the same fire resistance as the structure it is part of.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	May-25 (approx. date)	Amber	Some sections of this item have already been completed. Business Case for final stage of work will be undertaken by May 2022, with all work to be completed by approximately May 2025 (unable to determine exact date at this time). MWWFRS have been informed. This is multi-faced approached which will be reflected in re-issued fire notices from the MWWFRS in the next few weeks. 21/07/2020- MWWFRS has provided extension to 16/02/2021.
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_004	High	R4. Fire Risk Assessment • Ownership needs to be taken of the significant findings of the Fire Risk Assessment. Those items highlighted within the fire risk assessments need to be completed within the identified time scales. • Departments within the hospital that are not operated by the Hywel Dda University Health Board also have a duty to comply with this item and all other items relevant to them within this enforcement notice.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	This item should be completed by June 2020, within the original timescale of October 2020 set by MWWFRS. 21/07/2020- MWWFRS has provided extension to 16/02/2021.
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_005	High	R5. Add Device to and Update the Fire Alarm 1. Extend the smoke detection within the corridor of the Tyssul ward (adjacent to the Laser treatment room) and link it to the existing fire alarm system. 2. Exchange the smoke detection for a heat detection within the staff room Block 32FF. 3. A large number of Detector heads were seen to be outdated, this was also noted within the risk assessments, the fire detection needs to be updated in accordance with BS 5839 part 1. 4. There needs to be fire alarm repeater panels available for both wards within Block 2 FF. All of the above points should comply with WHTM 05 03, part B and BS 5839 Part 1. The changes should be carried out and commissioned by a competent person.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	This item should be completed by July 2020, within the original timescale of October 2020 set by MWWFRS.
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_007	High	R7. Training for Own Staff Provide your employees with instruction and training so that they know the fire precautions you have put in place. They must also be familiar with what they need to do in case of fire to ensure that they are safe and can keep other people safe.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	As an interim measure e-learning module will be in place by December 2020, instead of face to face training. Delay to December 2020 due to COVID-19. Verbal discussion has taken place between Head of Fire Safety Management at UHB and Mid and West Wales Fire and Rescue Service. MWWFRS have agreed verbally with Head of Fire Safety Management at UHB that they are happy with this arrangement but no formal correspondence received to confirm. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_008	High	R8. Cooperation/Coordination Effective systems of communication must be established with those who are responsible for all departments to ensure all relevant persons are provided with suitable and sufficient information in respect of the fire safety measures implemented. The cooperation must ensure that the shared fire safety measure(s) protect you all.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	This item should be completed by June 2020 (covered by R4 above), within the original timescale of October 2020 set by MWWFRS. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_010	High	R10. Obstruction of Escape Routes Ensure that everyone can evacuate quickly and safely. 1. Cabinets and lockers should be stored in areas that do not impede escape in the event of an emergency these items should be removed from the corridors. 2. Remove fridge stored within staircase Block 8 FF. 3. Remove items stored in lift lobby 2/B within CCU. 4. Remove Bins Store within staircase Block 32 GF. 5. Remove Bins Stored at the entrance to SCBU	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	To be fully implemented by October 2020. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021

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BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_011	High	R11. Fire Fighting Equipment Remove the existing Dry Powder Extinguishers from within all of the departments of the hospital site.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	To be fully implemented by October 2020. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_012	High	R12. Storage of Refuse Manage all waste on site responsibly. Your refuse bins sited at the rear of the Renal unit are overflowing and combustible material is accumulating around this area. This is also the case in the courtyard of Block 32 and within the maintenance yard. If not carefully managed and controlled, rubbish stacked in a haphazard fashion in unsightly piles outside premises can lead to more rubbish being dumped or fly tipped. Graffiti, vandalism and arson may then follow in quick succession. When there is no segregated bin storage, wheeled bins should be chained together and to an immobile object such as a metal stake, at least 10 metres away from any building.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	To be fully implemented by October 2020. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021
BFS/KS/SJM/ 00107739- KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001077 39_014	High	R14. Access Particular attention needs to be taken regarding the access for fire service vehicles in the event of a fire at the Glangwili site. Whilst visiting the site to conduct the inspections over a week period, it was noted that the car parks were heavily overcrowded with vehicles parking in unauthorised areas, as a result the attending fire appliances would not be able to access all parts of the hospital. Access to all parts of the building should be available for the fire service at all times as mentioned in WHTM - 0502 Chapter 7 and Part B of Schedule 1 of the Building Regulations 2010.	Actions have not been provided by the service.	~~20/10/2020~~ 16/02/2021	Feb-21	Amber	To be completed by October 2020. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 16/02/2021
BFS/KS/SJM/ 00114719- /KS/890/02	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147 19_02_001	High	R1. Compartmentation – All Vertical Escape Routes. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Vertical Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Actions have not been provided by the service.	~~01/09/2020~~ 30/01/2021	Jan-21	Amber	This work is part of the stage 1 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of January 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021
BFS/KS/SJM/ 00114719- /KS/890/02	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147 19_02_002	High	R2. Fire Damper Systems - Maintenance Ensure that the fire damper systems are properly tested and maintained. Following completion of testing of these systems, documentation needs to be sent to my office confirming this. Fire damper systems should be tested as per British Standard 5588-9 Code 9, with a maximum testing interval of two years.	Actions have not been provided by the service.	~~01/09/2020~~ 30/01/2021	Dec-21	Amber	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021
BFS/KS/SJM/ 00114719 - KS/890/03	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147 19_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.		~~01/08/2021~~ 31/12/2021	Dec-21	Amber	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021
BFS/KS/SJM/ 00114719 - KS/890/03	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147 19_03_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.		~~01/08/2021~~ 31/12/2021	Dec-21	Amber	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021
BFS/KS/SJM/ 00114719- KS/890/04	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/04	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147 19_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.		Apr-22	Dec-24	Red	This work is part of the stage 3 WGH Fire Enforcement Programme. Commencement of work to take place in January 2022 (delayed by 4 months due to COVID-19). This will be a large piece of work involving entering individual wards and decanting of services as required. Completion date is currently estimated as December 2024. Estates colleagues are meeting MWWFRS on 16/06/2020 to agree revised date of December 2024. MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: -: The door leaf or leaves. -: The frame in which the door is hung. -: Hardware essential to the functioning of the door set, 3 x hinges. -: Intumescent seals and smoke sealing devices/Self closure. -: Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Actions have not been provided by the service.	Mar-20	Dec-21	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Actions have not been provided by the service.	Mar-20	Dec-21	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_003	High	R3. St Nons. Ensure the certificates showing testing of emergency lighting systems are provided via email at the earliest opportunity.	Actions have not been provided by the service.	Mar-20	Dec-21	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_004	High	R1. Bro Cerwyn. Ensure that everyone can evacuate quickly and safely by removing the combustibles from the escape routes- outside kitchen area and dead-end corridor to offices.	Actions have not been provided by the service.	Mar-20	Dec-21	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber..
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_005	High	R2. Bro Cerwyn. Reinstate the fire resistance in the following locations: Holes in ceiling areas of offices, water leaking onto electrical appliances and sockets.	Actions have not been provided by the service.	Mar-20	Dec-21	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KBJ/SJM/00115068	29/05/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. South Pembs Hospital	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00115068_003	High	R3. Ensure that door-sets that can resist fire and smoke for 30 minutes are provided in the following locations: • Compartment double doors in main ward on 1st floor. The term 'door-set' refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set. 3 x hinges • Intumescent seals and smoke sealing devices/Self closure.	Actions have not been provided by the service.	Dec-19	Oct-20	Red	Not yet complete, bigger piece of work than originally thought. Capital money has now been confirmed and work to be undertaken, revised date October 2020. Unclear if MWWFRS have agreed to this extension.
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Actions have not been provided by the service.	Jul-20	Dec-21	Red	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Estates colleague with MWWFRS on 16/06/2020, revised dates agreed in principle. Once new dates are officially agreed by MWWFRS (revised letter received) this recommendation will be changed back to amber. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Actions have not been provided by the service.	Jul-20	Dec-21	Red	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Estates colleague with MWWFRS on 16/06/2020, revised dates agreed in principle. Once new dates are officially agreed by MWWFRS (revised letter received) this recommendation will be changed back to amber. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be the preferred safer option, it was explained to me that this was due to the residents being able to smoke within the premises before the smoking ban to reduce the false alarm calls. • It was noted that there was a detector being covered at time of inspection within the kitchen of the Pembroke county block (First floor flat F block). You must ensure that this practice is not repeated, information must be given to the occupants explaining the severity of this action. • Due to the Server within the Means of escape an additional detector within the area of the device is required (due to the lintel between the detector and the server) noted within the Pembroke county and St Thomas block (but this should include all blocks if server is on escape route in the same way). The changes should be carried out and commissioned by a competent person.		Jul-20	Dec-21	Red	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Estates colleague with MWWFRS on 16/06/2020, revised dates agreed in principle. Once new dates are officially agreed by MWWFRS (revised letter received) this recommendation will be changed back to amber. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber..
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_006	High	R6. Establish Emergency Procedures Establish procedures to be followed in case of fire and nominate people to put those procedures into effect. Ensure that there are enough competent people to successfully implement an evacuation. Where premises are occupied on a shared basis, effective systems of communication must be established with those responsible for other premises to ensure all relevant persons are provided with suitable and sufficient information in respect of the fire safety measures implemented. All five blocks but namely the Kensington, Sealyham Blocks.	Actions have not been provided by the service.	Jul-20	Jul-20 Sept-20	Red	This work has started but been delayed due to COVID-19, will be implemented by September 2020

Appendix 2: Recommendations In Progress / Overdue

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
684A2014	Jun-15	Audit Wales	A Comparative Picture of Orthopaedic Services - Hywel Dda	Open		Scheduled Care	Lydia Davies	Director of Operations	684A2014_001	Not High	R10. Operating theatres: The rate of cancelled operations made by the Health Board was five per cent compared with the Welsh Government target of two per cent.	A theatres improvement programme is being formalised as part of the HB QJPP programme. In November 2015, the Deputy CEO requested a review of all cancelled operations. Like other NHS hospitals, Hywel Dda routinely tracks the number of operations cancelled 'on the day' of admission but does not track those cancelled on the day prior to admission, nor does it effectively track those patients cancelled on each hospital site against those detailed on the Myrddin report. The prior to the day numbers are not routinely collected or made available by hospitals, but give a much fuller account of cancelled operations. Hywel Dda has reported total cancellations (and reasons for them) to Welsh Government for a number of years but there are validation errors within the submissions. Improvements required : Data cleansing Bed reconfiguration and activity management Critical Care Escalation Sterile services / equipment Theatre Scheduling and Pre-assessment We recognise that we need to continue our work to reduce cancelled operations and deliver further improvement to ensure patients waiting for elective surgery receive the best possible experience and outcomes. We are fully committed to working with clinical colleagues to build on the work described above and ensure that we maximise the potential benefits from existing work streams. We will continue to focus on improved scheduling, booking processes and sterile services provision. A project manager has been appointed to lead on root cause analysis of remaining cancellations to identify where further improvement work should be focussed, and this together with learning from other Health Boards, will inform the next stage of our improvement work.	2015/16	Mar-22	Red	Follow up audit by Audit Wales is due Autumn 2020. Unable to currently implement this recommendation due to COVID-19. Plan is being put in place re-start operating theatres with a paper being provided to the Acute Bronze Committee In June 2020 to agree steps required for operations to take place (e.g. pre-assessment appointment, COVID-19 risk assessment, 2 week patient isolation prior to surgery day, etc.) and decision will need to be made on which site will be safest for routine operations to take place. Currently a lot of questions still to be answered.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_001b		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: b) removing the use of temporary records, including poly-pockets and ensure files are merged into the master patient record.	Temporary notes and poly-pockets are still in use across the organisation. The Health Board's self-assessment response indicated that the numbers received into coding offices are not high. However, clinical coders across the Health Board told us that the situation had deteriorated over the period since our last review. There has been a decline in the organisation, maintenance and condition of individual patient case note folders because of greater movement of patients around the Health Board and shorter lengths of stay. Both factors add to the challenge of ensuring the notes are maintained in line with standards, and available when needed by clinical coding teams as well as clinicians. A note is entered in Medicode whenever a polypocket is used as the source for coding. If an audit of the full case note is subsequently carried out, there will then be a flag to indicate that it was not available at the time of coding.	Sep-19	Oct-20	Red	An action plan has been developed via the Health Records Group. The Health Records Group has agreed to focus on the correct Tracking of Patient Records, with Temporary notes and poly-pockets looking to be addressed following this work. Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020. Health Records Group to meet on 24th August and they will be reviewing the audit recommendations and be able to provide a revised date following this. 06/08/2020- Health Records Group to meet on 24th August and they will be reviewing the audit recommendations and be able to provide a revised date following this if appropriate.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_001d		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: d) providing training for ward clerks and other staff in relation to their responsibilities for medical records	There is no ongoing programme of training to ensure that ward clerks maintain records in line with professional standards. Coding staff said that the standard of practice amongst ward clerks is highly variable, and there is no real ownership of the notes in some wards. Ward clerks are managed by individual specialties and wards. This increases the need for ongoing communication (with ward staff in general as well as with ward clerks) about the importance of maintaining standards of practice and for the provision of training.	Sep-19	Oct-20	Red	IThe Head of Information Governance and Head of Health Records have agreed that joint IG and Health Records training will commence from January 2020. Rooms are currently being secured at each site to allow staff to attend. Staff will be trained in IG at the same time to improve the IG compliance. We anticipate this work will take 4-6 months to complete with a number of sessions being held in all sites. ARAC April2020 update: Revised Timescale – Training to begin December 2019 for 4-6 months Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_001e		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	All the clinical coding teams are asked to track case notes correctly using the Myrddin Patient Administration System. The Health Board's self-assessment indicated that this always happens, except for when case notes are collected from a ward in the morning and returned that afternoon. However, coding staff indicated that case note tracking is generally poor, except at Withybush Hospital.	Aug-20	N/K	Red	An action plan has been developed via the Health Records Group. The Tracking of Records will be the focus of the Health Records Group for the next 6 months with a review at the end of this period along with lessons learned. The work plan suggests a number of phases to the work, ensuring that there are feedback loops and reviews. Timescale – 16 months, based around 4 x 4 month PDSA cycles. The first PDSA cycle was undertaken and lessons learned have been feed into the next PDSA cycle, which unfortunately was paused due to the COVID outbreak. It is anticipated that there will be a delay of 3-4 months. Assurance and risk officer requested clarification of revised date. Response from service- Health Records Group is leading on this chaired by Assistant Director of Informatics. This action needs to be reviewed as part of the work of the group.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_002c		R2. Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include: c) ensuring all staff receive consistent feedback on issues raised through validation and audit from all sites.	None of the coders are currently qualified to audit coding work. In 2017-18 it was decided to have a supervisor and a coder carry out an audit of 30 case notes each month and to feedback the results directly to individual coders. The arrangement was suspended so that all coding team resources could be directed towards clearing the coding backlog. At the time of our fieldwork the situation had not changed. The Coding Manager carries out data quality checks when time allows. However, his time has been heavily committed to providing a presence on each site to mitigate for the long-term sickness absence of one of the two coding team supervisors.	Original completion date not stated in report	Dec-20	Red	Until additional resources are made available this recommendation will be placed on hold. If the Executive Team wish this to be progressed, there will be effect on the coding completeness. As an estimate, in total each day a coding supervisor and a coder undertake audit work would account for 12,000 cases not being coded. Based on each coder having feedback and partaking in 1 audit day per month. This equates to a 1- 2% effect on the completeness. Apr 20 ARAC update: The Clinical Coding Team are undertaking minimal audits in line with NWIS, and these are being feedback to coders when available. Action is currently on hold until addition resource is available Aug 2020 update- Currently not enough resources for amount of work required. Interviews taking place w/b 03/08/2020, this new resource will assist in achieving this recommendation.

603A2018-19	Jun-18	Audit Wales	District Nursing: Update on Progress	Open (external rec)	N/A	Community and Primary Care (Ceredigion)	Tracey Evans / Sharon Daniel	Director of Operations	WAO_DistrictNursing_001	Not stated	R6. Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the casemix between teams compared with team resources.	The Health Board said that it expects this issue to be definitively addressed through the publication of the All Wales dependency tool, currently expected in 2020.	Jan-19	Mar-20 Nov-20	Red	28/05/2020- The National District Nursing Project Officer appointment was made in February 2020, however, this work stream has been delayed due to COVID-19. The development of the national patient acuity/dependency tool for District Nursing services was reviewed on 7th May 2020 by the AW Nurse Staffing Levels programme Lead and remains one of the priority developments for 2020. The patient case mix and the resources within each of the DN teams in Hywel Dda was, reviewed, pre COVID, and was ready for presentation to the Director of Nursing, Quality and Patient Experience at the end of March 2020. However, due to the plans to support District Nursing services during COVID this review is on hold. The aim is to re-visit this work stream in September 2020 and will be aligned to the National work plan. Further update therefore to be provided after November 2020.
No ref	Mar-18	Audit Wales	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Director of Planning, Performance & Commissioning	WAO_InfoBackUp_006		Disaster Recovery & Business Continuity. R8. Design and implement a schedule of regular back-up media and disaster recovery testing to provide assurance that applications and data can be successfully restored in the time required after the loss of a system.	No revised management response provided in this follow up report.	N/K	Mar-21	Red	As of May 2020 still in line for March 2021 deadline.
238A2017-18	Dec-17	Audit Wales	Follow-up Outpatient Appointments: Update on Progress	Open		Scheduled Care	Stephanie Hire	Director of Operations	WAO_Outpatient_006	Not High	R6: Put in place systems and processes that will allow the Health Board to identify patients with these conditions.	Robust quality controlled systems to be developed across the process for the usage of outcome forms to ensure reduce errors.	Mar-18	~~Jun-20~~ Jan-21	Red	A revised outcome form has been developed and created to ease the completion of the form and emphasise the directive to ensure the that the clinical conditions are updated. This was in testing phase with two specialties to ensure it meets the needs of the clinical team and medical records staff, however required changes have been delayed as a result of COVID-19. Revised timescale of January 2021 to allow further testing and final version to be approved and rollout to take place.
651A2015	Feb-16	Audit Wales	Hospital Catering and Patient Nutrition Follow-up Review	Open (external rec)	N/A	Nursing	Sharon Daniel	Director of Nursing, Quality and Patient Experience	WAO_Catering001	Not stated	R4b: We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	Introducing a computerised catering system will incur additional revenue costs as the inputting of live data is key to providing timely and accurate information. The costs associated with such systems would ordinarily need to be sourced from Capital funding. • A review of cost benefits will be undertaken during 2016 as part of the work on the Catering Business case development , with a view to including in the Outline Business case if the review demonstrates it to be appropriate to do so	Dec-16	N/K	Red	The national IT catering Solution is now available via All Wales Procurement Framework. The system has been introduced in part to Aneurin Bevan and representatives from Hywel Dda visited to consider the benefits of procuring the system. The feedback received is that the benefits realisation has yet to be assured and for this reason a business case has not yet been progressed. Director of Nursing, Quality and Patient Experience currently considering if this recommendation will be implemented, or if it will not be taken -
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_001		R1: Long term Set out a vision and plan for the future of the EPP to: • prioritise future developments; • establish the capacity of existing staff resources; and • identify the resources that would be needed to realise the vision for the service.	A new plan to address multi-mobility rehabilitation is being developed which includes EPP. Staffing resource and future developments for EPP will be covered as part of this. A workshop will be held in November 2019 to commence engagement activities with a view to finalising the plan in 2020/21.	Mar-20	Sep-21	Red	A paper had been completed for Executive discussion as COVID 19 crisis happened. Since the learning has started to evolve for COVID 19 patents and the fact we may not be able to do face to face group sessions for a prolonged period of time the relevant teams have begun discussions with how to deliver and support rehabilitation remotely Elements that are being tested include Attend Anywhere by the physiotherapists Patient Knows Best by difficult asthma and home oxygen teams. Digital films like Pocketmedic 2 new members of staff have been seconded for a year into the EPP team to support delivery of programmes and plan and prioritise need starting on 01/06/2020
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_003		R3: Address the barriers to promoting the EPP.	A bid for funding to undertake specific research to understand the barriers to engagement and take-up of the programme is being developed. The aim would be to complete the research by Feb 2021. Work is also on-going to develop a bespoke programme to reflect cultural and language needs in order to further support the Syrian Vulnerable Persons Resettlement Programme. A bid is being developed to seek funding to support this innovation through the Self-management and Well-being Fund. Bid submission date is Nov 2019 and if successful work will be completed by April	Feb-21	Dec-21	Red	All bids were unsuccessful. A new plan has yet to be discussed on how to deliver this work.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_004		R4: Include EPP web-links on information sent out by the team and on Health Board waiting list letters and holding letters.	EPP is represented on a Quality Improvement Communication Team project which will incorporate this action. This project will be completed by July 2020.	Jul-20	Jul-21	Red	Unable to complete project due to COVID 19 as yet change completed date to July 2021.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_005		R5: Involvement Work with patient experience staff to capture the experiences of patients who have moved on.	The EPP Team is working with the Patient Experience Team to develop a Family and Friends feedback tool. Plans are in place to hold an annual update event in each county to which all previous programme participants are invited to attend. The EPP Team are continuing to gather participant and tutor stories in order to promote the benefit of attending the programmes. This work is on-going throughout 2019/20.	Mar-20	Mar-22	Red	Unable to progress this work as yet but continues to be a priority.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_006		R6: Look for opportunities to involve younger people in the design and delivery of EPP courses, possibly through schools and colleges.	The EPP are planning to start working with sixthform schools and other settings alongside the Welsh Baccalaureate. Initially the Team will work with Bro Dinefwr School to develop this initiative by April 2020.	Apr-20	Dec-21	Red	Started to look at delivering a healthy eating session, have been unable to link into the Welsh Baccalaureate as the school had already set specifics for this, now on hold due to COVID 19 but will continue as soon as possible
No ref	Oct-19	Audit Wales	Integrated Care Fund (icf) Review Update (West Wales RPB)	Open		Partnerships & Corporate Services	Anna Bird	Director of Partnerships & Corporate Services	WAO_ICF_007	Not stated	R7. Rollout the use of the regional outcomes framework to all projects if the pilot is successful	• A new outcomes and benefits framework is being developed at regional level, for application initially against transformation fund projects and extension thereafter to cover the ICF programme.	Dec-20	Dec-20	Amber	On-going discussions taking place and the timescales may need to shift but will be reviewed again at the end of Quarter 1 2020/21
No ref	Oct-19	Audit Wales	Integrated Care Fund (icf) Review Update (West Wales RPB)	Open		Partnerships & Corporate Services	Anna Bird	Director of Partnerships & Corporate Services	WAO_ICF_008	Not stated	R8. Develop exit strategies for all Integrated Care Fund projects	• This will be a key focus for the 2020-21 programme of work which the RPB are finalising. This will be undertaken within the context of national discussions on future funding.	Dec-20	Dec-20	Amber	On-going discussions taking place and the timescales may need to shift but will be reviewed again at the end of Quarter 1 2020/21
385A2016	May-17	Audit Wales	Review of Estates	Open	N/A	Estates	Rob Elliott	Director of Operations	WAO_Estates001		R6: Widen the range of performance management KPI to include: ? time; ? cost; ? productivity; ? non-productive time; ? quality; ? service; and ? customer feedback.	Establish a Working Group to set out the IT requirements to capture this range of KPIs Implement any changes necessary to ensure these KPIs are reported. Actions/Timescales to be progressed during 2016/17 with reports to be provided to CEIMTSC as part of agreed work plan	Sep-19	May-20 Sept-20	Red	Likely to be pushed back as delivery of replacement of RAM4000 has been delayed- can't do any onsite installations at the moment due to members of staff currently working on COVID related work. Feb 20 ARAC TOA requested an update be provided Oct 2020
385A2016	May-17	Audit Wales	Review of Estates	Open	N/A	Estates	Rob Elliott	Director of Operations	WAO_Estates002		R8: Ensure the right number of people with the right skills are available now and in the future by developing fully funded plans for workforce and training.	Review to be undertaken of workforce plans to identify:- ? Existing resources/ age profile This is updated annually Currently working with Workforce and OD to develop an "apprentice academy" ? To consider all Investment plans and any subsequent resource impact within Estates.. ? Action plan to address identified gaps	Dec-16	Apr-20 Sep-20	Red	Most of the work on this has been completed but has now been knocked back due to COVID. A 'work in progress' type paper on future training of workforce has been shared with the CEO. Feb 20 ARAC TOA requested an update be provided Oct 2020

No ref	Aug-18	CHC	Women and children's services Visit report March 2018	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	CHC_W&C_001	N/A	R5. The health board needs to do all it can to resolve the current temporary reduced hours arrangements in PACU.	Discuss at Task and Finish Group with Medical Director for decision to be made	Sep-19	Dec-2020 Mar-21	Red	Due to COVID 19 PACU patients now seen at GGH. To be reviewed possibly Dec 2020. 27/07/2020 Requested update, chased and met with Lead go through updates required. to updates. 6/08/2020. Response received . All paediatric patients continue to be seen in GGH. Services will be reviewed March 2021 to account for the COVID 19 impact.
No ref	Jul-19	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	A&EWGH_001	N/A	R1. Health Board (HB) needs to help people find ways of getting patients the information that they need so that they can go to the right place, when they need care.	To review the leaflets available to patients directing them to appropriate services; To request that the communications team use social media & display boards to send consistent messages to the public around accessing services; To implement a streaming service prior to registration in ED	Nov-19	Dec-20	Red	1/6/2020 emailed for a response - Clinical Nurse Lead response received.. 03/08/2020 Service confirmed, reviewing the streaming process. As part of our Covid plans all patients are screened for Covid before coming into the hospital. We currently trying to have a doctor or ANP there during times of high demand who can see patients and assess / direct and discharge.
No ref	Jul-19	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	A&EWGH_004	N/A	R3. HB needs to make sure that people do not feel overlooked when they are waiting	To progress the plan to install electronic screen in the Majors area; To establish robust 'rounds' within the Department to check on patients who are waiting; To agree daily schedule with Red Cross volunteer service to support patients within the Department	Nov-19	Nov-20	Red	1/6/2020 emailed for a response - Response received Senior Sister ED to speak with Gareth Beynon as a paper has been written for Electronic Screens - delayed due to covid 19.
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_002	N/A	R2: The Health Board needs to consider some redecoration or improvements to patient areas could make the premises more presentable.	To work with Estates to agree a redecoration programme	Dec-19	Mar-21	Red	30/07/2020. CNS Discharge Planning CHC met with estates last week who have agreed to paint the patient areas – progress made.
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_004	N/A	R4. The resource gap (lack of trolley service or visiting shop, etc.) might be something that the local community might be able to address in some way.	To request support from the League of Friends and HB Volunteer Manager with implementing a trolley service/shop services. And also to examine if we are able to operate a personal shopper programme for patients.	Mar-20	Mar-21	Red	Unfortunately, the attempts made to recruit volunteers to the area to provide a personal shopping service has not been successful. We continue to work with the team to pursue this opportunity. 30/07/2020 This has not progressed the COVID situation has impacted on this – currently the staff will contact family members if patients need anything and they are then brought to the door. There has not been a League of Friends meeting since lockdown.
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_006	N/A	R6.The physiotherapy room in particular was not welcoming and it would be beneficial if this could be reviewed by the Health Board to identify if any changes could be made to make it more welcoming.	To arrange a meeting between the Head of Community Nursing and the Head of Physiotherapy and Estates Dept. to identify if any changes could be made to make it more welcoming. To discuss how the environment can be further advanced	Feb-20	Jul-21	Red	Outside storage condemned by Estates an alternative is being considered. 30/07/2020 This is also ongoing and there is work outstanding in the area which following my meeting last week estates where going to find out about funding.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	Mar-21	Amber	Due to COVID guidance from Royal College of Ophthalmologists only urgent and emergency appointments are being seen by target date, therefore not seeing risk factor 2 or 3 patients, which are validated by a clinician to establish that they can wait. In April there were 13,000 backlog of patients with risk 1 irreversible sight loss which has reduced to 11,000 as of May 2020. Currently seeing more of these higher risk patients as the referrals are not being made for lower risk patient (currently not working towards RTT Targets). By the middle of quarter 2 (August 2020) will have better idea of the waiting lists due to COVID and will review this recommendation at this time to establish if March 2021 deadline is still feasible.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	Mar-21	Amber	See update in recommendation 1- due to current COVID situation only those with greatest risk of sight loss now been given priority on the pathway. Recommendation to be reviewed in August 2020 to establish if March 2021 deadline is still feasible.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices004	N/A	R4. The Welsh Government and the NHS in Wales needs to make sure there are robust patient feedback arrangements in place to regularly monitor and review patient satisfaction	Development of a Patient Experience Group that reports to the Health Board Eye Care Collaborative Group	Apr-20	Jul-20 Aug-20	Red	Due to COVID the first meeting of Patient Experience Group that was scheduled for March 2020 did not take place. Director of Operations has also currently stepped down the Health Board Eye Care Collaborative Group. Currently exploring ways of how Microsoft Teams platform can support the sett up of virtual meetings/forums for this. 16/07/2020 update-Meeting of Eye Care Collaborative Group took place in June 2020 and agreed that the Health Board need to continue to progress a Patient Experience Group. This will be explored during August 2020.
No ref	May-18	CHC	What's your NHS like for you? Hearing from people with a learning disability	Open (external rec 5)	N/A	Unscheduled Care	Carol Cotterell	Director of Operations	NHSLikeForYou_001	N/A	R5. All Wales Working Group currently developing standards of practice for annual health checks including training programmes for GPs.	• Once finalised the standards of practice to be implemented across the GP practices • GPs to participate on All Wales Training Programme	Mar-19	Apr-20 Aug-20	Red	Educational Packs for GPs are ready to go and a launch at Welsh Government level is imminent – but no date has been received as yet. As soon as the pack is received the Community Learning Disabilities Team will participate in the delivery of the training to primary Care Teams.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	Jul-20 Aug-20	Red	WG have awarded the contract and implementation of EPR will be progressed on an All wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group - August 2020.
GP	Aug-18	CHC Contractors	Brynteg GP Practice, Ammanford Aug 2018	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	CHCGP_Brynteg_001	N/A	Practice need to make sure that the seating arrangements suit all needs, including people who may have limited mobility.	We will request grant support to change our seating arrangements when the next tranche of Health Board funding becomes available.	Mar-20	Dec-20	Red	The practice have applied for a grant to re-model the waiting room but is currently on hold pending a grant. They are hoping this can be processed later in the year after COVID-19.
GP	Aug-18	CHC Contractors	Brynteg GP Practice, Ammanford Aug 2018	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	CHCGP_Brynteg_002	N/A	Practice should consider introducing a Patient Participation Group	This is in the process of being set up in conjunction with new collaborative working with MG St practice.	Mar-20	Dec-20	Red	This is not practical at the moment but have recently completed a patient survey. There are too many unknowns at the moment but hoping that these can be completed before the end of the year (December 2020).
GP	Oct-19	CHC Contractors	Llynyfran Surgery, Llandysul	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	N/A	N/A	Practice should consider introducing a Patient Participation Group	This is in the process of being set up in conjunction with new collaborative working with MG St practice.	Mar-20	Dec-20	Red	This is not practical at the moment but have recently completed a patient survey. There are too many unknowns at the moment (due to COVID) but hoping that these can be completed before the end of 2020.

No ref	Jul-18	Delivery Unit	National report- The Quality of Care and Treatment Planning - Assurance Review of Adult MH&LD Services	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	NR_QCTP_002	N/A	R2: A 'train the trainer' programme focussed on the formulation of CTPs which are person centred, holistic and include recovery focused outcomes should be developed.	Bespoke training to be developed	Apr-20	Dec-21	red	MH&LD Management and WWAMH (a local and regional Mental Health development Charity) have been evaluating current and past Care Coordination training. Delays are due to the current Covid 19 situation. The proposed delivery method for the NHS staff will be Microsoft Teams and this is available for NHS staff. Likely to be 6 months before the pilot training is completed. Carers UK were asked to deliver a pilot training in the Ceredigion area in Feb but they have stopped delivering the Mental Health Care Coordination training and will not be delivering this in the future. A decision was then made to develop a bespoke training for the Hywel Dda area working with existing knowledge and experience within the NHS, LA, voluntary sector, carers, service users, and the peer led sector. WWAMH and the MHLD management will lead on this work. The pilot training will be reviewed and then rolled out over the following 12 months to a wider group. The training will involve people with lived experience and carers in the training and will be reflective learning and experience based. The training will be delivered to NHS staff, LA staff, voluntary sector organisations, private sector, and people with lived experience and carers. It will be delivered via MS Teams for NHS staff and Zoom for everyone else, although the WWAMH preferred format for group training is Zoom as it is more flexible and responsive for experience and reflective learning.
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio002		R2:Ensure that all administrative record keeping – both electronic and within the medical records – are maintained to the highest of standards.	Monthly audits of outcome form to establish % compliance - feedback any non-compliances with Clinical lead to address non-compliance.	Aug-19	Sep-20	Red	Unable to progress due to COVID priorities reviewed date for completion is now September 2020.
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio003		R3b: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): b. clinical agreement that all referrals sent to tertiary service clearly include the clinically determined PSD and current adjusted PSD, including a standardised referral form which is consistent across HDUHB.	For 100% of referral letters to have a PSD identified by November 2019 - audit undertaken in February 2020 demonstrates a 31% compliance. SDM Cardiology and Cardiology Service Support Manager to reinforce need of PSDs to referring clinicians and re-audit in 3 months.	Ongoing	Dec-20	Red	Unable to progress due to COVID priorities reviewed date for completion is now December 2020.
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio003		R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.	HDUHB was in the process of working with IT to setup another Sharepoint system to move towards the electronic referral of patients between Cardiology and Cardiac Surgery. However, this hasn't been progressed due to the All Wales Accelerating Cardiac Informatics work being progressed on Hospital to Hospital Referrals. Cardiology Service Delivery Manager currently in discussion with HDUHB Informatics and AWACI.	Ongoing	Dec-20	Red	Unable to progress due to COVID review date December 2020.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_002	N/A	R2.The UHB should implement a mortality review process for patients who die after a wait greater than 36 weeks for planned treatment, to seek assurance that the delayed treatment was not a contributory factor to avoidable harm.	Retrospective review to identify number of patients in 2019/20 Month 1-6 who were removed from the waiting list due to RIP while waiting over 36 weeks in order to identify scope of any issues	Aug-19	Oct-19 May-20 Aug-20 Mar-21	Red	Revised August 2020 daye was on track prior to COVID-19, however we now have a waiting list position which is larger than anticipated at this time. The whole waiting list is currently being clinically validated to ensure we are able to categorise the patient's urgency correctly. UHB is currently working with WG on a 5 stage process, which will include mortality waiting list review, to enable the UHB to recover its waiting times as a result of COVID-19. Revised date of March 2021 to review current progress of this recommendation.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_004	N/A	R4iii. The national work on patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) provides a framework for some planned care pathways.	Overseen by the Planned Care Programme assurance framework. PROMs and PREMs are in implementation (for example orthopaedics). Our follow up backlog bid to WG includes funding to further develop these systems.	Mar-20	Dec-20	Red	National work on PROM and PREM capture has progressed in some pathways. This work has been augmented by trials of functionality provided by third party suppliers and guided by standardised assessment tools that will integrate with the National Data Repository. The Value Based Health Care team are working to facilitate electronic PROM capture using the DrDoctor product in Trauma & Orthopaedics, Cardiac Services (Heart Failure) and Opthalmology by Q3 of FY 2020/21
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_004	N/A	R4iv. There is scope for the Health Board to expand its use of this framework.	Evaluation of service suitability for PROMs / PREMs to be evaluated for inclusion in 2020/21 transformational change programme.	May-20	Sep-20	Red	The evaluation of the DrDoctor product against the National PROM solution will be undertaken once the initial DrDoctor implementation has been completed. A business case is being developed to enable the expansion of PROM/PREM collection in other areas over the next 3 years, which will be submitted for consideration in September 2020.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_009	N/A	R9. Review of expectations for primary care consultations prior to referral for planned care is recommended to assist with improved management of patient expectations	Referral criteria forms part of the Transformation programme for all Scheduled Care services, with progress reported through establish groups. Electronic referral management continues to be rolled out across the Health Board. These processes are to be reviewed by the Assistant Director of Nursing (QI)	Mar-20	Mar-21	Red	Referral criteria forms part of the Transformation programme for all Scheduled Care services, with progress reported through establish groups. This has been delayed as a result of COVID-19 but will now be picked back up as part of Transformation programme.
No ref	Mar-19	Delivery Unit	All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Open	N/A	Mental Health & Learning Disabilities	Angela Lodwick / Sarah Burgess	Director of Operations	AWAR_PCCAMHS_005	N/A	R5. The HB should undertake an engagement exercise with GPs to improve liaison and a shared understanding of CAMHS pathways.	GP'sand Primary care staff will be provided with a Service Specification for referral to CAMHS LPMHSS	Nov-19	Dec-20	Red	01/05/2020 Assurance and Risk Officer met with Director and Interim Deputy. Date extended due to Covid 19, further email to Angela Logdewick , this will not be achieved quickly due to COVID and also 50% absence in Primary care .
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_002	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	Jun-20 Aug-20	Red	IMTP has been submitted but due to COVID there are alternative plans for the service being developed. Royal College of Ophthalmologists and Welsh Government (WG) guidelines on delivery of eye services is being received on an all most weekly basis due to the COVID. WG has provided guidance on an increased community Ophthalmology pathway, however but our Consultants are not in agreement with the guidance. Service Delivery Manager meeting with Director of Operations for Exec Team steer on potential to not accept the WG guidance. New timescale of June 2020 to review position of developing plans during COVID. 16/07/2020- New timescales of August 2020.

0	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_003	N/A	R3. Programme management resource be allocated to support the development and implementation of the long-term ophthalmic plan.	Business Justification Case for additional Service Manager support within Ophthalmology being considered by Panel.	Mar-20	Jul-20	Red	BJC was submitted but not successful in obtaining funding. In addition due to the current planning of the new 'norm' due to COVID it would not be suitable to bring a new person in at this time. New timescale July 2020 --to review the requirements of the recommendation in line with planning arrangements. 16/07/2020- This action will no longer be progressed. No additional Service Manager will be recruited.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_004	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	Jul-20 Aug-20	Red	IMTP submitted but no feedback provided as yet. New timescale July 2020 to review the requirements of this action. 16/07/2020- New timescale of August 2020
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_006	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	Jun-20 Aug-20	Red	Same recruitment challenges exist. 2 recruitment campaigns has been unsuccessful and third recruitment round pulled due to COVID. Currently exploring options with Swansea Bay UHB to design a regional ophthalmology model for South West Wales. Clinicians have been requested to provide their option appraisals by the end of May 2020.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_007	N/A	R7. As part of the medium-long term plan development, the cataract service options require appraisal prior to the commencement of the next planning cycle, supported by a clear, time-bound delivery plan.	Options included as part of the IMTP.	Mar-20	Jul-20 Sept-20	Red	16/07/2020- update from service. ARCH workshop to explore Regional Due to COVID situation the cataract service has currently ceased. 16/07/2020- Service is starting to review Urgent Cataract patients. New timescale of September 2020. Routine Cataracts will not commence during Q.2.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_008	N/A	R8. A revised plan/ funding mechanism for extension of W-AMD services should be developed to ensure there is sufficient capacity to meet this urgent demand.	Options included as part of the IMTP.	Nov-19	Jul-20 Sept-20	Red	During COVID the W-AMD service has continued and increased number of sessions have taken place (due to more routine services currently ceasing), therefore allowing us to improve our waiting list and eliminate the backlog. Plans to continue this post-COVID (once services are relatively back to 'normal) are currently developed. 16/07/2020- Due to COVID AMD service are meeting their demand due to changes to service delivery. This will continue through Q.2 - review September 2020.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_001	N/A	R1. The Health Board and its local authority partners should, as a matter of priority, improve integration across health and social care in learning disability services. This should include the alignment of policies & protocols to support joint working, the sharing of assessments, and the production of multi-agency CTPs.	As this is a high level action it sits within the HB Programme of work under transformation. A transformation fund has been made available across the Region and within this there is an allocation for developing integration. There are also clear links to transforming clinical services and transforming mental health services. A CTP Policy is being developed which will articulate the required joint working arrangements. Through the development of the WCCIS(integrated information database for Health and Social Care) there are minimum core data sets being developed as standardised across Wales and we are working with the All Wales Groups and DU to share these and understand how they can be implemented. As this is a high level action it sits within the HB Programme of work under transformation. A transformation fund has been made available across the Region and within this there is an allocation for developing integration. There are also clear links to transforming clinical services and transforming mental health services. A CTP Policy is being developed which will articulate the required joint working arrangements. Through the development of the WCCIS(integrated information database for Health and Social Care) there are minimum core data sets being developed as standardised across Wales and we are working with the All Wales Groups and DU to share these and understand how they can be implemented.	May-19	Mar-23	Red	No updates received.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_002	N/A	R2. A bespoke training programme to support the improvement of CTPs should be introduced to ensure that mental health and learning disability staff are, and remain, skilled in formulating CTPs and in enhancing the involvement and experience of service users in the process.	There is a Regional Workstream for Workforce Development and we are looking to ensure that this is aligned to work ongoing there. The TMH workstream is also taking this forward. Within LD a bid is currently being written for people who use services to help deliver and inform training and create be-spoke packages, this will include how we fund this work.	Mar-23	Mar-23	Amber	No updates received.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_005	N/A	R5. Improvements are required in the recording of MDT involvement in care and treatment planning which includes, recovery and progression processes, discharge planning, risk management and crisis planning. IT systems used to record assessments and CTPs should be streamlined to improve their integration within a single multidisciplinary CTP.	A regional workshop was held in February to look at MDT decision making and how this informs commissioning. As referenced above there is work on a National level to produce templates to support WCCIS. The overall lead for WCCIS implementation sits with IT, but we will continue to contribute to the development of national tools. Considering a pilot with Ceredigion who already have WCCIS.	May-19	N/K	Red	
18262	Feb-19	HIW	Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	WGHUnannounced001	N/A	R4. The health board is required to provide HIW with details of the action it will take to ensure that: Signage at the hospital is reviewed to ensure it is easy to navigate for all patients and visitors to the hospital	Signage to be reviewed, to include patient representation of those with visual impairment and alterations agreed as appropriate	Apr-19	Feb-21	Red	No updates received. 1/6/2020 emailed for a response - Response received: on hold due to Covid-19. More realistic date is Feb 21
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_014	N/A	R14:The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.	Clinical Directors to discuss the need for improved prescribing of oxygen with medical staffing. To provide training for ward staff on the use of oxygen therapy and prescribing.	Oct-19	Dec-20	Red	Senior Nurse currently working alongside Senior Nurse for Medicines Management to devise training package. Will form part of wider HB approach to addressing training needs for all practitioners in relation to oxygen administration. Suspended due to Covid-19 pandemic. To rearrange for October 2020
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_016	N/A	R16: The health board must ensure that pain is assessed and managed by an appropriately trained member of staff, and that records are accurately completed.	To provide training on pain assessment, management and evaluation on Ceri ward.	Oct-19	Dec-20	Red	Senior Nurse Manager is liaising with nurse specialist for pain and palliative team to review training needs on Ceri ward in relation to pain management and evaluation. Once scoping complete training dates will be available for on-ward training.
19105	Dec-19	HIW	Ystwyth Ward, BGH 03-04 Sep19	Open	N/A	Unscheduled Care (BGH)	Dawn Jones	Director of Operations	19105_013	N/A	R13: The location of the therapy suite is reviewed to make it more accessible to patients, and to minimise the risk of cross infection in an area that cared for immunocompromised patients	To relocated Leri day unit patients into the new Chemotherapy unit (that will be based in the Y Banwy footprint)	Mar-20	3 months after red COVID zone area removed	Red	The relocation of Leri day unit into a new Chemo Unit has been put on hold due to COVID- the new build is currently a red COVID zone area. This will be picked up once the red zone is no longer required, the timescale for which is currently unknown.

19105	Dec-19	HIW	Ystwyth Ward, BGH 03-04 Sep19	Open	N/A	Unscheduled Care (BGH)	Dawn Jones	Director of Operations	19105_015	N/A	R15: The health board must ensure that Deprivation of Liberty Safeguards, metal capacity and best interest assessments are routinely conducted.	To arrange further education and training by the mental health teams on timely assessments escalation and compliance. To support the implementation of the shared care project which will provide an outreach service form mental health to support ward staff	Mar-20	Aug-20	Red	The Safeguarding team provided outreach training and 1-2-1 training sessions prior to COVID. Majority of staff were trained but not all staff. This training will be picked up after COVID pressures have decreased.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_002	N/A	The health board must: Consider how the privacy of patients can be maintained if staff have discussions in the open plan bay area Consider gaining patients' views regarding visiting access of birthing partners.	Patient feedback questionnaire to be designed to collect patient views on birthing partners staying overnight.	Mar-20	Sep-20	Red	Unable to implement due to Covid 19 restrictions. Maternity services following RCOG and RCM guidance with only 1 birthing partner for delivery. Aim to review in Sept 2020 as awaiting further COVID 19 guidelines. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020. Update received-Unable to implement fully Due to Covid 19 restrictions following RCM guidance 1 birthing partner only advised. Review in Sept unclear how long restrictions will be in place.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_003	N/A	The health board must ensure that: Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards Notice boards containing information about staff on duty are updated at every shift change Notice boards are reviewed to provide health promotion information Information throughout the unit is made available bilingually.	To discuss with Head of Estates department the maternity signage across Glangwili General Hospital	May-20	Sep-20	Red	New signage not implemented due to the Covid 19 pandemic. Current departments have been reconfigured to other clinical areas and signage adapted. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020. Update received-Initial signage issues are on hold, due to the Covid 19 outbreak, which has resulted in services being reconfigured and signage adapted.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_003	N/A	The health board must ensure that: Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards Notice boards containing information about staff on duty are updated at every shift change Notice boards are reviewed to provide health promotion information Information throughout the unit is made available bilingually.	Clinical lead to meet with Head of Welsh Language services to discuss appropriate information being available in Welsh	Mar-20	Dec-20	Red	Letters available bilingually. Notice boards have been updated however further update will be following COVID 19 pandemic. To be reviewed Dec 2020. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020. Update received-Signage completed, letters completed.On hold due to Covid 19 as staff relocated, full implementation to be reviewed possible Dec 2020.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_004	N/A	The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation.	Audit to be undertaken on compliance of completed 'Birth Choices' documentation in the All Wales Handheld record	Mar-20	Aug-20	Red	500 Clinical notes audit has been undertaken and will be collated into a report new date given 31st August 2020. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020. Update received-Staff have completed a 500 note audit and a report is being collated.
19257	Jan-20	HIW	Withybush Hospital (Maternity), 3-4 December 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19257_007	N/A	The health board must consider the effectiveness of communication with staff including around the service change and how to address staff morale. The health board must ensure the content of the PROMPT guidance folders are tailored specifically for care within the unit and that future PROMPT training is aligned to the new service.	NHS staff survey to be distributed to all staff 01/03/20 to ascertain staff morale following organisational change.	Mar-20	Oct-20	Red	1/6/20 Delayed due to covid 109. Full staff survey is to be completed by Sept 2020. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020.Full staff survey will be completed by end of August . Report to be generated from this to be completed by Sept 2020. Update received Survey commencing in August and the rerport on the findings will be completed by teh end of Oct 2020.
19101	Feb-20	HIW	Llandovery, 26-27 November 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	19101_001	N/A	The health board is required to provide HIW with details of the action it will take to ensure that: * Palliative care rooms are provided with full privacy and gaps around windows are obscured * Visitor toilets provide access for wheelchair users * All patient areas are free from draughts	Work is underway to conceal the gaps in the window coverings. Spray purchased for the window, estates to apply – no date for this as yet.	Feb-20	Dec-20	Red	Spray purchased for the window estates to apply – no date for this 30/07/2020 CNS Discharge Planning CH Nurse has confirmed this is still ongoing I have Emailed Dawn to ask for a date when estates can complete – if no response I will escalate.
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_001b	N/A	R1: Information relating to smoking cessation and sepsis are made available on both wards	Sepsis posters to be displayed in each clinical area. Sepsis information leaflets to be displayed and available in ward information area	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_002		R2: Bilingual Skills Strategy is reviewed and updated	Workforce Strategy reviewed in Jan and Feb. Consultation in March delayed due to Covid/ Consultation to be completed, final version to be issued	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_003		R3: Staff ensure conversations with patients are conducted in a quiet manner to protect their patient confidentiality	Memo to be sent to staff and displayed to ensure staff promote utilisation of day room facility and multidisciplinary rooms to support conversations to maintain confidentiality, dignity and privacy.	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_006a		R6: Staff on Ward 7 are informed of their duty to keep patient information strictly private and confidential by closing the open section of the ""at a glance" board when not in use and Ward 11 is encourages to use the board ensuring sections are complete and information is up to date.	Memo to be sent to staff across all clinical areas reminding them of the need to maintain patient confidentiality in relation to displaying information	Jul-20	Jul-20	Red	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_006b		R6: Staff on Ward 7 are informed of their duty to keep patient information strictly private and confidential by closing the open section of the ""at a glance" board when not in use and Ward 11 is encourages to use the board ensuring sections are complete and information is up to date.	Practice of need to close "at a glance" board re-enforced in Senior Sisters Meeting. Ward 11 sister promoting utilising the board more effectively with information sections being completed	Jul-20	Jul-20	Red	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_006b		R6: Staff on Ward 7 are informed of their duty to keep patient information strictly private and confidential by closing the open section of the ""at a glance" board when not in use and Ward 11 is encourages to use the board ensuring sections are complete and information is up to date.	Observational weekly spot checks to be undertaken for 6 weeks to ensure compliance of closing and effective utilisation of the "at a glance" boards. Results to be discussed in monthly scrutiny meetings	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_007		R7: Information relating to staff compliance with hand hygiene, patient pressure damage, patient falls and ward compliance with the cleaning schedule is presented clearly and on a timely basis on ward notice boards	Knowing how we are doing board updated monthly, results discussed at monthly scrutiny meeting. Improvement action plans completed for areas of concerns, good practice shared in scrutiny meeting. Spot checks to be carried out monthly for 3 months	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_009		R9: Staff respond to call bells in a timely manner to ensure that patients' needs are fully met	Observational spot check audits to be completed over a 2 month period. Continued review and monitoring of patient feedback	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_010b		R10: Discharge planning and appropriate care packages are arranged for patients in advance of discharge and are subject to regular review	Senior Nurse Manager to undertake spot check on ward board rounds. Findings and learning to be discussed in monthly scrutiny meetings	Aug-20	Aug-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_010c		R10: Discharge planning and appropriate care packages are arranged for patients in advance of discharge and are subject to regular review	Discharge to Recover & Assess pathways being piloted in Ward 7 in July 2020	Aug-20	Aug-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_012		R12: Both wards provide patients and visitors with information relating to the CHC	Information leaflets to be obtained from the CHC and displayed within each clinical and communal area throughout the hospital	Aug-20	Aug-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_014		R14: Information relating to advocacy arrangements is made available on ward 11	Information leaflets to be obtained from the advocacy service and displayed within each clinical and communal area throughout the hospital	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_016		R16: All ward areas are cleaned to a high standard	Monthly cleaning audits undertaken to include nursing, cleaning and estates components. Results reviewed by Head of Nursing and Head of Facilities. Compliance needed 95% +	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_017a		R17: Consideration is given to providing appropriate storage facilities on both wards to ensure a trip free environment	Environmental spot audit to be undertaken by Senior Nurse Manager. Findings are discussed in monthly sisters scrutiny meetings with Senior Nurse Managers and Head of Nursing	Nov-20	Nov-20	Amber	

19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_017b		R17: Consideration is given to providing appropriate storage facilities on both wards to ensure a trip free environment	Review of storage in each area to ensure locked facility available	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_018		R18: All liquids and chemicals are stored in a closed cupboard	Meeting with staff to advise and ensure awareness on correct storage of liquid and chemicals. Awareness of COSHH policy to be raised and signposted to staff. Signatory list to be completed to advise that they are aware of correct processes	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_021a		R21: In line with the National Institute for Health and Care Excellence (NICE) guidelines, if a person is unable to reposition themselves, health and social care professionals should help them to change their position, to prevent the development of pressure ulcers. For safety reasons, repositioning is recommended at least every six hours for adults at risk, and every four hours for adults at high risk	Monthly pressure damage scrutiny reviews with Senior Nurse Managers and Head of Nursing	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_021b		R21: In line with the National Institute for Health and Care Excellence (NICE) guidelines, if a person is unable to reposition themselves, health and social care professionals should help them to change their position, to prevent the development of pressure ulcers. For safety reasons, repositioning is recommended at least every six hours for adults at risk, and every four hours for adults at high risk	Documentation audit spot check to be undertaken by Senior Nurse Manager to ensure guidance is being adhered to	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_021c		R21: In line with the National Institute for Health and Care Excellence (NICE) guidelines, if a person is unable to reposition themselves, health and social care professionals should help them to change their position, to prevent the development of pressure ulcers. For safety reasons, repositioning is recommended at least every six hours for adults at risk, and every four hours for adults at high risk	Signatory list to be completed to ensure all staff are aware of, and have read NICE guidelines	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_022		R22: All areas on the ward are cleaned to a high standard	Monthly cleaning audits undertaken to include nursing, cleaning and estates components. Results reviewed by Head of Nursing and Head of Facilities. Comoliance needed 95% +	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_023a		R23: Patients in side rooms presenting with infection are risk assessed to confirm if it is appropriate to allow the doors to the rooms to remain open	Staff to be re-familiarised with infection control policy. Memo and signatory list to ensure staff are aware of correct process.	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_023b		R23: Patients in side rooms presenting with infection are risk assessed to confirm if it is appropriate to allow the doors to the rooms to remain open	Weekly spot check to be undertaken by Senior Nurse Managers for 6 weeks to ensure guidance is being adhered to	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_024a		R24: Meals are delivered to patients in a timely fashion to prevent the food from going cold and wet with condensation	Weekly spot check to review timeliness of meal delivery	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_024b		R24: Meals are delivered to patients in a timely fashion to prevent the food from going cold and wet with condensation	Continued review and monitoring of patient feedback	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_026		R26: The Deprivation of Liberty Safeguards (DoLs) policy is updated to reflect the Liberty Protection Safeguards in line with the Mental Capacity (Amendment) Act 2019	Protocol drafted for managing the MHA/MCA interface. Currently out for consultation. Final version to be approved by the MCA and Consent Group	Aug-20	Aug-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_027		R27: Training on mental capacity assessments and deprivation of liberty referrals is delivered to staff on ward 11	Training to be arranged and delivered to all staff on ward 11 signatory list to be compiled.	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_028		R28: An assessment of a patients mental capacity is completed and documented in full and timely action taken to ensure the best interests of the patient are protected	Senior Nurse Managers spot checking and promoting appropriate referral evidence of spot checks over two months to be collated. Findings to be discussed in monthly scrutiny meeting	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_029		R29: All computer screens are locked when left unattended to prevent a potential breach of confidentiality	To discuss with IT regarding screensavers	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_030a		R30: Patient case notes are adequately locked away when not in use to prevent unauthorised access	Staff to be reminded of Information Governance standards	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_030b		R30: Patient case notes are adequately locked away when not in use to prevent unauthorised access	Ensure staff have undertaken Information Governance Training	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_030c		R30: Patient case notes are adequately locked away when not in use to prevent unauthorised access	Think Information Governance posters to be displayed	Sep-20	Sep-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_030d		R30: Patient case notes are adequately locked away when not in use to prevent unauthorised access	Spot checks to be carried out weekly for 6 weeks to ensure compliance with patient case notes usage	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_031		R31: Hand written nursing notes should be signed, dated and timed to provide evidence of timely care	Documentation audit completed twice yearly	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_032a		R32: Patient discharge plans and care requirement are considered and documented in full to enable efficient and effective discharge planning	Memo to be sent to staff to remind of documentation standards expected	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_032b		R32: Patient discharge plans and care requirement are considered and documented in full to enable efficient and effective discharge planning	Bi-weekly spot check in place to promote compliance	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_032c		R32: Patient discharge plans and care requirement are considered and documented in full to enable efficient and effective discharge planning	Discharge training sessions arranged to promote effective discharge planning	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_034		R34: Regular meetings are scheduled and documented for staff on ward 11 with minutes circulated to all staff for information and review	Regular ward meetings minutes and shared with team	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_035		R35: Staff to be made aware of the content of the revised Health and Care Standards that were introduced in April 2015	Document to be made available to all staff in ward 7 and 11. Signatory list to be completed	Oct-20	Oct-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_036a		R36: Reports from staff who indicate they have been subject to discrimination by management are investigated and addressed	Promote Health Board values. Ensure staff are encouraged to be open and honest and aware of the Health Board policies to support any concerns. To work with Quality Assurance and Safety Team to promote the Speaking Up Safely Model and approach in Withybush General hospital	Nov-20	Nov-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_036b		R36: Reports from staff who indicate they have been subject to discrimination by management are investigated and addressed	To nominate representative from Withybush General Hospital to be a member of the Health Board Speaking Up Safely Working Group	Jul-20	Jul-20	Red	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_036c		R36: Reports from staff who indicate they have been subject to discrimination by management are investigated and addressed	To receive a presentation on Speaking Up Safely at the August Withybush General Hospital Quality and Governance Meeting	Aug-20	Aug-20	Amber	
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_037		R37: The health and wellbeing of staff working regular night shifts is reviewed regularly and also their ability to attend meetings and training during the day	Staff encouraged to attend meetings and rotate regularly on to day shifts to support training and meetings. Senior Nurse Manager to review training / meeting attendees to ensure this is being facilitated	Nov-20	Nov-20	Amber	
18173	Feb-19	HIW MHLD	North Ceredigion Community Mental Health Team (Gorwellion) 20-21 Nov 2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	18173_015	N/A	The process for staff supervision must be robust to ensure all staff receive meaningful supervision in a timely and consistent way	Develop and implement supervision guidelines for directorate to include standardised supervision template, frequency and type of supervision	Aug-19	Dec-20	Red	06/07/2020 Update received from Interim Head of Nursing, Mental Health & Learning Disabilities. The supervision procedure is in its 2nd draft and will be going out to the WCDG membership for comment prior to ratification, anticipated date for closure 31st December 2020 this will allow us the time to ensure implementation .
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	Head of Service to send a communication brief to all CMHT staff to remind them they must record the offer of advocacy services in service users electronic record.	Mar-20	Jul-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to July 2020

19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	To use staff meetings and supervision to ensure staff are reminded of this.	Mar-20	Sep-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to Sept 2020
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	To send a communication briefing to staff reminding them that they must record the offer of advocacy services in care notes To use staff meetings and supervision to ensure staff are reminded of this.	Mar-20	Sep-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to Sept 2020
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities			19106_007		The health board and local authority must ensure that all service users are made aware of how to contact the CMHT out of hours.	Service Users to contact Delta Wellbeing for access to Local Authority out of hours.	Sep-20	Sep-20	Amber	
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_010		The health board and local authority must ensure that service users are given enough time to discuss their needs and treatment.	To ensure that all Service users are offered a CTP pre review meeting, this will ensure that CTPs are allocated adequate time for the review on an individual basis.	Sep-20	Sep-20	Amber	Query on this management response Sara to check no update received. nc
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_012		The health board and local authority must ensure that care and treatment plans are person centred and strength based with documented evidence of service user engagement in the process.	CTP training session to be competed with the team.	Sep-20	Sep-20	Amber	Not reached date yet Delayed due to covid 19, working with external supplier to deliver CTP trair
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_013		The health board and local authority must consider installing an emergency call system within the consulting rooms and other clinical areas.	To complete a risk assessment of the consulting rooms and clinical areas to determine any requirement for an emergency call system.	Jun-20	Sep-20	Red	Delayed due to Covid19, Senior MH Nurse allocating work to Manager.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_013		The health board and local authority must consider installing an emergency call system within the consulting rooms and other clinical areas.	To act on the results and recommendations.	Jun-20	Sep-20	Red	Delayed due to Covid19, Senior MH Nurse allocating work to Manager.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_014		The health board and local authority must provide HIW with a copy of the most recent ligature risk assessment.	To send ligature risk assessment to HIW	Mar-20	Jun-20	Amber	1/06/2020 risk assessment completed establishing the mechanism to send to HIW via secure portal.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_017		The health board must ensure that staff employed by the health board receive further training to enhance their understanding of their roles and responsibilities under the SSWBA.	Refresher training session to be arranged	Sep-20	Sep-20	Amber	Not reached date yet
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_020		The health board must ensure that the staff induction process is formalised.	To produce a staff induction check list in line with LA.	Jun-20	Sep-20	Red	Delayed due to Covid 19, work is being progressed.
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_003	N/A	The health board must ensure that the new observation panels on each room can be used by staff	Latent defect following new installation – estates department to contact contractor/manufacturer to resolve defect.	Jun-19	N/K	Red	Latent defect has been disputed with the manufacturers, issue escalated to Senior Manager Rob Elliot. 6/07/2020 Covid has delayed this and the issue is with an external contractor, this has been escalated to the company as Covid restrictions ease.
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_010	N/A	The health board must repair or replace the damaged flooring within the whole unit as this causes a risk to patient safety	Submit Capital Bid of £10,000 to replace flooring. (Subject to approval and availability of Capital)	Dec-20	Dec-20	Amber	no progress
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	HDUHB will ensure there is an up to date Transition Policy in place for transition from S-CAMHS to AMHS	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	This Policy will be formally ratified by the Written Policy Control Group and reviewed by the multi disciplinary group every 3 years or when national policy indicates.	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Transition workshop/s will be held across both services to provide training & awareness on transition and disseminate good practice including the Welsh Governments documents : - HDUHB Transition Policy /Pathway - T4CYP Good Transition Guidance for CAMHS - Young Persons Passport - NICE Guidelines Transition - Emotional needs of young people and families –systemic approach	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_022	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	HDUHB will develop a multiagency Transition Steering Group which will provide oversight and effective governance on transition	Aug-19	Dec-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_022	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	The Steering Group will have clear Terms of Reference which include the following: - Monitor implementation of the Transition Policy - Review of the data on all transitions 6 monthly - Coordinate training on Transition & pathways - Quality assurance on adherence to policy/ processes HDUHB will undertake an audit of transition on an annual basis to review its compliance with Transition Policy via the Quality Assurance Team (Appendix 5)	Aug-19	Dec-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_026	N/A	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	HDUHB will implement the Young Persons Passport to increase awareness of transition, increase their participation in the transition process and provide support.	Sep-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_027	N/A	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	A transition referral will be completed to formalise the handover of care as per Transition Policy.	Sep-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Not known	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_032	N/A	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.	Colleagues in adult mental health services will be provided with training to understand the developmental needs of young people and their families in accessing mental health services and the need for a individual systemic approach for some young people in accessing services.	Sep-19	Mar-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.

No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_001	N/A	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.	Refine the current GP/Primary Care link working system which will be implemented as part of the delivery of Transforming Mental Health.	Dec-22	Dec-22	Red	01/05/2020 Date linked to transforming program. Query strategic log?
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_002	N/A	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern	Develop bespoke training to be delivered in conjunction with service users/carers/third sector. This will include effective crisis and contingency planning and will be audited through the established CTP Audit. Monitored via Mental Health Legislation Scrutiny Group (MHLSG).	Sep-20	Sep-20	Amber	01/05/2020 Working with external provider CTP training to deliver training date extended due to Covid 19.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_007	N/A	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations	Develop bespoke training to be delivered in conjunction with service users/carers/third sector. Compliance will be audited through the established CTP Audit to be monitored via the MHLSG.	Mar-20	Dec-21	Red	01/05/2020 Working with external provider CTP training to deliver training date extended due to Covid 19.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_008	N/A	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve	Develop bespoke training to be delivered in conjunction with service users/carers/third sector with compliance monitored via MHLSG through CTP audits.	Mar-20	Dec-21	Red	01/05/2020 Working with external provider CTP training to deliver training date extended due to Covid 19.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_018	N/A	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users	Discussions to take place at the transformation board for partnership consideration to develop a joint plan.	Nov-19	N/K	Red	No update received in May 2020.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_021	N/A	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection	The MH/LD Directorate continues its commitment to co-producing the implementation of its Transforming Mental Health Programme. A data and evaluation work stream has recently been established to review data gathering processes and develop means of continuous quality improvement. The UHB are being assisted by Swansea University. Ensure information systems are updated with a move to Welsh Patient Administration System (WPAS) anticipated this year, followed by migration to Welsh Community Care Information System (WCCIS) across health and social care services.	Dec-22	Dec-22	Amber	01/05/2020 Long term action linked to the Transforming Mental Health pro
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_023	N/A	All CMHT staff should receive training in the following; RED • Mental Health Act • Social Services and Well Being Act • First Aid and the use of defibrillators	Produce training plan to ensure all CMHT staff are trained in the Social Services and Well Being Act.	Nov-19	N/K	Red	No update received in May 2020.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_023	N/A	All CMHT staff should receive training in the following; RED • Mental Health Act • Social Services and Well Being Act • First Aid and the use of defibrillators	Identify CMHT staff trained in First Aid and produce a training plan to ensure all CMHT staff are trained.	Nov-19	N/K	Red	No update received in May 2020.
No ref	Not known	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_023	N/A	All CMHT staff should receive training in the following; RED • Mental Health Act • Social Services and Well Being Act • First Aid and the use of defibrillators	As CMHT premises do not currently have defibrillators as standard equipment, the service will consider the introduction of this equipment taking into account the additional cost and training implications with the MH/LD BPPAG ratifying the final decision as to whether this provision is introduced	Jun-19	N/K	Red	1/5/2020 defibs to be purchased by the facility and erected on external wall , no staff training required - can we close this recommendation?
19009	Not known	HIW MHLD	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Open	N/A	Mental Health & Learning Disabilities	Melanie Evans / Kay Isaacs	Director of Operations	19009_007	N/A	The Health Board must ensure that their policy/s on the interface between DoLS and MHA is compliant in law to ensure it does not diverge from the principle in law	Following reviews of current legislation, interface guidance between DOL's and MHA will be developed and draft will be sent to HB legal department for review prior to ratification.	Jul-20	Jul-20	Red	1/05/2020 Awaiting National advice, outside the control of the HB.
HDUHB1718-35	Apr-18	Internal Audit - Theatres Directorate HDUHB		Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_002	Medium	R10. The practice of providing unnecessary 'rest days' to staff at BGH should be promptly reviewed. Any future agreement on rest time, following a period of on-call, should be in line with the A4C NHS terms and conditions of service.	Work already underway to remove compensatory rest day from roster and align on-call practice with A4C and the NHS Wales Harmonising On Call Arrangements (May 2012). This finding is directly linked with Grievance in progress. Working group established to address issues and concerns. As of 13 Feb 2018, HoN Scheduled Care assumes responsibility with SNMs for all elements of workforce	Nov-17	N/K	Red	The recommendations cannot be addressed until grievance process is comp
HDUHB1819-33	Feb-19	Internal Audit - Records Management HDUHB		Open	Limited	Health Records/ Planning, Performance & Commissioning (Informatics)	Sian-Marie James	Director of Planning, Performance & Commissioning/ Director of Partnerships and Corporate Services	HDUHB1819-33_001	Medium	R1. Management should ensure the Corporate Records Management Strategy and Policy are submitted to the Business Planning & Performance Assurance Committee for approval.	Following internal discussions, the Corporate Office is leading the review and updating of the Corporate Records Management Strategy and Policy. This will require contributions and input from a number of teams across the UHB. Once reviewed, these will be submitted to the Business Planning & Performance Assurance Committee at the earliest opportunity.	Sep-19	Sep-20	Red	Apr 20 ARAC update: Due to COVID outbreak, the work associated with many of the recommendations has been delayed by at least 3-4 months. A revised policy was due to be considered at the March 2020 IGSC, however this was postponed due to current outbreak. A meeting had been scheduled with the Information Governance Team to progress this work, but due to the pandemic, two meetings have been cancelled. An extension until September 2020 would be appreciated to allow time agree an approach and action the work required.
HDUHB-1920-34	Aug-19	Internal Audit - Environmental Sustainability Report HDUHB		Open	Reasonable	Estates	Terri Shaw	Director of Operations	HDUHB-1920-34_001	Medium	R1: Management should ensure narrative within the Sustainability Report includes explicit discussions of organisational targets and direction in terms of performance as outlined in the Manual for Accounts.	An Energy Strategy is currently being developed, which will identify carbon reduction targets for any projects delivered. This wasn't available in 18/19 but will be available for reporting in the 19/20 Sustainability Report.	May-20	Mar-21	Red	The Decarbonisation strategy is on hold for the Health Board as Shared Services are aiming to review the Carbon footprint of all HB's by March 2020 and then produce an 'All Wales Decarbonisation Strategy' with targets to align with the Welsh Government targets by July 2020. Hywel Dda University Health Board will then complete its Decarbonisation strategy to align with the all Wales Strategy which will have target going forward by March 2021. Progress against these targets will be reported in future Sustainability Reports.
HDUHB-1920-05	Oct-19	Internal Audit - Welsh Language Standards Implementation HDUHB		Open	Reasonable	Partnerships & Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_002	Medium	R2. Management should ensure progress updates of the completion of the Readiness Assessments and any subsequent actions are reported to the Workforce & OD Sub-Committee.	This will be implemented with immediate effect.	Dec-19	Oct-20	Red	As the Workforce & OD Sub-Committee meetings have been stood down (due to Covid-19), it is suggested that this recommendation is reviewed in October 2020.
HDUHB-1920-05	Oct-19	Internal Audit - Welsh Language Standards Implementation HDUHB		Open	Reasonable	Partnerships & Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_003	Medium	R3. Management should establish interim arrangements to enable the reporting of Health Board compliance against the Welsh Language Standards whilst key performance indicators and monitoring processes are being developed.	A Welsh Language update is reported to the Improving Experience Sub-committee, which includes reports demonstrating compliance against the Welsh Language Standards.	Oct-19	Oct-20	Red	Prior to the Covid-19 pandemic, it was agreed that consideration would be given to establishing a Group sitting under the auspices of the Well-being of Future Generations (Wales) Act 2015 that would specifically focus on the Welsh Language and cultural issues. As the Improving Experience Sub-Committee had not met for some time, this would provide a vehicle for ensuring the Welsh Language Standards were effectively performance managed and scrutinised. This action has been delayed. Revised date of October 2020 provided.
HDUHB 1920-16	Jan-20	Internal Audit - Medical Devices HDUHB		Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_003	Medium	R3: Management should ensure the identified medical devices policies and procedures are promptly reviewed and submitted for approval.	To review current procedure for the management of safety notices and alerts and issue for consultation. (Complete) To present the revised procedure to the appropriate committee for ratification (June 2020)	Jun-20	Aug-20	Red	Procedure reported to QSEAC June 2020 but further amendments are required. Final approval to take place at QSEAC in August 2020.
HDUHB 1920-26	Feb-20	Internal Audit - Bronglais General Hospital Directorate Governance Review HDUHB		Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_004	Medium	R4. The Bronglais General Hospital Management Committee should establish an annual work plan to ensure organisational business objectives and goals provided by supporting groups, committees and external sources are captured and reported.	A work plan will be developed by the BGH Management Committee to ensure key items are listed and reviewed throughout the year. In addition, the newly re-established Quality Forum, Chaired by the Head of Nursing, will operate as a formal sub-group of the BGH Hospital Management Committee. The QF will receive reports outcomes and review actions from QSEAC, external reviews – HIW etc., development of the BGH Clinical Strategy, capital projects and site improvements plan. The minutes and actions from the QF will be submitted to the HMC in order to provide assurance on delivery.	Mar-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Initial assessment of management finding found this recommendation to not be addressed, however this is subject to change during the QA process and receipt of additional evidence. Tracker to be updated once follow up report submitted to ARAC.

HDUHB 1920-26	Feb-20	Internal Audit · HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_007	Medium	R7. Bronglais Hospital Management should ensure the Health Board registers of gifts, sponsorship and hospitality are accurate and up-to date, with staff reminded of their requirement to comply with the Standards of Behaviour Policy.	Staff are aware of the need for gifts declaration and the process to follow. The instances of this have been low in number but examples can be provided in order to assure that this is in place. However, to ensure future compliance with the Standards of Behaviour Policy, a reminder will be issue to employees at Bronglais General Hospital informing them of their requirement to declare and register gifts, sponsorships and hospitality on the Health Board register.	Feb-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Initial assessment of management finding found this recommendation to be partially addressed, however this is subject to change during the QA process and receipt of additional evidence. Tracker to be updated once follow up report submitted to ARAC.
HDUHB 1920-26	Feb-20	Internal Audit · HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_008	Medium	R8. Directorate Management should liaise with Finance colleagues to identify further actions to address the financial challenges impacting on the forecasted year-end overspend.	The ability to manage and deliver within budget is impacted due to key drivers affecting Bronglais General Hospital – in the main agency premium costs (40% nurse vacancy rate) and variable pay for doctors to cover vacancies. BGH Management will continue to liaise regularly with Finance colleagues through regular on site meetings and monthly workshops to address overspends. Progress is being made where possible, e.g. the avoidance of using agency doctors, which has been in place for the past two years. Medium to long term plans have also been identified that will aid in the improved recruitment of staff (and therefore reduction in agency costs). This includes the 5-year nurse recruitment strategy that will see the establishment of a local School of Nursing & Faculty of Health Sciences at Aberystwyth University.	Apr-20	N/K	Red	31/07/2020- Follow up review currently taking place by Internal Audit. Internal Audit awaiting evidence against this recommendation. Tracker to be updated once follow up report submitted to ARAC.
HDUHB 1920-20	Feb-20	Internal Audit · HDUHB	Cyber Security (Stratia Report)	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Paul Solloway/ Anthony Tracey	Director of Planning, Performance & Commissioning	HDUHB 1920-20_001	Medium	R1. A cyber security role for the Health Board should be properly defined and operating appropriately so to enable the Health Board ICT department to fully use the security products available to them.	Management response to be agreed at ARAC June 2020: Agreed. Following the announcement of the Digital Priorities Invest Fund (DPIF) from Welsh Government, the Health Board secured resources to appoint a Band 6 Cyber Security post. However, due to the funding letter only arriving in December 2019, and the requirement to spend the investment by March 2020, the funding for 2019/20 was utilised to strengthen the cyber tools within the Health Board. The recurring funding will be directed towards funding a full time post for cyber security, to provide the monitoring of the tool sets purchased, both at a national and local level. The post has been through the appropriate governance mechanisms within the Health Board and is ready to be advertised as soon as funding from Welsh Government is received, which is imminent. It is anticipated the post holder will have a start date of September 2020.	Sep-20	Sep-20	Amber	Revised management response reported to ARAC June 2020. Aug 2020 update- No suitable candidates from first job advert, further advert will be undertaken. In the interim looking to use short term contractors to progress this work in the interim.
HDUHB_1920_40	Mar-20	Internal Audit · HDUHB	IM&T Assurance – Follow Up	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Sara Brain	Director of Planning, Performance & Commissioning	HDUHB_1920_40_003	Medium	WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	The business manager was able to supply a paper which was produced for the Executive Team in June 2019, this paper evidences that work is underway to address the noncompliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence that this recommendation, to seek advice on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to is in train.	May-19	Jul-21	Red	Update June 2020- this is currently going through full OCP for Switchboards. Estimated delivery now July 2021.
HDUHB1819-17	Feb-19	Internal Audit · HDUHB	Charitable Funds	Open	Substantial	Finance	Jennifer Thomas	Director of Finance	HDUHB1819-17_001	Low	R3. The Charitable Funds Financial Administration and Governance Policy should be reviewed and updated appropriately	The Charitable funds Policy is currently under review.	Feb-19	Ap-20 Jul-20	Red	The Charitable funds procedure is being updated further due to the Charitable funds strategy meeting. This has been delayed further due to COVID-19.
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: - Ward sisters to ensure that requisition forms are correctly completed and receipted.	Jun-20	Jun-20	Red	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: - Quarterly schedule of spot check audits held in pharmacy department and undertaken by Pharmacy – spot checks on CD order books will be done as part of 3 monthly CD stock check	Jun-20	Jun-20	Red	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: - Pharmacy to feedback any anomalies from spot check audits to nursing staff – feedback to ward/department manager via e-mail.	Jun-20	Jun-20	Red	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_003	Medium	R3: The Pharmacy Department should ensure that full stock controlled drug reconciliations are undertaken on all applicable wards a minimum of every three to six months, with a record of the wards visits accurately recorded and maintained on the monitoring spreadsheets.	It is noted that this element of policy implementation has not been routinely implemented. Some of the challenge is availability of a pharmacist and senior nurse to undertake the reconciliation. However, it is accepted that this area needs further work. - Effective Control Systems for controlled drug reconciliations to be implemented across the hospital sites/including Maternity units and Paediatric areas	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_003	Medium	R3: The Pharmacy Department should ensure that full stock controlled drug reconciliations are undertaken on all applicable wards a minimum of every three to six months, with a record of the wards visits accurately recorded and maintained on the monitoring spreadsheets.	It is noted that this element of policy implementation has not been routinely implemented. Some of the challenge is availability of a pharmacist and senior nurse to undertake the reconciliation. However, it is accepted that this area needs further work. - Rolling programme of CD reconciliation to be developed by each site for wards, clinical areas and community hospitals with confirmation feedback of completed audits in senior pharmacy team meeting.**Each site has a rolling programme, however, undertaking of audit has been delayed due to COVID-19 outbreak	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_004	Medium	R4: Management should ensure that medication error incidents recorded on Datix are approved in a timely manner in line with Health Board policy and procedure.	All DATIX Incidents Reports to be investigated and remedial action implemented to mitigate risk.	Sep-20	Sep-20	Amber	
HDUHB-1920-18	May-20	Internal Audit · HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_004	Medium	R4: Management should ensure that medication error incidents recorded on Datix are approved in a timely manner in line with Health Board policy and procedure.	All DATIX Incident reports relating to Nursing Medication Error and breaches of 30 day non-compliance to be reviewed in local site/Directorate scrutiny meetings.	Sep-20	Sep-20	Amber	
HDUHB-1920-38	May-20	Internal Audit · HDUHB	Review of PADR Process (Follow Up)	Open	Reasonable	Workforce & OD	Robert Blake	Director of Workforce & OD	HDUHB-1020-38_002	Medium	R2. Management should ensure managers and leads across the organisation receive PADR training in order to aid them in undertake appraisals in line with Health Board expectations, thus increasing the quality of the reviews. PADR Training Follow Up Comments In the original report, a review of the bespoke and NHS bespoke passport training register maintained by Workforce & OD identified seven (of 11) sampled wards and departments where at least one employee had not received PADR training. A review of the Workforce & OD register, as at April 2020, continued to identify three of the seven wards where no employee had received PADR training – Catering BGH, Endoscopy BGH and Ceredig Ward BGH.	Management response from original report: PADR training is included in the managers' passport; however, since the publication of the audit report drop-in sessions have been arranged across the organisation to support the PADR process. The first session in Carmarthen was well attended with 20 individuals receiving refresher training. Alternative methods of providing PADR training will be explored to include Webinar type training to provide increased coverage this will be monitored by Workforce & OD Sub Committee. Further sessions will be scheduled throughout 2019/20.	Mar-20	Sep-20	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales. 16/07/2020- Update provided by Senior Organisational Development Manager. Quarterly reviews in place with sites to highlight areas of poor compliance however these have been temporarily stood down due to COVID-19. It is hopeful to have these reviews back up and running soon and in addition the service is looking into extra resource to drive this forward. Revised deadline of December 2020 provided for review process to be back up and running and for further work to take place to embed this into the normal culture of the UHB.

HDUHB-1920-38	May-20	Internal Audit - Review of PADR Process (Follow Up) HDUHB	Open	Reasonable	Workforce & OD	Robert Blake	Director of Workforce & OD	HDUHB-1020-38_003	Medium	R3. Management should undertake a periodic sample verification of PADR compliance figures to ensure accuracy of reported information. PADR Compliance Figures Follow Up Comments The original report noted instances where the PADR compliance figures recorded within the ESR system were inaccurate for a sample of wards and departments. Concluding a review of PADR compliance levels, as at 31st March 2020, we can confirm that ward and department compliance figures are only recorded and maintained on ESR. Due to the outbreak of coronavirus (COVID-19), we were unable to verify PADR numbers against the figures recorded in ESR.	Management response from original report: As noted above this will be built into the PADR policy and revised process moving forward. A random sample will also be selected by the OD team on a quarterly basis and findings reported to managers as necessary. Areas of concern will be discussed as part of the Chief Executive performance review process. As noted above this will also be included in future updates provided to Workforce & OD Sub Committee. The ESR team will also be in contact with the areas noted above who stated they did not use ESR to record PADRs to rectify this and ensure ESR is updated moving forward.	Jul-19	Dec-20	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales. 16/07/2020- Update provided by Senior Organisational Development Manager. Quarterly reviews in place with sites to highlight areas of poor compliance however these have been temporarily stood down due to COVID-19. It is hopeful to have these reviews back up and running soon and in addition the service is looking into extra resource to drive this forward. Revised deadline of December 2020 provided for review process to be back up and running and for further work to take place to embed this into the normal culture of the UHB.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_001	Medium	R1. The Director of Public Health should review training processes currently in operation within the Health Board and ensure this is accurately reflected in the Business Continuity Planning Policy.	The Policy will be amended to reflect that training for BCM and associated TNA and record keeping has been replaced with hands-on-support, guidance and instruction by the Emergency Planning Team to individual(s) responsible for creating the BC Plan for each department.	Nov-20	Nov-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_002	Medium	R2: Management should ensure the Business Continuity Planning Policy is reviewed and updated to reflect current processes and procedures before being submitted for approval at the People, Planning & Performance Assurance Committee	A review of the Health Board's Business Continuity Planning Policy was postponed earlier this year due to the Coronavirus outbreak. As we are still in response mode to this crisis, we agree to review the policy as it stands as an interim measure. The reviewing of this Policy was intentionally paused in the New Year following learning taken from the extreme pressures and sustained periods of escalation of the urgent care system, particularly during December 2019. It was proposed that we would develop a Business Continuity Framework to aid escalation and de-escalation during periods of high demand or pressure in the system. This work was taken over by events at the end of January / beginning of February 2020.	Nov-20	Nov-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_003	Medium	R3: The Emergency Planning Team should periodically escalate instances of continued non-compliance where business continuity management plans have not been reviewed and implemented by departments to the appropriate group or committee.	The Emergency Planning Team will develop and implement a process of escalation to the appropriate Executive Director in relation to repeated noncompliance with BCM planning.	Sep-20	Sep-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_004	Medium	R4: The Emergency Planning Team should escalate non-complaint departments that have not undertaken a core function analysis and risk identification exercise to the appropriate Executive Director.	The Emergency Planning Team will develop and implement a process of escalation to the appropriate Executive Director in relation to repeated noncompliance with BCM planning.	Sep-20	Sep-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_005	Medium	R5: The Emergency Planning Team should escalate non-complaint departments that have not submitted a business continuity management plan to the appropriate Executive Director.	The Emergency Planning Team will develop and implement a process of escalation to the appropriate Executive Director in relation to repeated noncompliance with BCM planning.	Sep-20	Sep-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-32	Mar-20	Internal Audit - Rostering HDUHB	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_005	Low	The Rostering policy should be updated to reflect the good practice observed of rosters being produced 6-8 weeks in advance. (This would also align the policy with what is detailed in the 'Audit Tool' of the 'Interim Guidelines to Support Effective Rostering for Nurses and Midwives Appendix of Rostering Policy').	Policy to be updated in line with Allocate rollout June 2020	Jun-20	Mar-21	Red	Allocate delay, new guidance document live from 08/01/2020 new policy to be written in line with Allocate system Q4 2020-2021.
HDUHB-1920-32	Mar-20	Internal Audit - Rostering HDUHB	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_006	Low	The Health Board should consider that ward/departments are asked to formalise their annual leave arrangements to ensure transparency of working practice across the organisation.	Workforce and Nursing are creating an abstraction overview to track all unavailability including annual leave, this will allow senior managers to pick up incorrect variance across wards and departments and will allow workforce to report. Introduction of Allocate will also allow dashboards for all managers to easily identify issues. (Leave rules will be created in Allocate to warn managers when going over leave allowance) Date completion end of 2020.	Dec-20	Dec-20	Amber	Allocate delay due to COVID will be part of roll out plan.
HDUHB-1920-10	Jun-20	Internal Audit - Business Continuity HDUHB	Open	Reasonable	Public Health	Head of Health Emergency Planning	Director of Public Health	HDUHB-1920-10_006	Medium	R6: The Emergency Planning Team should review the feasibility of uploading and maintaining all business continuity plans on the intranet. Where changes are identified, this should be reflected in the Business Continuity Planning Policy, otherwise all directorate, service and department plans should be shared online.	All Departmental Business Continuity plans to be shared, managed and reviewed through departmental shared drives. This new process will be reflected in the Policy. In addition, model BCM plans will be placed on the intranet as examples of good practice for guidance purposes.	Nov-20	Nov-20	Amber	Draft Internal Audit reported to ARAC April 2020 with no management response included.
HDUHB-1920-05	Oct-19	Internal Audit - Welsh Language Standards Implementation HDUHB	Open	Reasonable	Partnerships & Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_001	Low	R1. Management should consider introducing a Welsh Language Standards e-learning module as part of the ESR training programme to ensure staff and managers understand their roles and responsibilities in line with the Standards.	The Welsh Language Services Team has contributed to a national piece of work being co-ordinated by Betsi Cadwaladr UHB and Shared Services, in the Once for Wales spirit of partnership, and the outcome is an e-learning resource. Timescale for this is currently unknown, but we plan to roll out once launched. In the meantime, we are targeting focused training and awareness and cascading through key teams.	Oct-19	Oct-20	Red	Overtime is not payable to employees in Band 8 and 9. If work needs to be undertaken by staff in these pay bands in order to meet service needs these can be paid in exceptional circumstances only at a lower banding e.g. covering a rota gap to maintain service delivery. This arrangement would be authorised by a senior manager. Temporary specific provisions apply for any work associated with Covid-19. The Payroll Department have been asked to draw any claims for overtime at Band 8 and 9 level to the attention of the Senior Workforce Manager; Terms, Conditions and Benefits for advice and guidance as to whether claims are within terms and conditions of employment and can proceed for payment.
HDUHB-1920-17	Jun-20	Internal Audit - Mortality Rates HDUHB	Open	Reasonable	Medical	John Evans / Subhamay Ghosh / Ian Bebb	Medical Director & Director of Clinical Strategy	HDUHB-1920-17_002	Medium	R2: Management should ensure that the information recorded on the mortality review form is fully completed by the reviewer as instructed.	We acknowledge that some Stage 1 forms are not completed and appreciate that for auditing purposes this is difficult to reconcile. These blank entries are chased where capacity allows and we will write to Hospital Directors regarding the full completion of these forms going forward. We would however state that Q8 does not form part of the mandatory UMR questions and was only put in place to provide further clarity for the escalation to Stage 2 and avoid ambiguous "text" responses. In the cases where Q8 was left blank there was no indication on the form to suggest a Stage 2 was required and was therefore felt appropriate not to escalate to Stage 2.	Jun-20	Jun-20	Red	
HDUHB-1920-17	Jun-20	Internal Audit - Mortality Rates HDUHB	Open	Reasonable	Medical	John Evans / Subhamay Ghosh / Ian Bebb	Medical Director & Director of Clinical Strategy	HDUHB-1920-17_003	Medium	R3: Management should ensure that all future Mortality Scrutiny Group meetings are minuted and retained on file.	Going forward, all bi-monthly meetings will be minuted and shared with the group prior to the next meeting, as per Terms of Reference.	Jul-20	Jul-20	Red	
HDUHB-1920-04	Jun-20	Internal Audit - Health & Safety HDUHB	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_002	Medium	R2: Management should ensure that mechanisms are in place to capture the findings following risk assessments undertaken by directorates, services or departments to ensure actions are implemented to mitigate the identified risks	Datix Risk is now being reviewed and scrutinised by the Health & Safety Team. Control measures are being evaluated and where necessary departments visited to establish if they provide the adequate level of protection for staff or others. Any concerns regarding controls to reduce the risks will be documented and monitored. Key performance indicators are under development and will be shared with HSAC once finalised. Risk report to be provided and monitored at each directorate quality meeting and corporate Health & Safety risk register to be presented at agreed intervals to HSAC.	Sep-20	Sep-20	Amber	

HDUHB-1920-04	Jun-20	Internal Audit - Health & Safety HDUHB	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_003	Medium	R3: Management should liaise with directorates and services to ensure that arrangement currently in place meet the requirements set out in the Health & Safety Policy.	The Health & Safety Team will develop a model of introducing 'H&S Champions / Co-ordinators' into several departments during 2020/21. H&S Co-ordinator model currently being developed with the aim to submit the proposal to the H&SA Committee August 2020. The champions will co-ordinate and implement local H&S arrangements and advise the Heads of Department if performance / compliance does not reach the standards required. The role will involve proactively working with the Health & Safety Team to establish and maintain a culture of safe, environmentally friendly practices across the organisation. Working with the Directorate senior management team, they will be responsible for implement the Health & Safety Policy and systems, and keeping up-to-date with the relevant legislation. In the meantime, the H&S Team are undertaking H&S departmental audits that commenced March 2020. Planned annual programme in place.	Aug-20	Aug-20	Amber	
HDUHB-1920-04	Jun-20	Internal Audit - Health & Safety HDUHB	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_004	Medium	r4: Management should introduce key performance indicators to enable the organisation to measure and monitor health and safety performance	During 2020/21 the Health & Safety Team will gather data on the following and if necessary introduce additional KPIs: * Percentage of workforce trained in manual handling and fire safety awareness; * Number of risk assessments reviewed as well as percentage of actions generated by risk assessment completed; * Number of safety tours completed by Senior Manager In addition, the Health & Safety Team is currently designing a H&S Quality Dashboard which will be able to display both H&S incident data and data from the new Datix RIDDOR module to allow senior managers to easily access statistical information to inform their meetings and gain assurance. This will be available via the IRIS.	Sep-20	Sep-20	Amber	
HDUHB-1920-04	Jun-20	Internal Audit - Health & Safety HDUHB	Open	Reasonable	Nursing (Health & Safety)	Rob Elliott / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-1920-04_005	Medium	R5: Management should ensure the Health Board receives an annual health and safety report detailing the issues and actions undertaken over the previous 12 months to ensure compliance with legislation.	In line with the establishment of the Health & Safety Assurance Committee the Health, Safety and Security Department will produce an annual report on the anniversary of the committee's inauguration. This will be written in to the Terms of Reference of the new committee. An initial Annual Report is currently being prepared for consideration by July 2020.	May-21	May-21	Amber	
SSU_HDA_1920_01.2	Jun-20	Internal Audit - Capital Assurance- Follow Up SSU	Open	Reasonable	Planning, Performance & Commissioning	Anthony Tracey	Director of Planning, Performance & Commissioning	SSU_HDA_1920_01.2_003	Low	R3. Data Centre Project (original R8): The remaining two outstanding actions identified at the action log will be prioritised for completion (O). (Relates to the Data Centre Project)	Partially implemented Work is underway to complete these tasks. There is an issue with completing one of the actions by the end of March due to Asbestos issues which are waiting to be resolved. All other tasks will be completed. Noting the above, the priority rating has been reassessed as low.	May-19	Jul-20 Sep-20	Red	May-19 derived from original completion date in the original report. 05/08/2020 update- SBAR to be reported to next CEIMT to close out audit action.
HDUHB-1920-14	May-20	Internal Audit - Contracting SSU	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_005	Medium	R5. Management should ensure where SLA contract issues arise they are reviewed and reported to directorate and/or service management.	This recommendation is accepted, and a process will be put in place to ensure that review requirements are highlighted to directorates.	Oct-20	Oct-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - Contracting SSU	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_006	Medium	R6. To ensure a consistent approach is being undertaken in the establishment of contracts, management should ensure standard operating procedures are developed and implemented immediately.	This work is being undertaken at present, we are expecting to have all Standard Operating Procedures in place by September.	Nov-20	Nov-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - Contracting SSU	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_007	Medium	R7. Contract leads should ensure a copy of all contracts are submitted to the Contracts Team and uploaded onto the contracts register.	This recommendation is accepted. The contracts team will work with contract leads and the Operational Directorates to get copies of the contracts.	Dec-20	Dec-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - Contracting SSU	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_008	Medium	R8. Management should ensure that reviews in relation to the extension of SLA contracts should be fully documented and authorised by appropriate individuals.	This will form part of the work being undertaken by the contracts team working with the Operational Directorates and Business Partners. There will be a value based framework drafted to support either: 1. The on-going commissioning of said services 2. The service continues but support to change (this is to support the directorates and their needs) 3. The service no longer offers value for money and will be decommissioned	Oct-20	Oct-20	Amber	
HDUHB-1920-14	May-20	Internal Audit - Contracting SSU	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_009	Medium	R9. Management need to ensure that all agreements between the Health Board and other parties are fully signed and dated by authorised signatories prior to the commencement of the contractual period.	This has been remedied as part of the 20/21 contracting round between Health Boards.	Jul-20	Jul-20	Red	
SSU-HDU-1920-13	May-20	Internal Audit - Water Safety - Bronglais General Hospital SSU	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_004BGH	Medium	R4. Management/ WSG should formally consider the cost / benefit of BMS upgrade options to ensure compliance with the WHTM.	Agreed. Management have since reviewed the cost benefits of this enhancement, specifically in relation to the reduction of staff time to perform manual temperature testing. It also provides additional levels of assurance that enhanced monitoring is in place at the site. Additional wireless monitoring will now be installed at the site to cover intermediate points of pipework. Specialist companies have already been engaged. Tenders for this will be issued by July 2020, commencement of work in August 2020 with a full completion by	Sep-20	Sep-20	Amber	
SSU-HDU-1920-13	May-20	Internal Audit - Water Safety - Bronglais General Hospital SSU	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_005BGH	Medium	R5. Management should ensure that "as fitted" drawings are sufficiently detailed (inclusive of risk factors) to inform risk assessment and remedial works in accordance with HTM 04.	Agreed. Management have already engaged with external consultants to address the outstanding as fitted drawings at the site. This will be issued for tender in July with a commencement on site in August and completion by the end of September. This information will be used to support the new 2020 legionella risk assessment in identifying any areas of non-compliance with pipework dead-legs of other	Sep-20	Sep-20	Amber	
SSU-HDU-1920-13	May-20	Internal Audit - Water Safety - Bronglais General Hospital SSU	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_006BGH	Medium	R6. A site risk assessment should be commissioned and appropriately informed in relation to the "as fitted" infrastructure / configuration in accordance with the WHTM / HSE requirements (i.e. sufficiently detailed to show risk factors within the configuration).	Agreed. Management have now programmed a commencement date for the 2020 legionella risk assessment at the site with consultants. This will be programmed in two phases. Phase 1 commencing in July 2020, focusing on areas of the site where there are detailed as fitted drawings to support the risk assessor. Phase 2 of the works will commence following receipt of the outstanding drawings in September 2020. On receipt of the reports, the findings will be reviewed carefully to prioritise any actions that require addressing. Actions will also be tracked and presented at the WSG for reporting.	Oct-20	Oct-20	Amber	
SSU-HDU-1920-13	May-20	Internal Audit - Water Safety - Bronglais General Hospital SSU	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_007BGH	Medium	R7. Management should routinely report to the Water Safety Group the implementation status of recommendations arising from external reviews, including those of; the Authorised Engineer; Welsh Water (infringement notices); and site survey risk assessment.	Agreed. Management can confirm that: Infringement notices - There are currently 2 high risk actions outstanding at the site. This work is now being programmed for completion in September, via the 2020/21 capital allocation. Authorising Engineer Audit Actions – All outstanding actions will be addressed by October 2020. Actions were subject to addressing staff shortages (HTM Gap Analysis), which has now been concluded. All of the actions contained in the (new) 2020 external water risk assessment will be tracked accordingly and communicated to the WSG by the designated RP.	Oct-20	Oct-20	Amber	
SSU-HDU-1920-13	May-20	Internal Audit - Water Safety Follow-Up - Withybush General Hospital SSU	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_009WGH	Medium	R9. Location specific risk assessments should be accurately informed in relation to the infrastructure / configuration in accordance with the WHTM / HSE requirements. Outstanding The application for funding to commission this assessment is acknowledged. The priority rating has been re-assessed in the context of the additional mitigations of updated drawings, and risk	The 2020 legionella site risk assessment is now being programmed for commencement in August 2020. The new as fitted drawings will now support this assessment in greater detail.	Dec-19	Sep-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.

SSU_HDA_1920_01.2	Jun-20	Internal Audit SSU	Capital Assurance- Follow Up	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance & Commissioning	SSU_HDA_1920_01.2_001	Medium	R1. Cardigan Integrated Care Centre (original R1): Clarification should be provided to differentiate between the Project Group quorum, members and attendees.	Superseded: Noting that the Cardigan project is now complete and handed over, a Post Project Evaluation (PPE) should be undertaken to identify lessons learnt (including an assessment of Internal Audit recommendations and their application at future projects). Specifically issues identified at the Cardigan project i.e. Inclusion of quoracy arrangements in approved Project Group terms of reference; Development of full activity based resource plans for all stages of the project which should be subject to regular review; The regular review and update of the Project Governance Framework throughout a project's duration; and Preparation of management control plans at the outset of projects.	May-19	Nov-20	Red	May-19 derived from original completion date in the original report
SSU_HDA_1920_01.2	Jun-20	Internal Audit SSU	Capital Assurance- Follow Up	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance & Commissioning	SSU_HDA_1920_01.2_002	Medium	R2. Cardigan Integrated Care Centre (original R8,9 & 10): The UHB should: obtain the surety bond for the foul drainage (O). identify appropriate resolution for the storm drainage (O). review the advice provided at the time of procuring the land to determine whether there is any recourse from the advice provided (O).	Partially Implemented. Appropriate supporting documentation was reviewed to confirm the UHB had: obtained a surety bond; and identified appropriate resolution for the storm drainage. With regard to determining whether there was any recourse for the advice provided at the time, management advised that there were concerns in pursuing the recommendation further; and that it is likely the costs of pursuing would outweigh the benefits. These concerns are acknowledged and it is recommended that Executive approval of the decision to address the Internal Audit recommendation is presented and approved at the next CE&IMT meeting.	May-19	Jul-20	Red	May-19 derived from original completion date in the original report
SSU_HDA_1920_01.2	Jun-20	Internal Audit SSU	Capital Assurance- Follow Up	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance & Commissioning	SSU_HDA_1920_01.2_004	Medium	R4: Bronglais Front of House: The planned post project evaluation (PPE) exercise for the Bronglais Front of House development will consider the issues raised in the prior Bronglais audit reports as follows: An evaluation of the adequacy of design solution for the development; Confirmation (or otherwise) that the original business case assumptions remain valid, or implications will be assessed; and performance against the targets of the business case will be	Outstanding At the time of issuing this report, the completion of the Front of House scheme was scheduled for June 2020. This is the end of the defects period for the final phase [Theatre Evacuation lift]. The Project Director will lead the completion of the PPE by March 2021.	Sep-19	Mar-21	Red	Completion date of September 2019 refers to the timescales provided in the original report -SSU_HDA_1819_01 Capital Follow Up (W&C Phase 2, and Bronglais Front of House).
SSU_HDU_1920_01.01	Jun-20	Internal Audit SSU	Estates Assurance Follow Up	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU_HDU_1920_01.01_001	Medium	R10: Management will consider the viability of accommodation both with and without SIFT monies.	Partially implemented Management advised that there has been no progress reported from Finance to identify where the SIFT funding for accommodation is placed on a recurring basis on the Bronglais, Prince Philip and Glangwili sites. Subsequently, no progress has been made on moving the SIFT monies centrally to Medical Education.	Jun-19	Sep-20	Red	24/07/2020 Clarification on SIFT allocation is being sought. Concerns raised are In terms of Management will consider the viability of accommodation both with and without SIFT monies and this audit point moving across to the Medical Directorate. Reservations about this. are :- SIFT monies are there to follow the student and pay for accommodation. It is to 'purchase' accommodation (& all other training requirements) not to provide it. The provision and viability of accommodation is a question for the Organisation rather than externally funded SIFT monies (which could be withdrawn at any point).
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_001	Medium	R1: The allocation of project roles at the current stage of the project should be reviewed to ensure effective control.	Agreed. The Health Board will carry out a review of the allocation of project roles to ensure effective control	Sep-20	Sep-20	Amber	
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_002	Medium	R2: Contract documentation for the various parties should be appropriately completed prior to commencement of duties.	Agreed. Both the Project Manager and Supervisor contracts have now been completed. The Health Board are currently in discussion with the Cost Adviser concerning their contract. The Cost Adviser contract will be resolved	Jul-20 Sep-20	Jul-20 Sep-20	Red	Discussions are still ongoing with Cost Advisor. Project Manager has been asked to interpret point of contract which are in dispute. Looking to resolve this as soon as possible, revised timescale of September 2020 provided.
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_005	Medium	R5: UHB Management will review the delegated arrangement for the appointed Project Manager and confirm appropriate definition and operation	The Project Group will undertake a review of the process for authorising un-costed PMIs of a non-urgent nature and potentially high value to ensure effective control of costs.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_009	Medium	R9: Future - Clarity should be obtained from NWSSP; SES on framework expectations in respect of activity schedules	The Project Manager, supported by the Cost Adviser, will produce a report explaining the arrangements that have been put in place to facilitate the effective assessment of project delays in lieu of a fully costed activity schedule. The Health Board will obtain clarification from NWSSP-SES on framework expectations in respect of activity schedules prior to future projects.	Aug-20	Aug-20	Amber	
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_010	Medium	R10: Noting that limited action can be taken at this project, management should include commercially assessed delay damages within future contracts in accordance with national framework guidance	Agreed. The Health Board will seek clarification from NWSSP-SES in the expectations in respect of delay damages for future projects	At future projects	At future projects	Amber	
SSU-HDU-1920-02	Jun-20	Internal Audit SSU	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Planning, Performance & Commissioning	Paul Williams	Director of Planning, Performance and Commissioning	SSU-HDU-1920-02_011	Medium	R11: A reconciliation should be undertaken of identified/remaining project risks, affirming both the programme and available contingency, and reported to the Project Group through to project completion	Agreed. A reconciliation of identified / remaining project risks, affirming both the programme and available contingency, has been completed. The outcome was reported to the Project Group on Tuesday 12th May 2020. The risk register will be updated regularly (at least every two months) and at key project stages to the end of the contract	Jul-20	Jul-20	Red	
SSU-HDU-1920-07	Jun-20	Internal Audit SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_003	Medium	R3: Management should ensure evidence of appropriate insurance coverage is provided prior to the commencement of work.	Accepted. Refer to the recommendation 2. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07	Jun-20	Internal Audit SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_004	Medium	R4: RAMS (where applicable) should be requested, checked and retained prior to the contractor commencing the relevant activity on site.	Agreed. The Job Requisition and Authorisation form [as per the new policy] stipulates the return of a RAMS by the appointed contractor. Estates Officers will be expected to sign acceptance of the receipt and content of the RAMS for retention at the specific site. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07	Jun-20	Internal Audit SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_006	Medium	R6: A robust, and consistent, site access control system should be implemented across all sites that ensures: Daily sign in / out of ALL contractors Uniquely identifiable badges issued and recorded on the sign in/out register Robust process for management of contractors out of hours A sign in/out system should be in place at each community site, using measures appropriate to the site, with ALL contractors required to action daily	Agreed. The sign in / out process currently followed at GGH will be rolled out to all sites. For community sites, an additional section within the Asbestos Registers will be used for contractors to sign in / out and they will informed of this expectation prior to going to site. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-07	Jun-20	Internal Audit SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_008	Medium	R8: Management should formalise the output of contractor monitoring and report to an appropriate forum.	Agreed. This will be a standing agenda item for the Operational Delivery Group meetings for Operational Officers to provide updates / escalate concerns. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB	Sep-20	Sep-20	Amber	

SSU-HDU-1920-07	Jun-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_009	Medium	R9: Management should embed a standard formal sign off process across all sites that: 1. Confirms completion of the work; and 2. Facilitates the sharing of any lessons learnt.	Agreed. All Site Operations Managers will be reminded of the requirement for formal sign off on completed works. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_006WGH	Low	R6. The Water Safety Plan should be updated to accurately reflect requirements and the UHB's approach to pipework labelling. Additional observation Finding 6 of the October 2019 audit noted that labelling of pipework: "should be maintained on an ongoing basis in refurbished / new build areas and in accessible areas such as plant rooms (as separately required by WHTM04)". The revised Water Safety Plan (as of November 2019) states that there should be: "Clear labelling of pipework in new installations and major refurbishment." i.e. does not make explicit reference to existing accessible pipework. For completeness we have therefore raised an additional recommendation: Additional recommendation For clarity, the Water Safety Plan should additionally specify policy relating to pipework labelling in accessible areas such as plant rooms (in accordance with HTM 04, and findings of the October 2019 audit)	Agreed. The Withybush General Hospital Water Safety Plan (WSP) has been changed to incorporate the need to label accessible pipework.	Mar-21	Mar-21	Amber	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is a new additional recommendation included in the new report
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of a) Welsh Water (infringement notices); Partially addressed a) Partially addressed These are now substantially actioned. Completion is now reported as: ☑ Showerheads is 98% ☑ Dead-end removal is 90% ☑ Tap Alterations is 94%	Agreed a) Management can confirm that the recommendations it has received from the Welsh Water Infringement Notices have been tracked and actioned accordingly.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of b) the Authorised Engineer b) Partially addressed NWSSP: Specialist Estates Services tracker states 73% of actions from April 2019 have been actioned, these largely relate to the "low" risk / priority items. Only 14 of the 37 "high" recommendations have been actioned (38%). (Only 3 of these "high" priority recommendations are stated to await resource /	Authorising Engineer Audit Actions – All outstanding actions will be addressed by October 2020. Actions were subject to addressing staff shortages (HTM Gap Analysis), which has now been concluded.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of c) site survey risk assessment. Partially addressed We were advised that the majority of recommendations from 2016 have been actioned, subject to confirmation at the 2020 risk assessment (see item 9 above). We recognise that the above action status will have been superseded (e.g. in the case of NWSSP:SES recommendations being the position as of April 2019). Accordingly the changed position as advised by management is noted. It is also noted that that such are the extent of recommendations at such technical reviews that a number of issues will typically be outstanding at any point in time. Additionally noting active reporting, there is evidence that management are actively addressing the same, and the risk rating has been amended accordingly.	c) Management have now programmed a commencement date for the 2020 legionella risk assessment at the site with consultants. This will be programmed for August 2020. On receipt of the report, the findings will be reviewed carefully to prioritise any actions that require addressing. Actions will also be tracked and presented at the WSG for reporting.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
No ref	Nov-16	Peer Review	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Open (external rec)	N/A	Women and Children's Services	Margaret Devonald-Morris	Director of Operations	PeerReview-CYPDiabetes001	N/A	R1. Absence of a 24 hour on-call advice system	Discuss development of a regional / All Wales 24/7 helpline with other UHBs as a more cost effective alternative to UHB specific arrangements.	Mar-16	N/K	Red	14/05/2020 MDM confirmed this has been completed, 1/6/2020 Remains open until confirmation of outcome requested from SDM.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open (external rec)	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	PeerReview-GGH001	N/A	R1. Lack of 24 hour neonatal transfer service Currently CHANTS, the neonatal transfer service in South Wales is only operational between the hours of 0800-2000 .Outside of these hours babies remain on the unit or transfers are undertaken on the goodwill of transport/NICU consultants	Neonatal network to review plans for 24 hours transport service Mitigation • Follow Local protocol(s) for emergency out of hours stabilisation to support management of babies pending arrival of CHANTS retrieval service. • DATIX report all delays of transfer • Close working with local tertiary NICU • Carry out non- CHANTS transfer as appropriate	To be confirmed by Neonatal Network	N/K- outside gift of UHB.	Red	22/05/2020 Senior Nurse confirmed all actions within the HB remit have been completed further work is to be set by Wales Neonatal Network & WHSSC.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	PeerReview-GGH003	N/A	R6. Training and education Only 55% of nurses are Qualified in Specialty (QIS). 6 out of the 7 consultants and 87% of nursing staff are NLS compliant.	Completed training programme in place to support staff to achieve QIS. Due to the nature and length of available neonatal training programmes, the training of a further 6 WTE staff will not be completed until December 2023. Continue efforts to recruit QIS neonatal nurses	Dec-23	Dec-23	Amber	Long term action.27/07/2020 requested update, chased and meeting to update organised 6/08/2020.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	PeerReview-GGH004	N/A	R7. Guidelines There is a potential for confusion over which guideline to use due to the number available	Schedule of available guidelines to be revised	Dec-19	Jul-20	Red	22/05/2020 Schedule of available guidelines to be revised. A new consultant is working on this and guidelines should be in place by the end of July/Aug for new tranch of staff. Date given as 30/07/2020
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	PeerReview-GGH005	N/A	R9. Transitional Care There is no transitional care facility	Dedicated transitional care facility will not be available until completion of Phase 2 scheme. However transitional care is currently provided in the post-natal ward. No further interim action is proposed pending availability of a dedicated transitional care facility.	Dec-19	Nov-20	Red	22/05/2020 There have been delays in the phase 2 scheme which will impact on the ability to have a designated transitional care area.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	PeerReview-GGH006	N/A	R10. Infection Prevention and Control The panel felt that some neonatal elements were not reflected in the Health Board IPC Policy	Liaise with infection prevention and control department to develop a neonatal appendix to the Standard Infection Prevention and Control Precautions Policy at next policy review	Aug-20	Aug-20	Amber	Not reached date yet. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service Yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director.	Dec-19	Dec-21	Red	This was being addressed by the TCS work group- now postponed by COVID – restart details have been requested. Some improvements in shift fill have been observed and the move to increased telephone advice consultations are supporting cross- border issues, but this is seen as a temporary measure and sustainable solution is still required.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Review the use of Urgent Care Practitioners utilising the lessons learnt from Shropdoc and Cardiff & Vale.	Link with the HEIW /111 team to develop this function as part of winter planning. To confirm with Steve James	Mar-20	Dec-20	Red	111 colleague to chase Shropdoc and will request further clarification from OOH forum workforce group.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Physician Associates to also be considered as part of the longer term strategy.	This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign.	Mar-20	Dec-21	Red	This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign.

No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Development of the face-to-face pharmacist role in Prince Phillip Hospital.	No longer sits with the UHB. Funding held by 111. When qualified the role will be housed by PPH.	Mar-20	Oct-20	Red	The course and supervision for F2F consultation skills was due to early 2020, however due to winter pressures we felt that we could not support pharmacists attending during this period or release a GP to provide dedicated supervision during one of the busiest times in OOH. The pharmacy lead is looking at alternative course dates.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH006	N/A	R6. Wider Workforce Planning The clinical competencies framework need to be considered for supporting ACP's, UCP, HCSW etc. and should now drive the future workforce planning	Initial meetings with Assistant Directors of Nursing have taken place. Senior Workforce Development Manager is assisting in mapping out workforce requirements.	Dec-19	Dec-20	Red	Initial meetings with Assistant Directors of Nursing have taken place and frameworks will be assessed within the nursing directorate. Senior Workforce Development Manager is assisting in mapping out workforce requirements as a part of TCS agenda, delayed significantly by COVID. Awaiting confirmation of restart.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH013	N/A	R13. Communication and Feedback A feedback form needs to be developed for staff to support learning outcomes and issues from bases /shifts	Note: Use the NHSD form as a basis for refinement for local team Currently in development with OOH IT support	Jan-20	Oct-20	Red	Currently in development with OOH IT support, however this has been delayed by several months as I.T support has been redirected to assist with COVID-19 pressures. In the interim there are mechanisms in place to allow staff to feedback. Currently in development with OOH IT support, however this has been delayed by several months as I.T support has been redirected to assist with Covid pressures. In the interim there are mechanisms in place to allow staff to feedback.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical /operational staff In hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	Mar-20 Oct-20	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH010	N/A	R10. 111 Service It was noted a large number of compliments were received in HD. It was agreed this information would be shared on an All Wales basis and lessons learnt would be shared. It was agreed patient surveys would be looked at in the future.	In hand including CHC and APP OOH surveys.	Dec-20	Dec-20	Red	Patient survey is outstanding and will be picked up again (delayed by several months due to Covid-19).
201803909	Apr-20	Public Service Ombudsman (Wales)	8631	Open	N/A	Unscheduled Care (WGH) / MH&LD	TBC	Director of Operations	201803909_002		R2. Address with the staff responsible for Mr C's care on the mental health ward at the First Hospital, the shortcomings referred to at a) above, using the relevant parts of this report as a learning tool and in a manner which generates clear documentary evidence of that learning by way of, for example, meeting minutes, training materials, staff attendance logs etc.	Action plans held with Ombudsman Liaison Manager.	May-20	Aug-20	Red	The remaining action is being undertaken but COVID-19 has put limits on how this may be achieved. More time has been requested from PSOW to complete outstanding action. Ombudsman Liaison Manager has chased Clinician who has confirmed the evidence will be available early August to send to PSOW.
201902393	Apr-20	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_005		Implement any recommendations arising from this expert report and engage the NHS redress procedure, if appropriate and with your agreement.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201902393	Apr-20	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_006		Undertake enquiries to determine how the original complaint responses provided conflicting information and implement measures to ensure improved accuracy in the future.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201902393	Apr-20	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_007		Remind all clinicians of the necessity to notate in the clinical record when a patient does not consent to interventions and the conversation associated with this. In addition, clinicians will be reminded to ensure that patients with Barrett's Oesophagus are 'counselled' about the possible future course of their condition and the risks associated with it.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201902393	Apr-20	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_008		Remind all gastroenterologists and other appropriate clinicians of the need to ensure that repeat endoscopies are planned at the relevant intervals for patients diagnosed with Barrett's Oesophagus.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201905316	Mar-20	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_004	N/A	R4. If any failings in the care and treatment provided to Mrs B are identified by the expert, the Health Board will provide within 1 month of the receipt of the expert clinical report: • A written apology for any failings identified by the expert. • Any reimbursement of private consultation fees recommended by the expert.	Action plans held with Ombudsman Liaison Manager.	Aug-20	Aug-20	Amber	
201905316	Mar-20	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_005	N/A	R5. The Health Board will implement any future care and treatment recommendations made by the expert in line with the timescales recommended by them.	Action plans held with Ombudsman Liaison Manager.	Aug-20	Aug-20	Amber	The service have only just formally reviewed the report and have sought further clarification from the expert. Clarification rec'd 28/07/2020. The UHB will be able to implement the actions.
201905316	Mar-20	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_006	N/A	R6. Within 1 month of the receipt of the expert report, the Health Board will implement any improvements in practice recommended by the expert.	Action plans held with Ombudsman Liaison Manager.	Aug-20	Aug-20	Amber	
201905316	Mar-20	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_007	N/A	R7. Within 3 months, the Health Board will review their Putting Things Right policy and process for investigating concerns and produce a revised handbook for relevant staff. This will be supported by a skills-based training programme to ensure improved quality of investigation outcomes	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201905316	Mar-20	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_008	N/A	R8. The Health Board will submit evidence of completion of all these measures to the Ombudsman.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	
201806599	Jun-20	Public Service Ombudsman (Wales)	201806599 (7584)	Open	N/A	Unscheduled Care (GGH)	TBC	Director of Operations	201806599_003	N/A	R3: Within three months of the date of this report the Health Board provides guidance to ED staff regarding the assessment of patients with known co-morbidities that could make them more susceptible to infection. It should provide the Ombudsman with evidence that this has taken place		Sep-20	Sep-20	Amber	
201901190/20190120 9/201904157	Jun-20	Public Service Ombudsman (Wales)	201901190/201901209/201904157 (12924)	Open	N/A	Unscheduled Care (WGH)	Sonia Luke	Director of Operations	201901190/20190120 9/201904157_003	N/A	R3: Within six months of the date of this report the Health Board should review its policies on the management of patients who present to the ED with sudden onset head and neck pain, to ensure that it is in line with the NICE Guidance referenced above, and remind relevant staff of the updated guidance		Dec-20	Dec-20	Amber	
201901190/20190120 9/201904157	Jun-20	Public Service Ombudsman (Wales)	201901190/201901209/201904157 (12924)	Open	N/A	Unscheduled Care (WGH)	Sonia Luke	Director of Operations	201901190/20190120 9/201904157_004	N/A	R4: Within six months of the date of this report the Health Board should review its policies on the management of patients who return to the ED within a short time span, with worsening symptoms, and consider whether further action should be taken to ensure that such patients are reviewed by a senior clinician before they are discharged.		Dec-20	Dec-20	Amber	
201902060	Jun-20	Public Service Ombudsman (Wales)	8951	Open	N/A	Unscheduled Care (GGH)			201902060_005		R5: Within three months of the date of this report the Health Board considers the feasibility of introducing an automated respiratory referral system for patients noted to have sudden and unexplained drops in oxygen saturations.		Sep-20	Sep-20	Amber	
201902060	Jun-20	Public Service Ombudsman (Wales)	8951	Open	N/A	Unscheduled Care (GGH)			201902060_006		R6: Within three months of the date of this report the Health Board reminds the Concerns Team of the requirement to adhere to NHS complaint handling regulations in issuing explanatory update letters, and; provides the Ombudsman with details of the review of the process of sending complaint responses by email referred to in its letter to this office of 13 September 2019.		Sep-20	Sep-20	Amber	

RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	Mar-21	Amber	This is part of a wider site plan and progress was being made across key areas but now, is necessarily on hold, due to Covid. Acute stroke is the only one where day rate tariff is now in place.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.2 Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid	Mar-21	Mar-21	Amber	As above, as part of wider site plan. Working collaboratively with SC in regard to reinstatement of scheduled activity (Covid plan) which is working well. Also exploring options for local site management representation for SC.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.3 Diagnostics – in particular cardiology, MRI etc are improving at pace with respiratory the next area for focus	Mar-21	Mar-21	Amber	On hold due to Covid MRI is the only complete area. Others in hand but limited due to Covid
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.4 Work on going across the HB to improve tertiary pathways in the South (Swansea./Cardiff), the north (Wrexham) and in to England recognising that 25-40% of BGH clinical work is from across the border of other HBs	NK	NK	Amber	Routine work on hold due to Covid
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.5 Examples of where services risk is uppermost due to workforce/capacity are neurology (tertiary SLA), dermatology (tertiary and virtual links) & acute stroke & rheumatology	NK	NK	Amber	Acute stroke plan complete Neurology – working with tertiary team Dermatology – as above but on hold due to Covid Rheumatology is a tertiary service
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP01	R1. Improve networking and collaboration with other sites and health boards	1.6 Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties. The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	NK	NK	Amber	In hand – OP work is being progressed by SC. Again, increase in routine work on hold due to Covid Increased weekly engagement with BCU for discharge planning
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP02	R2. Work across NHS Wales to develop formal national networks and protocols for specialist advice	2.2 Reduce cardiac intervention waits by repatriation of as much work back to HD as possible – e.g. long term plan for a cath lab at GGH to reduce angiography referral plus pacing, CT angiography implemented at BGH Cath lab for HDUHB is yet to be progressed.	Dec-20	Dec-20	Amber	Plan in place to reinstate CTA for P1 & P2 pts. July 2020 Same for pacing – to be agreed
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP03	R3. Address the unnecessary problems and barriers created by cross-health board referrals	3.1 This can be complex given the geolocation of BGH but progress on overcoming some of this is covered in point 1 above. Significant progress is being made at a sub specialty level in some areas. Our greatest challenge remains BCU and the area of their HB which utilises BGH as the main acute provider. S Gwynedd is a small and very far south part of the BCU patch and so can tend to be overlooked in terms of developing robust pathways and ways of working, though this is improving and the Covid period has in fact aided this to some extent.	Mar-21	Mar-21	Amber	This is not an action in its own right but feeds other actions referred to in this plan Site plan incorporates increased formal working arrangements with the S Gwynedd team
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP04	R4. Develop new teaching and qualification opportunities for trainees and specialty doctors	4.1 The Foundation programme has identified BGH as priority posts where additional activity is added to the standard F1 curriculum. These postholders will be expected to deliver a mentoring role (following training) to the year 3 carers from Cardiff University. We are currently exploring additional educational programmes delivered locally or via online for simulation training, education and leadership	N/K	N/K	Amber	In progress Allocated additional F1 under this scheme. Reviewed rosters and F docs now have dedicated consolidated training time
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP04	R4. Develop new teaching and qualification opportunities for trainees and specialty doctors	4.2 BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility	Dec-20	Dec-20	Amber	On hold – Covid
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP04	R4. Develop new teaching and qualification opportunities for trainees and specialty doctors	4.3. 2 NHS locum consultants are progressing through a combination of CSAR & Article 14 accreditation and 2 others in USC who do have specialist registration are on the brink of being appointed to substantive roles.	Sep-20	Sep-20	Amber	Cardiology – almost complete In place for acute stroke In place for respiratory consultant and MG
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP04	R4. Develop new teaching and qualification opportunities for trainees and specialty doctors	4.4 Extend mentorship options for VTS post holders	N/K	N/K	Amber	In progress - this is a deanery action.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP04	R4. Develop new teaching and qualification opportunities for trainees and specialty doctors	4.5 Increase the number of Physician Associates working in BGH from 3 (2 in post) to 6.	Mar-21	Mar-21	Amber	In progress – some delay due to Covid and the need to identify funding
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP05	R5. Develop the postgraduate education centre, including clinical skills and simulation equipment	5.1 Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth |University. Both developments will include clinical skills facilities	Dec-21	Dec-21	Amber	Update to be provided by John Evans, Assistant Director, Medical Directorate.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP05	R5. Develop the postgraduate education centre, including clinical skills and simulation equipment	5.2 Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc	Dec-21	Dec-21	Amber	Update to be provided by John Evans, Assistant Director, Medical Directorate.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP05	R5. Develop the postgraduate education centre, including clinical skills and simulation equipment	5.3 The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	Dec-21	Amber	Update to be provided by John Evans, Assistant Director, Medical Directorate.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP05	R5. Develop the postgraduate education centre, including clinical skills and simulation equipment	5.4 Working with Aberystwyth University to establish a Faculty of Health Sciences with School of Nursing locally (awaiting accreditation from RCN_	Mar-23	Mar-23	Amber	On track
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP05	R5. Develop the postgraduate education centre, including clinical skills and simulation equipment	5.5 Establish how the SIFT funds are accounted for within the HB	Sep-20	Sep-20	Amber	In hand Monies allocated to improve accommodation on site
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP06	R6. Ensure training posts are attractive with time for research, teaching and quality improvement	6.3 Potential for a Rural Medicine module (rotation) in the future to be based at Aberystwyth University in line with evolving Royal College thinking.	Mar-23	Mar-23	Amber	Long term plan
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP08	R8. Improve on-site accommodation and support for trainees, clinical fellows and specialty doctors	We are aware that this is a critical problem for BGH and has been raised with the HB. The Estates team have improvements to the BGH site accommodation in their programme of works for 2020/21. Delayed due to Covid.	Mar-21	Mar-21	Amber	Work programme agreed and about to commence
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP09	R9. Learn from the experience of other remote and rural hospitals e.g. Ysbyty Gwynedd	9.1 This will be undertaken with colleagues from Betsi Cadwaladr UHB and other Health Boards with similar characteristics of remoteness and rurality. Contact to be made with BCU to discuss their experience with remote and rural hospitals, e.g. Ysbyty Gwynedd.	NK	NK	Amber	On hold due to Covid
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP09	R9. Learn from the experience of other remote and rural hospitals e.g. Ysbyty Gwynedd	9.2 Identify other remote and rural areas with similar characteristics such as NHS Ayrshire and Arran and make contact.	NK	NK	Amber	On hold due to Covid
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais	Open	N/A	Medical /BGH	Hazel Davies	Medical Director	RCP10	R10. Work with local authorities to consider improvements to travel and road infrastructure.	10.1 Contacts are established with Ceredigion County Council, however there are limited options given BGH geolocation.	NK	NK	Amber	Limited/on hold due to Covid

Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_002	Not stated	CE+ 2: Removing old/unnecessary/unsupported software from the estate will reduce the potential attack surface as well as removing inherent vulnerabilities. Vendor software i.e. Adobe Reader and Adobe Flash Player on a large number of hosts requires patching to a supported level. Adobe Reader and Adobe Flash are standalone software applications that can normally be updated or patched with low impact on other applications or services.	No progress. Detailed audit of installed software to be undertaken. Initial snapshot showed 32,000 software applications and updates installed. No further progress as no Cyber security resources have been allocated to the department.	Not known	Mar-21	Red	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_003	Not stated	CE+ 3: On the HDUHB supported infrastructure, up to date Microsoft Windows security updates, patches for vendor software 7-Zip and VPN client Cisco AnyConnect should be implemented, and a more comprehensive patch management plan agreed for future updates.	Microsoft security patches are now deployed as per CE+1. Other vendor patches cannot be addressed until Cyber security resources are available to ICT.	Mar-21	Mar-21	Amber	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_005	Medium	CE+ 5: Six monthly network scans will allow progress on the points mentioned above to be measured over time, and give a clearer, ongoing picture of the Health Boards exposures. It will also allow efficient and effective deployment of IT resources.	Reliant on NWIS National procurement of vulnerability scanning solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood.	N/K (outside the gift of the UHB)	N/K (outside the gift of the UHB)	Red	Reliant on NWIS National procurement of vulnerability scanning solution. In the interim local scans are taking place in the interim.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_008	Medium	A.7.3 & A.9.2: A robust movers and leavers process to be introduced and continually monitored.	Hywel Dda Policy (301) is in place for user account management. A 'task and finish' group has been setup to improve the current operational processes. A review of user accounts has resulted in removal of more than 4000 unused accounts. Updated policy to be presented to IGSC for approval. New user forms are live on the ICT Portal and Trustmarque has been commissioned to automate and improve the current process based on technologies now available in O365.	Dec-20	Dec-20	Amber	
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_009	Medium	A.8.1: The asset register for technical items to be fully completed. Work to complete the IAR to be maintained so that it is complete by the time that GDPR comes into force.	Work is progressing well through the Information Asset Owners group. Technical asset register has been completed for servers and network switches. These are currently being mapped to Information Asset Owners.	Dec-20	Dec-20	Amber	
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_011	Medium	A.11.1: Staff resources to be provided to allow the communications room security audits to be completed across the Health Board in a timely fashion.	Communication room security audits are complete. A formal risk assessment will be submitted to IGSC outlining resources required to address.	Dec-20	Dec-20	Amber	
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_015	Medium	A.12.4:NWIS are purchasing the LogRhythm SIEM solution. Once the purchase and staff training has been completed its deployment to the various Health Boards should be expedited.	Reliant on NWIS national procurement of LogRhythm solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood (2 HDD staff members attending LogRhythm	N/K (outside the gift of the UHB)	N/K (outside the gift of the UHB)	Red	Reliant on NWIS national procurement of LogRhythm solution. Awaiting a response from NWIS.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_016	Medium	A.12.6: A CE+, or similar scan, to be carried out periodically (suggest 6 monthly) to provide an independent view of the patching status of the infrastructure.	Reliant on NWIS national procurement of vulnerability scanning solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood.	N/K (outside gift of UHB)	N/K (outside gift of UHB)	Red	Reliant on NWIS national procurement of LogRhythm solution. Awaiting a response from NWIS.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_012	Medium	A.12.1: The remaining XP machines should be segmented off the main network and access to them strictly controlled, all unnecessary services removed from user access.	Windows XP devices has reduced from 33 to 23. Awaiting update to Audiology and Chubb security system to enable upgrade to Windows 10. Review of remaining systems is underway and report will be made available for IGSC	Aug-20	Aug-20	Amber	
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_013	Medium	A.12.2: Further staff resources to be allocated to enable a more robust server patching regime to be achieved.	Paper has been provided to the executive team to identify the resources required to improve the rates of server patching. This equated to 3 x Band 5's. No funding has been identified so patching still at best endeavours using existing resources.	Not known	Mar-21	Red	funding from Welsh Government to fund Band 6 post to take this work forward has been received and role currently going out to advert. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020. Status is red as no progress made to date.
No ref	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services.	Mar-20	Mar-20	Red	Language skills data from Primary Care contractors is not collected. Staff in the four Managed Practices however have to log their Language skills on ESR. Over summer 2019, the Primary Care team administered a questionnaire, on behalf of Welsh Government, with all four Primary Care contractor areas to assess compliance with the six Welsh Language Duties for Primary Care contractors. In response to the Duty to encourage the wearing of a badge, provided by the Local Health Board, by Welsh speakers, to convey that they are able to speak Welsh, 63% of Primary Care contractors who responded to the questionnaire reported that they were meeting this (although this isn't an audit of language skills).
No ref	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	PCTWL_008	N/A	R8. Health Education and Improvement Wales, health boards and higher education establishments need to work together to develop a clear connection between the recruitment process on the basis of linguistic ability and the contents and medium of the training provision within higher education establishments.	The Health Board will publish the new Bi-Lingual Strategy, which sets out the skills assessment by department to inform workforce planning and the recruitment process.	Mar-20	Sep-20	Red	AMT - Issue of bilingual strategy has been delayed due to Covid-19 workload. Revised due date for issue targeted as 30 Sept. 2020
No ref	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	PCTWL_013	N/A	R13. Health boards and primary care clusters should develop a framework for ensuring effective progression between identifying the linguistic needs of the local population, providing education and training based on these needs, and recruiting and appointing primary care workers with bilingual professional skills	The Health Board will publish the new Bi-Lingual Strategy, which sets out the skills assessment by department to inform workforce planning and the recruitment process.	Mar-20	Sep-20	Red	AMT - Issue of bilingual strategy has been delayed due to Covid-19 workload. Revised due date for issue targeted as 30 Sept. 2020

CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_001	N/A	R1. The Health Board must conduct a review to check that appointment letters sent from other departments comply with standard 5 and act upon the results of the review.	Apr-20	Oct-20	Red	All investigations from Welsh Language Commissioner were placed on hold during the Covid-19 period. Awaiting confirmation from the Commissioner's office for a new deadline. October 2020 placed as revised timescale, this date will be reviewed once clarification received from Commissioner
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_002	N/A	R2. The Health Board must conduct a review to check that forms provided to the public by other departments comply with standard 36 and act upon the results of the review.	Apr-20	Oct-20	Red	All investigations from Welsh Language Commissioner were placed on hold during the Covid-19 period. Awaiting confirmation from the Commissioner's office for a new deadline. October 2020 placed as revised timescale, this date will be reviewed once clarification received from Commissioner
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_003	N/A	R3. Hywel Dda University Health Board must provide sufficient written evidence to satisfy the Welsh Language Commissioner that it has carried out enforcement actions 1-2.	Apr-20	Oct-20	Red	All investigations from Welsh Language Commissioner were placed on hold during the Covid-19 period. Awaiting confirmation from the Commissioner's office for a new deadline. October 2020 placed as revised timescale, this date will be reviewed once clarification received from Commissioner

Reports Closed on the Audit Tracker since ARAC June 2020

Report name	Lead Executive/Director
Audit Wales: Radiology Service	Director of Operations
CHC: Time To Go Home	Director of Primary Care, Community and Long Term Care
Coroner Regulation 28: Inquest Touching the Death of EMI	Director of Operations
HIW: Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018	Director of Operations
HIW/CHC Contractors: Llynyfran Surgery, Llandysul	Director of Primary Care, Community and Long Term Care
HIW/CHC Contractors: New Quay Surgery Visit Report, November 2019	Director of Primary Care, Community and Long Term Care
HIW/CHC Contractors: Ash Grove Medical Centre, Llanelli, November 2019	Director of Primary Care, Community and Long Term Care
HIW/CHC Contractors: Fishguard Health Centre, October 2019	Director of Primary Care, Community and Long Term Care
HIW/CHC Contractors: Llynyfran Surgery, July 2019	Director of Primary Care, Community and Long Term Care
HIW/CHC Contractors: Amman TawePartnership, GCG Surgery 12/11/2019	Director of Primary, Community and Long Term Care
Internal: Audit Health & Safety	Director of Nursing, Quality & Patient Experience
Internal Audit: IM&T Directorate (has been superseded by HDUHB 1920-40 IM&T Assurance – Follow Up)	Director of Planning, Performance & Commissioning
Internal Audit: PC and Laptop Security (Follow Up) (has been superseded by HDUHB 1920-40 IM&T Assurance – Follow Up)	Director of Planning, Performance & Commissioning
Internal Audit: Research & Development Governance Review	Medical Director
Internal Audit: Estates Directorate Governance Review (Follow Up) (it has been agreed that the outstanding recommendations from the follow up report will be tracked via the original report)	Director of Operations

Internal Audit: National Standards for Cleaning in NHS Wales	Director of Operations
Internal Audit: Capital Follow Up (has been superseded by SSU_HAD_1920_01.2 Capital Assurance – Follow Up Report)	Director of Planning, Performance & Commissioning
Internal Audit: Cardigan Integrated Care Centre (has been superseded by SSU_HAD_1920_01.2 Capital Assurance – Follow Up Report)	Director of Planning, Performance & Commissioning
Internal Audit: Data Centre Project (has been superseded by SSU_HAD_1920_01.2 Capital Assurance – Follow Up Report)	Director of Planning, Performance & Commissioning
Internal Audit: Estates Follow Up (Residential Accommodation / Backlog Maintenance / Fire Precautions Follow Up) (has been superseded by SSU_HAD_1920_01.1 Estates Assurance – Follow Up Report)	Director of Finance
Internal Audit: Review of Discharge Processes (Follow-up)	Director of Operations
PSOW: 201805835 (Datix Reference 8015)	Director of Operations
PSOW: 201906087 (Datix Reference 13585)	Director of Operations
PSOW: 201902238 (Datix Reference 12260)	Director of Operations
PSOW: 201807683 (Datix Reference 9460)	Director of Operations
PSOW: 201904831 (Datix Reference 14088)	Director of Operations
PSOW: 201901989 (Datix Reference 13248)	Director of Operations

Reports Open on the Audit Tracker since ARAC June 2020

Report name	**Lead Executive/Director**	**Final report received at**
HIW: Wards 7 & 11, Withybush General Hospital (February 2020)	Director of Operations	Quality, Safety & Experience Assurance Committee August 2020
HIW: Puffin Unit / PACU, Withybush General Hospital	Director of Operations	Quality, Safety & Experience Assurance Committee August 2020
HIW: PACU & Cilgerran Wards, Glangwili General Hospital	Director of Operations	Quality, Safety & Experience Assurance Committee August 2020
Internal Audit: Business Continuity	Director of Public Health	Audit & Risk Assurance Committee June 2020

Internal Audit: Capital Assurance- Follow Up	Director of Planning, Performance & Commissioning	Audit & Risk Assurance Committee June 2020
Internal Audit: Estates Assurance Follow Up	Director of Operations	Audit & Risk Assurance Committee June 2020
Internal Audit: Glangwili Hospital Women & Children's Development Phase 2	Director of Planning, Performance & Commissioning	Audit & Risk Assurance Committee June 2020
Internal Audit: Health & Safety	Director of Nursing, Quality & Patient Experience	Audit & Risk Assurance Committee June 2020
Internal Audit: IM&T Assurance	Director of Planning, Performance & Commissioning	Audit & Risk Assurance Committee June 2020
Internal Audit: Mortality Rates	Medical Director / Director of Clinical Strategy	Audit & Risk Assurance Committee June 2020
Internal Audit: National Standards for Cleaning (Follow Up)	Director of Operations	Audit & Risk Assurance Committee June 2020
PSOW 201806599 (Datix 7584)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201901190/201901209/201904157 (Datix 12924)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201902060 (Datix 8951)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201902169 (Datix 10946)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)

Name of Report	Reviewing Body	Date of Report	Red (behind Schedule	Amber (on schedule	Green (completed)	Recommendation	Action	Reason that action has not been implemented	How is this issue being managed/ resolved in long term	New Executive Director	New reporting officer	New area responsible for implementing recommendation	Progress update	Estimated revised Completion date (if known)	Not completed (red)/ Completed (green)	Comment
Bronglais Unannounced Hospital Inspection - Enlli, Ceredig & Ystwyth Wards 07-08 Sep 2016 (Older Adult MH, General Surgical /Trauma and Orthopaedic and Stroke)	Health Inspectorate Wales (HIW)	December 2016	2	0	56	Recommendation for Ceredig and Ystwyth wards- The Health Board needs to ensure staff can access patient records in a timely manner.	IT infrastructure to be reviewed to assess suitability for use on wards. Development of IPad based systems to promote access to health records at bedside.	As part of the 2018/19 refresh of the digital strategy there is a reaffirmed commitment to becoming a paper light organisation, however this is dependent upon a business case to Welsh Government. To date this has not been submitted.	Implementation of the electronic patient record will require dedicated project management support and funding. The Deputy Director of Operations and the Health Records Manager have been asked to produce terms of reference for a project group which is being progressed, however it will not be possible to implement the objectives without the necessary resources being in place.	Director of Operations (same as original).	Director of Operations	Health records	15/07/20 The inaugural Health Records Modernisation Programme Group (HRMPG) meeting took place on 23rd April 2019. The context of the current records management situation was set out and key principles were agreed. At the next HRMPG held on 3rd September 2019 five specific work streams were agreed, with a confirmed lead who would be responsible for progressing each project and delivering the outcomes agreed. In order to accelerate progress and improvement it was considered essential that bespoke and dedicated resources were provided to augment the efforts of day to day managers. Even though leads had been identified, due to their daily work commitments it was unlikely that individuals would be in a position to afford the significant time commitment needed to push forward each initiative to conclusion, without additional support. Each lead is responsible for busy front line services and hold senior roles within the organisation with operational and strategic management responsibilities. To ensure delivery and in order to support the completion of work associated with each work stream, there was a requirement for 1.8 WTE support staff from the programme management office. The PMO support would be split into two sectors, with one part time member of staff (0.8 WTE) working directly with four of the less complex work streams and one full time member of staff specifically assigned to the scanned patient record work stream. A paper requesting additional support was submitted to the Executive Team in March 2020 and the outcome was further discussions were required.	Approx. March 2023	Red	24/07/2020- Update provided by Deputy Director of Operations
External Governance Review	Commissioned report	April 2015	3	0	55	RS.7: The Executive Team should review the current position with regards to records management, and agree proposals for consideration by the Business Planning and Performance Assurance Committee.	Provide a report on the current records management position to an Executive Team meeting and agree proposals for consideration by the Business Planning and Performance Assurance Committee.	BPPAC received the Health Records Management Report and discussed the key challenges experienced by the Health Records service. However the issue of poor and inadequate facilities within the Health Records Service with insufficient storage capacity for patient records and a lack of investment in electronic systems to deliver a sustainable model still remain.	A project board has now been formed, led by the Director of Operations, and has met twice in 2019. Its focus being the broader issues of health records management beyond the acute records. From the September 2019 meeting a workplan is being developed and this will be used as justification for securing project management resources which have already been acknowledged in principle by the executive team.	Director of Operations (same as original)	Director of Operations	Health Records	15/07/20 The inaugural Health Records Modernisation Programme Group (HRMPG) meeting took place on 23rd April 2019. The context of the current records management situation was set out and key principles were agreed. At the next HRMPG held on 3rd September 2019 five specific work streams were agreed, with a confirmed lead who would be responsible for progressing each project and delivering the outcomes agreed. In order to accelerate progress and improvement it was considered essential that bespoke and dedicated resources were provided to augment the efforts of day to day managers. Even though leads had been identified, due to their daily work commitments it was unlikely that individuals would be in a position to afford the significant time commitment needed to push forward each initiative to conclusion, without additional support. Each lead is responsible for busy front line services and hold senior roles within the organisation with operational and strategic management responsibilities. To ensure delivery and in order to support the completion of work associated with each work stream, there was a requirement for 1.8 WTE support staff from the programme management office. The PMO support would be split into two sectors, with one part time member of staff (0.8 WTE) working directly with four of the less complex work streams and one full time member of staff specifically assigned to the scanned patient record work stream. A paper requesting additional support was submitted to the Executive Team in March 2020 and the outcome was further discussions were required.	Approx. March 2023	Red	24/07/2020- Update provided by Deputy Director of Operations
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R1.1: Concerns raised in relation to delays in follow up care.	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R1.1: Concerns raised in relation to delays in follow up care. Partial Progress Following a successful bid for funding through the eye care sustainability fund, non-recurrent funding was allocated to deliver a Community Glaucoma Data Capture Scheme and Enhanced Referrals for Cataracts. These projects commenced early Oct 2019 and have supported with releasing capacity in Secondary Care. 98% of patients have been allocated a Health Risk Factor by the end of September 2019 which will allow for a review and baseline assessment to be undertaken.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R1.3: Requirement to introduce a service framework for service delivery.	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R1.3: Requirement to introduce a service framework for service delivery. Delivery of the Glaucoma community data capture commenced in Oct 2019, however, was paused from March 2020 due to COVID-19.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R2.1. Lack of progress with ODTC in Ceredigion	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R2.1. Lack of progress with ODTC in Ceredigion. 05/09/19 update- Discussions are continuing as part of the Mid-Wales collaborative programme. During COVID-19 Community Optometrist Hubs were set up in each cluster to support with Emergency Eye Care, these were successful and support the development of ODTC working.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R2.2: Concerns raised in relation to delays in follow up care	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R2.2: Concerns raised in relation to delays in follow up care. Partial Progress Following a successful bid for funding through the eye care sustainability fund, non-recurrent funding was allocated to deliver a Community Glaucoma Data Capture Scheme and Enhanced Referrals for Cataracts. These projects commenced early Oct 2019 and have supported with releasing capacity in Secondary Care. 98% of patients have been allocated a Health Risk Factor by the end of September 2019 which will allow for a review and baseline assessment to be undertaken.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R2.3: No identified lead consultant for Glaucoma	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R2.3: No identified lead consultant for Glaucoma. Partial progress Service Delivery manager is working with the recruitment and campaigns team to positively promote recruitment and successfully attract substantive clinicians. Following numerous recruitment campaigns the Health Board are working with Swansea Bay through the ARCH project to scope the options for Regional working across Ophthalmology with Glaucoma being the first priority.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R2.4: Critical need for substantive appointments of Consultant Ophthalmologists	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R2.4: Critical need for substantive appointments of Consultant Ophthalmologists. Successful recruitment of 2 x Locum Consultants to Ceredigion. 1 commenced Sept 2019 with the second in Dec 2019. Substantive Job was advertised with 1 appropriate applicant. Due to COVID-19, a recruitment panel cannot be convened until Oct 2020.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Focus on Ophthalmology: Assurance Reviews	Delivery Unit	March 2016	1	7	3	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	Since 2016, the Service has undergone significant change in clinical personnel, leadership and scope. The introduction of the Welsh Eye Care Measures (ECM) has introduced a new level of scrutiny to delivery of eye care across Wales.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	R2.6: Concern over the number of patients not reviewed within their target date. Partial Progress Following a successful bid for funding through the eye care sustainability fund, non-recurrent funding was allocated to deliver a Community Glaucoma Data Capture Scheme and Enhanced Referrals for Cataracts. These projects commenced early Oct 2019 and have supported with releasing capacity in Secondary Care. 98% of patients have been allocated a Health Risk Factor by the end of September 2019 which will allow for a review and baseline assessment to be undertaken.	March 2022 (as per Eye Care Plan 2018-22)	Red	

Follow-up Outpatient Appointments: Update on Progress	Audit Wales	December 2017	1	1	8	R9: Plan for longer-term modernisation of outpatient services by taking stock of: • clinical resources, including medical, nursing and allied health practitioners, required; • the change capacity and skills required; and • internal and external engagement with stakeholders.	This piece of work is being led through the Transforming Clinical Service (TCS) Strategy which is currently in the Design phase. Initial TCS proposals expected by July 2018 will take account of proposed future model of outpatient services across the Health Board.	This piece of work is being led through the Transforming Clinical Service (TCS) Strategy.	In March 2019, the Board approved 'A Healthier Mid & West Wales Portfolio of Programmes: Scoping, Governance & Delivery Document' which set out the framework for the three Programme Delivery Plans central to this strategy. Key to this WAO recommendation is the Transforming our Hospitals programme (to be led by the Deputy Chief Executive) which will provide the focus for the longer term modernisation of outpatient services across Hywel Dda. The supporting programme delivery plan is expected to be developed by 31st July 2019.	Director of Operations (same as original)	Keith Jones (same as original)	Scheduled Care	This programme for modernisation of outpatients, whilst delayed in part by the COVID-19 response has also allowed the Health Board to progress at rapid pace with the implementation of digital platforms whilst reducing the requirement for face to face clinics (as part of the Digital Work streams Communication Strategy). Hywel Dda has piloting five digital platforms with further scrutiny sessions planned for the other digital platforms in early September 2020. The digital platforms are being introduced across the spectrum of primary, community, acute and tertiary care.	N/K	Red	02/03/2020- emailed Keith Jones for update by 26/02/2020. 04/08/2020- update provided by Stephanie Hire.
Guidance on safe clinical use of Magnetic Resonance Imaging (MRI)	Welsh Health Circular	February 2018	N/A	N/A	N/A	WG strongly recommend that the UHB formalise and support the appointment of a Magnetic Resonance Safety Expert with significant knowledge and experience of clinical magnetic resonance physics.	Appointing a joint MRSE with Swansea Bay University Health Board.	WHC unable to be implemented due no suitable MRSE appointment available.	A business case has been developed for the introduction and employment of an MRSE within Swansea Bay University Health Board, with the UHB expressing an interest in this appointment supporting the Hywel Dda service. MRI leads belong to an All Wales MRI Special Interest Group via the Imaging Quality Forum that shares good practice , thus reducing risks	Director of Operations	Amanda Evans (same as original)	Radiology	Lead MRI staff are involved in All Wales Radiology Quality forum discussions to share good practice and advice. Ad hoc and individual advice is sought from Swansea University. Engagement of Magnetic Resonance Safety Expert (MRSE) via current Service Level Agreement (SLA) with Swansea Bay. MRSE has been appointed, awaiting job plan for allocation to Hywel Dda UHB. This risk is on Datix (ref. 722) with a current score of 8 (High).	N/K	Red	Discussion held 30/06/2020 to identify Director of Operations as new Exec Lead
Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Health Inspectorate Wales (HIW)	February 2019	5	0	35	Consideration of ribotyping cases of C. Diff to establish if any cross-contamination, and share results across all relevant teams.	Ward Sister to review potential to allocate elective admissions for joint replacements into a designated area within Ward 1. A ward operational policy will be developed to reflect this review.	Ward 1 have 4 6 bedded bays plus 6 side rooms. The ward serves as a Trauma & Orthopaedic ward accepting both emergency and electives admissions. The current bed base in the hospital does not support/ allow a separate ring fenced elective/emergency bed allocation.	A wider Health Board long term Orthopaedic plan needs to be in place before these actions can be implemented at WGH.	Director of Operations (same as original)	Sally Farr (same as original)	Unscheduled Care (WGH)	Added to Strategic Log following Formal Exec Team 11/09/19.	N/K	.	30/06/2020 requested an update , no response to date.
Medicines Management in Acute Hospitals	Wales Audit Office	June 2015	1	0	16	R1b: Refresh its Medicines Management Strategy to provide an integrated vision across primary and secondary care that is developed in full partnership between pharmacy, medical and nursing staff.	One of the key roles for the newly appointed Head of Medicines Management will be to update and refresh the strategy for the service. Employing the County Leads, who all have busy operational and managerial roles, as rotating interim Heads of Medicines Management has not allowed strategic aims to be tackled.	Awaiting outcome of Transforming Clinical Services Strategy development for the Health Board.	On completion of the Transforming Clinical Services Strategy the pharmacy strategy will be aligned. The key elements have been identified and include: -Improving patient experience -Reducing medicines related harm - Technology and Innovation -Workforce - Efficiency and Productivity	Director of Primary, Community and Long Term Care	Jenny Pugh-Jones	Strategy	24/09/19- Work is in progress in the development of the strategy, aligning to the Health Board's A Healthier Mid and West Wales and also the recently published Pharmacy Vision to support A Healthier Wales developed through the Welsh Pharmaceutical Committee. In addition further strategic documents such as the Transforming Access to Medicines(TrAMS) and the Chief Pharmacists work plan are informing the director of travel. 20/07/2020 - While the main elements of the strategy have been developed, aligned to both the Health Board Clinical Strategy, Three year plan and the Pharmacy Vision document Pharmacy: Delivering a Healthier Wales there remained wider consultation prior to finalisation. This work has been delayed significantly due to Covid-19, and now with a new, fresh view for transforming clinical services and potential for significant re-set the projected timescale for completion has been delayed until Sept 2021. This will allow sufficient time to ensure any strategy is fully aligned to new ways of working and consultation on the strategy and possible further delays due to covid-19. A SOC (Strategic Outline Case) has been submitted to WG and we are waiting for feedback in order to determine the next steps	01-Sep	Red	30/08/19- emailed Jenny 30/08/19 and chaser email 24/09/19. 17/07/2020 request for update has been sent, await response. highlighted the date overdue. Jenny responded and the date of estimated completion changed to reflect the delay.
Medicines Management in Acute Hospitals	Wales Audit Office	July 2015	1	0	16	R3b:Develop a costed option appraisal to fully address the deficiencies in its aseptic units.	This work is now moving forward under the leadership of Jenny Pugh Jones, in conjunction with the aseptic leads and the All Wales QC Pharmacist.	The Health Board is working closely with ABMU (under the ARCH initiative) and Welsh Government to develop a business case for future provision of aseptic services across SW Wales.	A costed business justification case has been developed. So the action is complete. However the Transforming Access to Medicines (TRAMS) work has identified further options, one of which includes not replacing the GGH unit but utilising available facility capacity from other Health Boards as part of a National Strategy for building resilience in the provision of Aseptic Technical Services. The report is to be finalised in Dec 18 and presented to WG for consideration.	Director of Primary, Community and Long Term Care	Jenny Pugh-Jones	Equipment	24/09/19- On the recommendation of Welsh Government a Strategic Outline Case has been developed due to the need to align with a changing vision for aseptic services across NHS Wales as identified within the TrAMS project. The SOC is in final draft ready for submission for consideration of funding to progress to a full Business Case. The SOC has been aligned to the TrAMS work and identifies the need for replacement of the 3 existing units with one single unit to increase resilience across Hywel Dda and support a NHS Wales approach. 20/07/2020, A SOC (Strategic Outline Case) has been submitted to WG and we are waiting for feedback in order to determine the next steps	NK	Red	A costed business justification case has been developed. So the action is complete. 20/07/2020 Requested an update regarding this recommendation, as it states completed. response received from Jenny PJ -limited and restricted in what the HB can do, highlighted date for completion unable to complete as awaiting outcome from WG . 20/07/2020 response received.
Medicines Management in Acute Hospitals	Wales Audit Office	August 2015	1	0	16	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	The Welsh Government (WG), NHS Informatics Service (NWIS) and all health bodies should agree a detailed, time-bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery of the plan.	The HB complies with this action thorough continued support and being part of the work programme to achieve (HD Consultant Lead Chairs the National Group) to finalise the business case and secure funding for e-prescribing systems across NHS hospitals.	Director of Primary, Community and Long Term Care	Jenny Pugh-Jones (responsible officer remains the same)	Informatics	01/03/19- The business case for replacement of the Pharmacy system (over 25 yrs old) has been approved . This is the first step to implementation of an e-prescribing and medicines management system. Anticipated upgrade for UHB is Q1 in 2020-21. The case for e-prescribing continues with no exact timescales. NWIS are leading on this project and the UHB continues to fully support. 24/09/19- Approval has been given for the replacement of the pharmacy system , which is the first step in this project. The Health Board is working closely with NWIS (who lead the project) and the Project Board to work through the implementation. Currently the time line for Hywel Dda is October 2020. Work continues on the business case for e-prescribing as part of a national initiative. 04/08/2020 The WHEPMA system business case is under development for submission to WG at national level. This will radically change the way I which the whole health services operates.	Not known	Red	30/08/19- emailed Jenny 30/08/19 and chaser email 24/09/19. 04/08/2020 Request for update and response received. New system is being developed and led by NWIS and WG, completion date is currently unknown.
Peer Review - Gynaecology - 9th Jan 2015 & Review 3 Jul 2015	Peer Reviews	October 2015	1	0	4	R4b. Maintain a cohesive & functioning Multi-Disciplinary Team.	To continue HB efforts to recruit additional Consultant Radiologist capacity to support	Recruitment efforts to attract substantive consultants continuing, but it is a very difficult to recruit to profession.	Supporting General Radiologist locum consultant appointments in place. These General Radiology posts allow Radiologists with a specialist interest (including Gynaecology, Breast and Haematology) to prioritise specialist expertise. The Director of Workforce & OD has confirmed the UHB has run a campaign for radiologists, and continues with recruitment drives to attract applicants. This is an overarching strategic objective for the service.	Director of Workforce & OD	Lisa Gostling, Director of Workforce & OD	Workforce/Radiology	30/09/19- Update from Workforce & OD- Job description is currently with the Royal College for approval prior to advertising four posts. Since the last update the UHB has employed one further Consultant Radiologist who commenced employment on 19/08/19. 23/07/2020 Substantive and Locum Consultants recruited over the last 12 months: Substantive and locum posts have both been advertised 3 times over the last 12 months 100-MED-GGH- 078/A/B 100-MED-GGH-078-L/L1/L2.No SAS/Jnr positions advertised/appointed over last 12 months. Global Fellows, a Royal College initiative has resulted in two appointees (Specialty Drs) who are now going through the onboarding process. They are both from Egypt and we have received assurance from the Royal College of Radiologists that they have sourced within the parametres of the Recruitment Code of Conduct.	Not known	Red	email sent to Lisa and Amanda 30/08/19 and chaser 24/09/19. July 2020 requested an update, new system received all updates at one time. Forms part of W&OD Tracker Amanda updated .
Peer Review: Respiratory Cancer Review 16/06/2016	Peer Reviews	June 2016	1	0	6	R6. Sustainability	Health Board strategic review of services where sustainability of current service model is challenging.	Sustainability of all services subject to review via TCS programme.	Being reviewed as part of TCS programme.	Director of Operations (same as original).	Stuart Bancroft	Sustainability of service / Cancer	01/10/19 update- Further driven through need to approach both single cancer pathway and more importantly the optimum cancer pathway. Sustainability during periods of CNS vacancy has also proved challenging and the future particularly in respect of expected retirement of Lung CNS, has focussed the team to commence redesign of the lung cancer pathway, feeding into the Health Board's intermediate medium term plan. 22/07/2020 A Respiratory Lead has been appointed – Professor Keir Lewis who together with Stuart are formulating robust plans to make the Respiratory Service more sustainable. As part of this, weekly meetings are held between Professor Lewis and Stuart and a Respiratory plan has been formulated to clearly define where the expertise sit across the healthboard. Also to note Leads and Deputy Leads within Respiratory specialist areas have been appointed i.e Lung Cancer	Awaiting decision of TCS.	Red	30/08/19- emailed Stuart and chaser email 24/09/19. 9/7/2020 Email sent requesting an update, no formal update received reminder sent today 17/07/2020. 22/07/2020, Alex has met with Stuart and provided me with a response.
Principles, Framework and National Indicators: Adult In-Patient Falls	Welsh Health Circular	April 2016	N/A	N/A	N/A	To ensure patients at high risk of osteoporotic factures are offered appropriate therapy to reduce risk in accordance with the all Wales Musculo-Skeletal Group (AWMSG) guidance.	In response to this action the Health Board established a Fracture Liaison Services Sub Group to develop a model and business plan to include standardisation of treatment for inpatients and outpatients. The proposed model will include reducing risk to high risk patients of osteoporotic facture.	It is acknowledged that considerable investment will be required to establish this service.	The Executive Medical Director / Director of Clinical Strategy has now taken over the lead on this initiative and an improvement plan is under development. In the interim the Health Board has continued to support the prescribing of therapy to patients at risk of developing osteoporotic fractures in accordance with the AWMSG guidance and appropriate assessment by a clinician. The importance of giving due consideration to the need for therapy is highlighted in the frailty assessment clinics and also gynaecology services for post menopausal women. The complex elements of this service development will need to be outlined in a business case as considerable investment will be required. A new Service Delivery Manager (SDM) for Stroke and Care Of The Elderly (COTE) is in post who will be absorbing the work to respond to this WHC as part of her new role.	Medical Director	Bethan Andrews	Medical	17/07/2020 Work has not progressed at pace due to the COVID 19 response. 1st high level meeting has now taken place with the medical Director/Director of Nursing , SDM and Head of Value based Health Care. Task and finish Group set up to finalise business case and future development of the service. 2nd meeting has taken place with secondary care and primary care (10/07/2020) The UHB now has appointed a Lead for COTE who will Lead from a clinical point of view.	Aug-21	Red	22/01/20- Bethan Andrews to lead on this strategic recommendation. Work has not progressed at pace due to the COVID 19 response.

Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R7: Phase out the obstetric and gynaecology out of hours consultant rota at Withybush with a target date of April 2016, integrating and strengthening the obstetric and gynaecological consultant team at Glangwili.	8. Clinical Task & Finish Group to be established (involving Directorate & GGH / WGH site representation) to undertake review of capacity and service implications.	Recommendation initially not supported. Subsequent proposals developed by clinical team, agreed in principle by Executive Team and shared with CHC Service Planning Committee. Awaiting CHC confirmation re extent of public engagement activities required. Target date for implementation remains subject to confirmation of engagement process.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services		Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R12: In order to meet RCoA standards and secure future allocation of anaesthetic trainees further additional sessions are needed on the labour ward.	17. Anaesthetic workforce development plan to be produced in parallel with HB IMTP.	Anaesthetic cover continues to be provided to Labour Ward. Workforce development priorities identified by clinical team. Financial implications unable to be accommodated within 2019/20 Annual Plan. Issue to be further assessed via clinical team job plan reviews Qtr 1 2019/20.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services	1st high level meeting has now taken place with the Medical Director/Director of Nursing, SDM and Head of Value Based Health Care.	Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R41: Review availability of emergency paediatric skills at Withybush against demand and redeploy the out-of-hours paediatric cover to contribute to activity at Glangwili.	52. Review out-of-hours cover arrangements via Task & Finish Group established to review the future provision of PACU service at Withybush Hospital.	Recommendation initially not supported. Clinical team proposals for an integrated rota have been progressed as part of the Paediatric Task and Finish Group work stream and monitored via the Board. Confirmation received from Engagement Team and CHC that options / proposals will need to be supported by a period of engagement with service users (prior to consideration by the Board) and a period of formal public consultation. Target date for implementation remains subject to the above.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services		Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R59: Strengthen nurse staffing in ED through urgent appointment of Registered Children's Nurses (one per shift) to provide general paediatric expertise. Longer term consider development of Emergency Nurse Practitioner (ENP) roles, including nurse prescribers, and a 5-year plan for training and retention.	71. ED workforce development plan to be produced in parallel with HB IMTP.	Workforce development priorities confirmed. 1 WTE additional RSCN appointed to support ED service with 2 WTE newly qualified nurses to commence training in September 2019. APNP development programme commenced.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services	Task and Finish Group set up to finalise business case and future development of the service.	Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R61: Formally merge the paediatric consultant team and remove the out of hours cover for Withybush with a target date of April 2016 once the paediatric, nursing and management team are sure that appropriate emergency arrangements (training access transfer) are in place. This assurance should be supported by monitoring of all attendances out of PACU operating hours to ensure appropriate case management occurred, and identify any incidents resulting from the changes.	73. Clinical Task & Finish Group to be established (involving Directorate & GGH / WGH site representation) to undertake review of capacity and service implications	Recommendation initially not supported. Clinical team proposals for an integrated rota have been progressed as part of the Paediatric Task and Finish Group work stream and monitored via the Board. Confirmation received from Engagement Team and CHC that options / proposals will need to be supported by a period of engagement with service users (prior to consideration by the Board) and a period of formal public consultation. Target date for implementation remains subject to the above.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services		Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R68: Support investment in the Community Children's Health service towards compliance with the RCN and RCPCH guidance for community child nursing. There is an urgent need for recruitment of Consultant Community Paediatricians	81. Continue recruitment efforts to fill current vacancies.	Recruitment efforts continuing. Locum appointments and additional sessions provided by substantive staff.	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services	2nd meeting has taken place with secondary care and primary care.(10th of July).	Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Royal College of Paediatrics & Child Health (RCPCH) Action Plan	Royal College of Paediatrics & Child Health (RCPCH)	November 2015	7	0	65	R69: Develop the roles of specialist nurses, for example in epilepsy, asthma/ respiratory.	82. Review current profile of specialist nurses and identify priority areas for development	Proposals identified and submitted for consideration via 19/20 IMTP / Annual planning process. Financial implications unable to be accommodated within 2019/20 Annual Plan. Issue to be further assessed via Paediatric T&F Group proposals for Board consideration (see Recommendation 41 above)	In April 2019, ARAC invited the Medical Director to discuss the pace of delivery in respect of the recommendations from this report. Through discussion it was agreed that as the outstanding recommendations required a strategic solution and potential service change these would be requested to be moved to the strategic log. The outstanding actions form part of service development work and are part of the UHB's overall Health & Care Strategy.	Medical Director (same as original).	Lisa Humphrey	Women and Children's services		Not Known	Red	30/06/2020 Emailed LH for an update on all 7 recommendations. 30/07/2020 follow up email. 05/08/2020 final chase Lisa Humphrey on annual leave. Paula reviewing awaiting response.
Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Health Inspectorate Wales (HIW)	November 2014	2	0	28	Corridors were also cluttered due to lack of adequate storage for large equipment.	Ward storage and clutter ongoing challenges due to nature of ward equipment needs and also size of ward areas. Plan in place with Estates for change of function of unused bathrooms into storage areas. Awaiting costs and plan of actions required. Further ward refurbishment needs being assessed by Estates and will be reviewed in line with refurbishment plans for site.	Will require support from the ward refurbishment programme to resolve actions outstanding.	The UHB is due to submit a Programme Business Case to Welsh Government (WG) in autumn 2018. This includes a comprehensive integrated programme for both major infrastructure investment and ward refurbishments across all the sites within the UHB.	Director of Operations (same as original).	Rob Elliot, Director of Estates, Facilities and Capital Management	Estates	The UHB now has appointed a Lead for COTE who will also lead form a clinical point of view. 03/07/2020- The mapping of the Programme Business Case (PBC) to the Transforming Clinical Services (TCS) has now been completed. Clarification is being sought on the appropriate UHB approval process the PBC will need to go through, prior to submission to Welsh Government.	Not known	Red	Previous updates: 22/02/19- Work on Programme Business Case (PBC) to align with TCS is currently underway. This work is required to be completed before the Business Case can be submitted to WG for consideration. Following discussions with WG the revised PBC is due to be considered by the Health Board in May 2019. This will however require individual BJCs to be developed to secure funding for specific schemes on a prioritised basis. GGH Site Manager not be bidding for Discretionary Capital ahead of the Programme Business Case/future BJCs referenced above. 03/09/19- Director of Planning, Performance & Commissioning is carrying out a piece of work to reconcile the PBC with the TCS, this is projected to be completed by December 2019 at which point the PBC will be submitted

Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Health Inspectorate Wales (HIW)	November 2014	2	0	28	We found that the environment was old, tired and some areas required refurbishment.	Estates working with Senior Nurse and Ward Manager to devise plan for refurbishment identifying priorities and will be managed as part of the site refurbishment plans with Estates.	Will require support from the ward refurbishment programme to resolve actions outstanding.	The UHB is due to submit a Programme Business Case to WG in autumn 2018. This includes a comprehensive integrated programme for both major infrastructure investment and ward refurbishments across all the sites within the UHB.	Director of Operations (same as original).	Rob Elliot, Director of Estates, Facilities and Capital Management	Estates	03/07/2020- The mapping of the Programme Business Case (PBC) to the Transforming Clinical Services (TCS) has now been completed. Clarification is being sought on the appropriate UHB approval process the PBC will need to go through, prior to submission to Welsh Government.	Not known	Red	Previous updates: 22/02/19- Work on Programme Business Case (PBC) to align with TCS is currently underway. This work is required to be completed before the Business Case can be submitted to WG for consideration. Following discussions with WG the revised PBC is due to be considered by the Health Board in May 2019. This will however require individual BJCs to be developed to secure funding for specific schemes on a prioritised basis. GGH Site Manager not be bidding for Discretionary Capital ahead of the Programme Business Case/future BJCs referenced above. 03/09/19- Director of Planning, Performance & Commissioning is carrying out a piece of work to reconcile the PBC with the TCS, this is projected to be completed by December 2019 at which point the PBC will be submitted
Thematic Review of Ophthalmology 2015/16	Health Inspectorate Wales (HIW)	January 2017	3	1	16	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	R6: Concerns around set monitoring for follow-up patients: A) The WG should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway. B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available. C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Whilst these actions have been completed, capacity challenges currently remain within the service which compromise timely access to follow-up care within required timescales	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.	Director of Operations (same as original).	Carly Buckingham	Scheduled Care (Ophthalmology)	A) Complete. Identified impact of patient harm due to delayed follow-up care. B) & C) update 29/07/2020- Partial Progress - Whilst the Health Board is prioritising patients by clinical need there is still a capacity gap to ensure care is provided for those patients with the greatest health need first. Following a successful bid for funding through the eye care sustainability fund, non-recurrent funding was allocated to deliver a Community Glaucoma Data Capture Scheme and Enhanced Referrals for Cataracts. These projects commenced early Oct 2019 and have supported with releasing capacity in Secondary Care.	March 2022 (as per Eye Care Plan 2018-22)	Red	
Thematic Review of Ophthalmology 2015/16		January 2017	3	1	16	R8: Lack of capacity/fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity)	R8: A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities. B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Although workforce plans have been developed, capacity gaps within the service remain due to significant vacancies within the hospital based Ophthalmology team. Whilst these gaps have been part mitigated by reliance on locum and outsourcing solutions, expansion of community optometrist support to the HES requires investment support via the WG Eye Care Sustainability Fund.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.		Carly Buckingham	Scheduled Care (Ophthalmology)	The service is working closely with the recruitment and campaigns team to further strengthen the Consultant and SAS level of recruitment. Discussions commenced with Swansea Bay for a Regional Ophthal service to support recruitment shortfalls. The Glaucoma and Cataract projects will see the Health Board working closely with community optometry practices to deliver care within Community settings and enable care closer to home and increased Secondary Care capacity.		Red	
Thematic Review of Ophthalmology 2015/16		January 2017	3	1	16	R15: Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists)	R15: Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	Although workforce plans have been developed, capacity gaps within the service remain due to significant vacancies within the hospital based Ophthalmology team. Whilst these gaps have been part mitigated by reliance on locum and outsourcing solutions, expansion of community optometrist support to the HES requires investment support via the WG Eye Care Sustainability Fund.	In December 2018, ARAC invited the Director of Operations to discuss to pace of delivery in respect of the recommendations from both these reports. Through discussion it was agreed that whilst the recommendations are not superseded by the new Eye Care Measures (ECM), there was clear alignment to the new ECM which is part of the UHB's broader Eye Care Sustainability Plan – This is a strategic priority for the UHB to deliver and will require investment to implement.		Carly Buckingham	Scheduled Care (Ophthalmology)	The Glaucoma & Cataract projects launched in Oct 2019. In addition, during the COVID -19 pandemic, community Optometrists developed emergency care hubs to support the HES and prevent patients requiring a hospital appointment. Primary Care will evaluate the success of this project.		Red	
Unannounced Hospital Visit - Unscheduled Care Directorate & Surgical Assessment Unit - 11 & 12 Aug 2015	Health Inspectorate Wales (HIW)	December 2015	1	0	17	The health board should consider its progress towards electronic patient records which could assist with the current lack of storage for paper records.	Previous Health Board work undertaken on Digitalised patient records project to be reviewed and business case to be re-submitted for consideration as part of the capital bids programme	As part of the 2018/19 refresh of the digital strategy there is a reaffirmed commitment to becoming a paper light organisation, however this is dependent upon a business case to Welsh Government. To date this has not been submitted.	A new task and finish group has been established under the Director of Operations to reassess the Health Board's readiness for a paper light Health Board.	Director of Operations (same as original).	Director of Operations	Health records	15/07/20 The inaugural Health Records Modernisation Programme Group (HRMPG) meeting took place on 23rd April 2019. The context of the current records management situation was set out and key principles were agreed. At the next HRMPG held on 3rd September 2019 five specific work streams were agreed, with a confirmed lead who would be responsible for progressing each project and delivering the outcomes agreed. In order to accelerate progress and improvement it was considered essential that bespoke and dedicated resources were provided to augment the efforts of day to day managers. Even though leads had been identified, due to their daily work commitments it was unlikely that individuals would be in a position to afford the significant time commitment needed to push forward each initiative to conclusion, without additional support. Each lead is responsible for busy front line services and hold senior roles within the organisation with operational and strategic management responsibilities. To ensure delivery and in order to support the completion of work associated with each work stream, there was a requirement for 1.8 WTE support staff from the programme management office. The PMO support would be split into two sectors, with one part time member of staff (0.8 WTE) working directly with four of the less complex work streams and one full time member of staff specifically assigned to the scanned patient record work stream. A paper requesting additional support was submitted to the Executive Team in March 2020 and the outcome was further discussions were required.	Approx. March 2023	Red	16/02/2018 from the Assistant Director of Informatics - The UHB should have a direction of travel by March 2019 and perhaps be on the journey. Implementing this is a long process and could take 5 years. Updates to be provided 6 monthly on progress. 05/12/18- Informatics Business Manager advised this now sits under the remit of the Deputy Director of Operations instead of Assistant Director of Informatics. 24/07/2020- Update provided by Deputy Director of Operations
Ward 6 - PPH - Unannounced DECI - 23Sep14 (Elective Orthopaedic)	Health Inspectorate Wales (HIW)	January 2015	1	0	14	RS:Toilet and washroom facilities should have colour coded doors to assist people who are living with sensory impairment.	Estates have been informed 28/10/2014 of the specific requirement /recommendation re Ward 6 PPH. The painting and signage of the doors of hygiene facilities doors across all in-patient areas will be part of timetabled, HDUHB wide refurbishment programme which reflects the Kings Fund, evidence based principles for a dementia –friendly environment Senior Nurse forum and Estates Lead will timetable to implement and monitor completion of work.	This good practice is recognised and is being implemented as ward refurbishments are undertaken across the Health Board. Currently this work plan is subject to approval and likely to take some time to develop. Ward 6 has not been identified as a priority area.	The UHB is due to submit a Programme Business Case to WG in Autumn 2018. This includes a comprehensive integrated programme for both major infrastructure investment and ward refurbishments across all the sites within the Health Board.	Director of Operations (same as original).	Rob Elliot, Director of Estates, Facilities and Capital Management	Estates	03/07/2020- Mapping of the Programme Business Case (PBC) to the Transforming Clinical Services (TCS) has now been completed. Clarification is being sought on the appropriate UHB approval process the PBC will need to go through, prior to submission to Welsh Government.	N/K	Red	old comments:22/02/19- Work on Programme Business Case (PBC) to align with TCS is currently underway. This work is required to be completed before the Business Case can be submitted to WG for consideration. Following discussions with WG the revised PBC is due to be considered by the Health Board in May 2019. This will however require individual BJCs to be developed to secure funding for specific schemes on a prioritised basis. PPH Site Manager not be bidding for Discretionary Capital ahead of the Programme Business Case/future BJCs referenced above. 03/09/19- Director of Planning, Performance & Commissioning is carrying out a piece of work to reconcile the PBC with the TCS, this is projected to be completed by December 2019 at which point the PBC will be submitted.
Women and children's services May 2017	Hywel Dda Community Health Council	October 2017	1	0	6	R4: In Glangwili the people we talked to were often in makeshift ward/unit environments and although many reported good experiences, this was in spite of the environment. Plans for Phase 2 building works are well advanced, but the Health Board needs to ensure better facilities are in place as soon as possible.	This was part of the reconfiguration proposal in 2014 and is part of the RCPCH action plan following review in 2015/2016. Monthly ward inspections by hotel services team and ward sister minor works highlighted to estates for improvement.	Awaiting confirmation from the WG on finance for the scheme to implement the improvements.	The WG have now confirmed finance for the scheme in April 2018 and it is envisaged the Phase 2 Construction will start in September 2018. This scheme will take approximately 2 years to complete.	Director of Operations (same as original).	Rob Elliot, Director of Estates, Facilities and Capital Management	Estates	03/07/2020- Due to the delays in work, and the anticipated changing working protocols, as a result of COVID-19 the contractor is proposing that the scheme will now likely be completed September 2021. This proposed revised end date is being reviewed by the UHB project manager.	Sep-21	Red	20/02/19- Phase 2 construction is currently taking place on site. 03/09/19- Phase 2 construction is currently taking place on site, due to complete 2020/21.