Bundle Audit & Risk Assurance Committee 21 April 2020

10.1 Audit Tracker - as presented to Board 16.04.20

SBAR Audit Tracker Board April 2020

Appendix 1

Appendix 2

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 April 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Management of outstanding recommendations from Auditors, Inspectorates and Regulators
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Board is asked to consider and agree how the outstanding recommendations from auditors, inspectorates and regulators should be managed by the Health Board during the Covid-19 pandemic.

Cefndir / Background

Audits, inspections and reviews generally 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 normally essential that recommendations from audits, inspections and reviews are implemented in a timely way to ensure the Health Board provides safe, quality services, complies with legislation and standards, and has effective and efficient processes and systems.

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this has subsequently led to NHS organisations, including Hywel Dda UHB, to focus on preparations and plans for dealing with an expected surge in demand of patients requiring interventions. The nature and scale of the response depends on the course of the disease. The situation is changing constantly and will require an agile response.

The Health Board is operating in unprecedented times, as it prepares to deal with the global pandemic of Covid-19. However, Boards do not stop being accountable at times of national crisis and because it is precisely at such times that Boards must step up and do – and be seen to be doing – the right thing (Good Governance Institute, 2020).

Asesiad / Assessment

UHB Central Tracker

The audit tracker currently has 320 open recommendations, 198 of which have passed their implementation date, 39 to be implemented between 01 April 2020 and 30 June 2020, and 55

due between 01 July 2020 and 30 September 2020. There are 28 further recommendations that are due to be implemented from 01 October 2020.

As the Health Board prepares to deal with the Covid-19 pandemic, capacity to implement these recommendations across services is reduced as resources are focussed on planning and preparations to deal with a surge in demand, increased levels of sickness and absence etc. Whilst the Health Board is working in unpreceded times, it is also still providing emergency, essential and urgent care to patients that is not related to Covid-19 and therefore still has a responsibility to provide safe and effective care to patients, provide safe environments and equipment, maintain proper records, etc. However this needs to be balanced with the resources it has available to minimise the threat posed by Covid-19.

The Board are asked to consider and agree how these recommendations should be managed during this time to provide clarity to services and directorates. The following points should be considered when making this decision include:

1. Letter dated 31 March 2020 from Healthcare Inspectorate Wales (HIW) advises that work will be paused that may impact frontline services and their staff, including all routine inspections of NHS. HIW will continue to monitor and follow up on any significant concerns regarding safety and quality of care. However, HIW will not request or require NHS providers to return any communications on reports or inspections that have already taken place for the foreseeable future. These arrangements will be kept under review.
2. On 23 March 2020, the Health & Safety Executive (HSE) extended the period specified in the 8 improvement notices from 01 May 2020 to 31 July 2020.
3. The Director of Estates, Facilities and Capital Planning has been in discussion with the Mid and West Wales Fire and Rescue Service (MWWFRS) in respect to extending the agreed timelines in respect of Withybush General Hospital in a formal and documented manner. Covid-19 has had a direct impact on the activity and capacity on the acute estate and the impact of social distancing and essential travel has also affected our ability to deliver within previously agreed timescales. MWWFRS have been asked to extend the current timelines by 3 months in order to review the position and any ongoing restrictions to progressing this work at pace. Discussions with MWWFRS have been positive and they are fully supportive of this approach and it is expected this position is confirmed in the next few days.
4. On 01 April 2020 Audit Wales (the new corporate identity for Wales Audit Office) informed the UHB that audit recommendations will remain valid, however they fully understand that NHS bodies' ability to implement them as originally planned is going to be significantly compromised as the response to the pandemic takes priority. Audit Wales will take an entirely pragmatic view on that when normal business eventually resumes, and would fully expect to need to revisit some recommendations to take account of recovery planning. Audit Wales did stress, however, that audit recommendations which are related to important aspects of organisational governance and financial management should remain firmly within NHS bodies' line of sight as a means of ensuring business is conducted as effectively as possible in the current circumstances.
5. Correspondence from the Public Service Ombudsman for Wales (PSOW) stating that they are still committed to delivering their statutory responsibilities however do not want to place additional pressure on service providers. They will continue to assess and investigate complaints but understand that responses may not be within usual timescales and will check upon commencement of an investigation whether the Health Board can engage with it. They expect to be kept informed of the Health Board's ability to engage with them.

6. Welsh Government (WG) contacted Health Boards on 31 March 2020 to confirm as part of their exercise to relieve administrative pressure on the NHS at this time, they are suspending until 01 October 2020 the requirement for organisations to submit quarterly limited or no assurance NHS Internal Audit Report returns for 2019/20 Q4; 2020/21 Q1 and 2020/21 Q2 (i.e. up to September 2020). WG will review the requirement prior to the start of October 2020 and confirm the position with the UHB.
7. Letter dated 31 March 2020 from Hywel Dda Community Health Council did not specifically mention their inspection timetable or the recommendations the UHB are implementing as a result of their inspections to date, however they did request the following:
    - Prior notification of any urgent service change wherever possible by telephone/email to a CHC officer or CHC Chair, however they accept that there will be times when the CHC has to be told following an urgent decision or service change. Documentation if available should continue to be shared with them.
    - They need to be assured that the Health Board will adapt and respond to feedback from patients. Whilst it may be more difficult during the pandemic, this is still very important.
    - They would expect temporary services to revert when there is a return to more normal operating circumstances. Any changes that persist will promptly need to go to the Services Planning Committee for discussion.
8. Internal performance management arrangements have been stood down until the end of June 2020 (at the earliest), and only essential Committee meetings are going ahead.
9. Services have been prioritising Covid-19 planning and therefore have not been able to provide updates since beginning of March 2020.

In summary, whilst our auditors, inspectorates and regulators understand that that the Health Board are in unprecedented times, they have been clear that will be maintaining a watching brief and will expect the organisation to prioritise appropriately.

Based on the above, there are a number of recommendations which must be progressed as planned or in line with revised timescales. A breakdown of these recommendations can be found in Appendix 1. These are:

Inspectorate	**No. of recs deemed still to be implemented by original timescales, or new date agreed by regulator**	**Justification**
HIW Immediate Assurance	6 Immediate Assurance recommendations	See point 1 above. There are currently 6 outstanding recommendations from HIW Immediate Concerns improvement plans. These recommendations relate to replacement of resuscitation trolleys, removal of separate medicines cabinet and ensuring safe medicines management processes, improving staffing levels and the update of the Venous Thromboembolism (VTE) policy.
Health & Safety Executive (HSE)	28 recommendations from 8 improvement notices (including the 13 material breaches)	See point 2 above. The HSE has amended the compliance date to 31/07/20.
Mid and West Wales	12 recommendations	See point 3 above. Awaiting confirmation from MWWFRS on their position. As these

Fire and Rescue Service (MWWFRS)		are enforcement notices related to legislation these should be implemented in line with agreed timescales.
Audit Wales (AW) and Internal Audit (IA)	All 'high' priority recommendations AW – 18 IA - 27	See point 4 above. There are 8 WAO Reports that have not prioritised the recommendations and these will be reviewed with individual services going forward

Below is a synopsis of the recommendations currently on the Central Audit Tracker. Updates are usually collated from Services on a quarterly basis in preparation for the Executive Team Performance Reviews. These were suspended until July 2020 (at the earliest) therefore it should be also be noted that updates from Services have been minimal since planning for COVID-19 commenced in March 2020, therefore some of the recommendations may have been implemented. Appendix 2 provides a breakdown of the recommendations as listed in the table below.

	Number of overdue recommendations i.e., original Implementation date has passed	**Number of recommendations due to be implemented between April to June 2020**	**Number of recommendations due to be implemented between July to September 2020**
HIW (Acute & Community)	31	5	1
HIW (MH&LD)	14	0	2
Audit Wales	23	10	1
Internal Audit	57	10	1
Community Health Council	26	1	8
HSE	0	0	28
MWWFRS	13	0	9
PSOW)	3	10	3
Coroner Reg 28	1	0	0
Delivery Unit (NHS)	15	0	0
Peer Review	11	0	2
Welsh Language Commissioner	4	3	0
TOTAL	198	39	55

How should these be managed during Covid-19 situation

The issues and risks identified by our auditors, inspectorates and regulators still exist notwithstanding the approach they have provided (outlined above), and in some instances compliance may be even more important now.

Following consultation with the Chief Executive, Chair and the Chair of the Audit and Risk Assurance Committee, it was clear that whilst an outright suspension of the implementation of

audit, inspectorate and regulator recommendations would be the simplest approach, it would be poor governance, not in the best interests of patients and staff, and could be more problematic for the Health Board when normal service resumes. Therefore it is proposed that the Health Board takes a much more nuanced approach.

Whilst there is recognition of the significant pressure on services, there needs to be a balance between managing the capacity pressures and challenges presented by the COVID pandemic and managing the 'business as usual' issues and risks. This assessment needs to be undertaken by management, as they have the ownership (accountability and authority) and depth of understanding to make the right decision for the right reason.

The Chief Executive has agreed that a directive will be issued to all Executive Directors (Corporate functions) and General Managers (Operations Directorates) confirming that whilst monitoring and scrutiny is being suspended in respect of the implementation of recommendations that are outstanding or due by 30 June 2020, there is still the expectation that management will ensure their service is safe and the risk of harm to patients and staff is managed and minimised.

Therefore Executive Directors and lead Officers will be asked to:

- Continue to implement recommendations that are outstanding or due in respect of HIW immediate assurance plans, HSE improvement notices/material breaches, MWWFRS enforcement notices and high priority recommendations issued by Audit Wales and Internal Audit and advise the risk and assurance team when implemented.
- Review all other recommendations and assess whether they can be implemented within timescales as planned.
- Advise the risk and assurance team of the recommendations that will not be implemented providing a clear reasoning, an explanation of how the risk will be managed in the interim, and a provisional timescale (ie, 3 months after return to normal service).
- A status report will be provided to the Audit and Risk Committee in June 2020 providing the outcome of the above work.

Argymhelliad / Recommendation

The Board is asked to:

- Confirm that the following must be implemented by the relevant service in line the agreed timescales:
    - ✓ 6 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
- Agree the proposal for the management of all other recommendations up to 30 June 2020, and agree to review before this date.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Structured Assessment 2016 & 2017
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	If the Health Board decides to suspend the implementation of all auditor/Inspectorate and regulator recommendations, the Health Board may not achieve value for money and miss efficiency opportunities.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	If the Health Board decides to suspend the implementation of all auditor/Inspectorate and regulator recommendations, the Health Board may not be delivering safe and effective care to patients who are being who are receiving non-covid-19 related care and treatment.
Gweithlu: **Workforce:**	Given the current workforce pressures associated with the planning and dealing with Covid19 pandemic, the Health Board may not have the workforce capacity to implement auditor/Inspectorate and regulator recommendations as planned.

Risg: **Risk:**	The gaps in controls identified by auditor/Inspectorate and regulators will not be managed appropriately and risks may be more likely to materialise whilst the Health Board focuses on Covid-19 planning.
Cyfreithiol: **Legal:**	No direct impacts from this report.
Enw Da: **Reputational:**	If the Health Board decides to suspend the implementation of all auditor/Inspectorate and regulator recommendations, the above impacts may materialise and the Health Board will need to be able to justify its decision to suspend this work.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	• Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Status of report	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_001	R1: The Health Board is required to provide HIW with details of the action it will take to ensure that: Resuscitation trolleys are replaced to provide appropriate storage for emergency drug boxes to prevent unauthorised access to the drugs they contain. The drawers on the trolleys are stocked in line with the Health Board Resuscitation policy (352) check list and documented as checked on a daily basis and after use. We identified that the trolleys on wards 7 and 11 are not fit for purpose. Emergency drug boxes should be marked for emergency use, unlocked and tamper-evident, in line with the Resuscitation Council guidelines. However they are stored on the top of the trolleys in full view of patients and the general public. Unauthorised access to emergency drugs could compromise patient and public safety. The drawers on the trolley in Ward 11 are untidy and cluttered and staff would not be able to locate the correct items in an emergency, or be able to adequately check the contents were in line with policy.	To monitor and follow up on delivery and seek support from Pharmacy & Resuscitation Officer for the changeover.	Mar-20	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_002	R2: The Health Board is required to provide HIW with details of the action it will take to ensure that: Keys to the controlled drugs cupboard on ward 7 are held in line with the Health Board Medicines policy. Controlled drugs on ward 7 and medication fridge temperatures on ward 11 are checked and evidenced as checked on a daily basis. A review of the daily checklist on ward 7 identified controlled drugs had not been evidenced as checked on 24th December 2019 and the 1st and 2nd January 2020. The key to the controlled drugs cabinet on ward 7 was kept in a separate cabinet and not on the person in charge of the ward or designated deputy as required in the Health Board Medicines policy. At the time of the inspection the lock on this cabinet had not been activated and could be accessed by all staff with access to the room. We identified that Ward 11 did not have documented checks on fridge temperatures for 6 days during the course of January 2020.	To remove the separate cabinet.	Feb-20	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_003	Q3: The Health Board is required to provide HIW with details of the action it will take to ensure that: The Health Board has a system in place to ensure all patients have a patient identification band or risk assessed equivalent to ensure staff can correctly identify patients and provide the right care. We saw two patients on ward 7 and two patients on ward 11 that were not wearing patient identification wristbands. The absence of a patient identification wristband can result in misidentification and the compromise of patient care and safety.	To set up a Medicines Management Task & Finish Group across the Health Board to ensure safe Medicines Management processes are in place.	Feb-20	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_005	Q5: The Health Board is required to provide HIW with details of the action it will take to ensure that: An effective and traceable system is in place to ensure a servicing programme is followed and completed for patient beds on ward 11. An effective and traceable system is in place to ensure a servicing programme is followed and completed for clinical equipment including mattress pumps and an ECG machine on ward 11. A review of hi/low profile beds on ward 11 identified that some had no service records and others had not been serviced since 2017. A lack of, or infrequent servicing of beds may compromise the effective use the bed and in turn compromise patient safety. We saw examples of service records of mattress pumps on ward 11 that indicated the servicing period had expired and was overdue. We saw a service record for an Electrocardiogram machine on ward 11 that indicated the service was due 4/10/19. A lack of, or infrequent servicing of clinical equipment may compromise the effective use of the equipment and in turn compromise patient safety.	Across Health Board inpatient bed contract has recently commenced (03/02/2020) with an external company. To develop a service plan which will be overseen by the Clinical Engineering Department.	May-20	May-20	Amber	In Progress
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Immediate Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101IA_001	R1: The health board is required to provide HIW with the actions it will take to meet the agreed and appropriate staffing levels in Llandovery Hospital to provide a service that ensures the delivery of safe and effective care.	Ongoing reviews and recalculation of nurse staffing levels, will be undertaken, in line with the principles set out in the All Wales Nurse Staff (Wales) Act. Which considers l the acuity, quality and 'professional judgement' data These reviews have commenced and aim to be completed by end March 2020.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Immediate Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101IA_001	R1:The health board is required to provide HIW with the actions it will take to meet the agreed and appropriate staffing levels in Llandovery Hospital to provide a service that ensures the delivery of safe and effective care.	An experienced ward sister has been seconded to the ward to provide interim leadership (3 days per week pro tem). This arrangement will be reviewed on the 16th December 2019 as this is the anticipated date of the return of the ward sister and will be reviewed with the seconded ward sister remaining on site if necessary.	Dec-19	N/K	Red	Not Implemented
19102	2019/20	HIW	Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Immediate Improvement Plan	Open	Community & Primary Care (Pembrokeshire)	Director of Operations	19102I1_001	R7. The health board policy for the management and prevention of VTE finalised and disseminated to all appropriate staff.	The Health Board VTE policy to be completed and distributed to all appropriate staff.	Sep-19	N/K	Red	Not Implemented
JHET/HD/04102019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/01_001	1. 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.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/01_002	2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.		May-20	Jul-20	Amber	In Progress

JHET/HD/04102019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/01_003	3. Identify sources of information on violence and aggression incidents and near misses, to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded b. Records of the number and type of incidents at each site where porters are called to deal with violence and aggression; c. Records of restrictive physical interventions related to violence and aggression; d. Referrals to Occupational Health related to violence and aggression; e. Information from employee groups who do not have access to Datix; f. Information from employee representatives; g. Information from those providing training under the All Wales Violence and Aggression Passport.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/01_004	4. Identify how the findings from monitoring, audit and review will be considered and consulted on, and responsibilities allocated to ensure that suitable and timely action is taken and completed.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/01_005	5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/02_001	1. 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.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/02_002	2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/02_003	3. Identify sources of information on manual handling incidents and near misses, and use these to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded; b. Referrals to Occupational Health related to musculoskeletal disorders; c. Sickness absence records related to musculoskeletal disorders; d. Information from employee groups who do not have access to Datix; e. Information from employee representatives; f. Information from those providing training under the All Wales Manual Handling Training Passport.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/02_004	4. 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.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/02_005	5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/03	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/03_001	1. 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		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/03	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/03_002	AND 2. 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.		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/04	2019/20	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/04_001	1. 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		May-20	Jul-20	Amber	In Progress
JHET/HD/04102019/04	2019/20	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/04_002	AND 2. 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		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/05_001	1) With the assistance of a competent person assess all risks that involve manual handling of loads with the Laundry at Glangwili Hospital.		May-20	Jul-20	Amber	In Progress

LPJ/HD/04102019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/05_002	From the findings of your assessment; 2) 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/05_003	3) 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/05_004	4) 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/06_001	1. In consultation with employees and with assistance of a competent person, critically review the implementation and effectiveness of your current arrangements for assessing risks and learning from incident investigation outcomes for managing and reducing those risks.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/06_002	2. 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/06_003	3. 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/06_004	4. 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/06_005	5. 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/07_001	EITHER 1) Avoid hazardous manual handling operations 'so far as is reasonably practicable', by redesigning the task to avoid moving the load or by automating or mechanising the process.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/07_002	OR 2) 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/07_003	3) 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 4) Implement any other equally effective measures to remedy the said contraventions.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/08	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/08_001	EITHER 1. 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.		May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/08	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Open	Estates	Director of Operations	JHET/HD/04102019/08_002	AND 2. 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.		May-20	Jul-20	Amber	In Progress

BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00113573_001	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughtout 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 compramise strips and seals of fire doors.		Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00113573_002	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.		Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00113573_003	R3. St Nons. Ensure the certificates showing testing of emergency lighting systems are provided via email at the earliest opportunity.		Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00113573_004	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.		Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00113573_005	R2. Bro Cerwyn. Reinstate the fire resistance in the following locations: Holes in ceiling areas of offices, water leaking onto electrical appliances and sockets.		Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00115068	2019/20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. South Pembs Hospital	Legislative requirements	Open	Estates	Director of Operations	BFS/KBJ/SJM/00115068_001	3. 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.		Dec-19	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_001	R1. All items identified in the significant findings of your Fire Risk Assessment will need to be completed within the identified time scales.		Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_002	R2. 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 & Waldo Suite (Mental Health Department) 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. 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.		Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_003	R3. Ensure that the escape route next to staff room G16, which leads into a small yard area, is cleared of all obstructions and remains available for escape purposes at all times. Wheeled bin compound, electrical appliances and combustible items in escape route will need to be removed.		Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_004	R4. Reinstate the fire resistance in the following location(s) • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devises are functioning in line with its design specifications and manufacturer's instructions		Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_005	R5. Reinstate the fire resistance in the following location(s) • Fire resisting Glazing removed from main corridor of St Caradogs & replaced with thin plywood boarding.		Mar-20	Mar-20	Red	Not Implemented

ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_006	R6. The fire alarm system will need to be inspected by a qualified fire alarm engineer to ensure the system is fit for purpose and repaired/upgraded as necessary.		Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Open	Estates	Director of Operations	ED/KJ/00113573_007	R7. Ensure that all doors on exit routes are available and can be easily and immediately opened in an emergency by anyone who might need to use them.		Mar-20	Mar-20	Red	Not Implemented
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	R1. •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.		Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	R2. 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.		Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	R3. 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	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_004	R4. Ensure that everyone can evacuate quickly and safely by details. • Removing the photocopier to a safe location off the means of escape (within the Sealyham block) • Keeping all escape routes clear of all items Namely file cabinets and combustibles. (office Areas Kensington, Sealyham) • Notice boards should be placed behind a lockable screen if erected on a means of escape.		Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_005	R5. Ensure that escape lighting on all escape routes in all five locations mentioned above are operating to the standard required and in accordance with BS 5266 the emergency lighting should operate if the local lighting circuit fails. The system should be tested monthly and inspected bi-annually.		Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_006	R6. 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.		Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Open	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_007	R7. Upholstered furniture is to comply with British Standard 7176 or the equivalent European Standard. • Pembroke county community room.		Jul-20	Jul-20	Amber	In Progress

BFS/KS/SJM/0114719	2019/20	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	Legislative requirements	Open	Estates	Director of Operations	BFS/KS/SJM/00114719_001	R1. 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.		Sep-20	Sep-20	Amber	In Progress
BFS/KS/SJM/0114719	2019/20	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	Legislative requirements	Open	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R2. 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.		Sep-20	Sep-20	Amber	In Progress
BFS/KS/SJM/0114719 - KS/890/03	2019/20	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	Legislative requirements	Open	Estates	Director of Operations	BFS/KS/SJM/00114719_001	R1. 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.		Aug-21	Aug-21	Amber	In Progress
BFS/KS/SJM/0114719 - KS/890/03	2019/20	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	Legislative requirements	Open	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R2. 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.		Aug-21	Aug-21	Amber	In Progress
BFS/KS/SJM/0114719-KS/890/04	2019/20	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	Legislative requirements	Open	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R1. 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	Apr-22	Amber	In Progress
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Open	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_001	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Open	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_002	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Open	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_003	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Open	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_004	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Open	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_005	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	Not Implemented
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual001	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	Apr-20	Amber	In Progress

xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 002	R3a. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC; b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they provide a report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.	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. Transition arrangements for changes to Mental Health and Learning Disabilities quality report arrangements will be developed and worked through with the triumvirate team. Any specific exceptions requiring escalating to QSEAC escalated via OQSEAC, and appropriate staff asked to attend QSEAC as appropriate.	Apr-20	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 003	R3b. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee.	There is a Mental Health and Learning Disabilities directorate level governance committee. Work will be undertaken to strengthen and standardise the reporting arrangements to OQSEC (as recommendation 1)	Apr-20	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 004	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.	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	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 005	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	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	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 006	R4. To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1). Agreement that risks and learning will be, embedded into the standard reporting templates. The templates will also advise on how learning from risks and action plans are being shared across Directorate and other areas. Deep dives are currently being discussed at each OQSESC meeting and will continue, these will support in-depth conversation required. The Risk Registers are to be used to inform these. A Listening and Learning Group is being established to facilitate shared learning across the organisation. Reporting arrangements for the group will be finalised and endorsed through QSEAC.	Apr-20	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Open	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual 007	R7. To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.	Task and finish group established which is jointly chaired by Director of Nursing and Director of Planning. The work of the task and finish group has been expedited. A project plan is in place including agreement of the priority indicators to be populated and rolled out to directorates.	Apr-20	Apr-20	Amber	In Progress
1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2018_001	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.	Jun-19	Apr-20	Red	Not Implemented
1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2018_002	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.	Sep-19	Apr-20	Red	Not Implemented

1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2018_003	R4. Recommendation - Strategic planning To ensure the delivery of its health and care strategy, the Health Board should seek to resolve the outstanding request for funding from the Welsh Government to support the capacity needed to implement the strategy with the intended timescales.	The Health Board have identified that funding of £4.4m per annum is required in total in order to provide support to deliver the programme of change and to undertake work to develop the Programme Business Case. Welsh Government have confirmed that funding of £1.6m will be made available to the Health Board. This leaves a shortfall of £2.8m, which will need to be addressed as part of our planning deliberations.		Mar-20	Red	Not Implemented
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2019_001	R1. We found scope to reduce potential duplication of assurance between the Business Planning and Performance Assurance Committee (BPPAC) with the Health and Care Strategy Delivery Group (HCSDG). The Health Board should clarify the reporting lines of the Health and Care Strategy Delivery Group to ensure that the risk of duplication of assurance is mitigated.	The Board agreed the new governance arrangements at its meeting held on 30th January 2020. The paper clearly detailed the roles of the new BPPAC and the HCSDG (HCSDG will report to Executive Team instead of the Board which will reduce the risk of duplication with BPPAC). Terms of Reference and the Scheme of Delegation in terms of matters delegated to Committees will be reviewed and revised and presented to the Board in March 2020. The new arrangements will come into operation from 1st April 2020.	Apr-20	Apr-20	Amber	In Progress
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2019_002	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.	Apr-20	Apr-20	Amber	In Progress
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Open	Governance	Board Secretary	WAO_SA_2019_003	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. • 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. • Prioritise the re-formation of a wider clinical reference group to support the clinically led delivery of the Strategy with a programme of regular workshops to test / challenge and inform the delivery of the strategic programmes. • Re-introduce workplace champions (developed during the Transforming Clinical Services programme Discover and Design phases) in 2020 for delivery of the Strategy. • 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. • Cohort 2 of the EQIip programme have ensured projects identified are supportive of teams delivering change projects in line with the Strategic direction. • 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. • 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 • 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	Jul-20	Amber	In Progress
HDUHB1718-35	2018/19	Internal Audit - HDUHB	Theatres Directorate	Internal Audit Report	Open	Scheduled Care	Director of Operations	HDUHB1718-35_001	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 use.	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	Not Implemented
HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Open	Clinical Engineering	Director of Operations	HDUHB 1920-16_001	Management should put in place safeguards to ensure alerts and safety notices for all Health Board medical devices are fully captured.	TBC- The current procedure for the management of safety notices and alerts is under review. Following consultation it will be taken through Health Board processes for ratification and then implementation. The revised policy will ensure that the responsibility, for capturing all alerts received and actions taken is clear. With the introduction of the Once for Wales Concerns Management System which includes an alerts function, the Head of Quality and Governance has requested that an all Wales solution is considered. The Head of Quality and Governance will continue to the OfWCMS project to try and influence an all Wales solution. This will be done through the Programme Team and Programme Board.	Mar-20	Mar-20	Red	Not Implemented

HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Open	Clinical Engineering	Director of Operations	HDUHB 1920-16_002	Management should review the current approach to medical devices training for clinical and nursing staff to ensure: ▪ all training is coordinated through a central point; ▪ training provided by external parties can be quality assessed; and ▪ training records can be accurately maintained.	TBC-The medical device trainer is currently undertaking a mapping exercise to prioritise the training in accordance to high medium and low risk devices. The initial training plan will focus on the high risk to identify the specific trainers (including external parties); assess that they are delivering a quality assured programme and identify records of training. The trainers that deliver aspects of the mandatory training programme i.e. resuscitation and moving and handling are already recording device training onto ESR. The work stream will also identify any gaps in provision of training. There is only one medical device trainer for the whole Health Board. At present, a large proportion of the time is dedicated to coordinating the cascade assessors' programme for infusion devices. There is currently no administrative support for the trainer. To ensure a timely delivery of all of the recommendations there will be a requirement to increase both trainer and administrative resources.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-20	2019/20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Internal Audit Report	Open	Informatics	Director of Planning, Performance & Commissioning	HDUHB 1920-20_002	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.	Agreed. In conjunction with Recommendation 1, a detailed assessment of the gaps / tasks will be identified which in turn will form the work plan of the newly appointed cyber security resource. 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 esculation.	Jun-20	Jun-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Open	Medical	Medical Director	HDUHB 1920-09_001	R1. The Research & Development Sub-Committee should ensure that the annual report for 2018/19 is submitted to the appropriate committee meeting and future reports should be submitted within six weeks of the end of the financial year.	The report is complete and will be circulated to Committee members, in advance of its formal agreement at the next R&D Sub-Committee on 20.4.20. A formal and time bound process of producing end of year reports as part of the Health Board planning arrangements is currently being produced to ensure timely future annual reports. This will be presented at the next Senior Management Team meeting on 17.2.20 for approval and once approved will be completed in time for the annual report completion for the year ending April 2020.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Open	Medical	Medical Director	HDUHB 1920-09_002	R2. R&D Management should ensure individual researchers assigned investigation accounts promptly complete and submit their quarterly returns to Health & Care Research Wales via the Finance Department.	Information taken from the Hywel Dda UHB R&D Finance Process (Appendix 2) is as follows:- ▪ Spending plans (for amounts over £1,000) are to be provided to and reviewed by the R&D Senior Team at least 6 monthly. ▪ Spending plans must detail outline or planned spending / expenditure against income accrued, plus anticipated new income generated per annum. ▪ If income is less than anticipated (e.g. lower than expected recruitment), early discussion with the R&D Senior Team is essential. ▪ Any ad-hoc spend of £1,000 or more has to be approved by the R&D Senior Team. ▪ Failure to provide spending plans may result in the accrued income not being reinstated at the start of the new financial year. ▪ This income will be put into a general research support fund, managed by the R&D Department. While investigators are routinely asked to submit a spending plan for their 'investigator accounts', the response rate has been low. The Deputy Director for Research and Innovation issued a request for the return of spending plans, so that plans can be reviewed by the Research and Development Sub-Committee on 20.4.20. Where plans are not submitted, any money held on accounts will be added to the general research support fund, for which there is a plan. A revised plan for managing this process in the future will be presented by the finance lead at the next senior management team meeting on 17.2.20.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Open	Medical	Medical Director	HDUHB 1920-09_003	R3. The R&D, General Medicine and Finance Departments should come together and establish a reconciliation arrangement to ensure invoices received from Swansea University for the tenure of the former R&D Director are accurate and correct prior to payment by the Health Board.	The former R&D director is not paid directly by R&D. Invoices from Swansea University are received by Unscheduled Care and 0.2 sessions were recharged to R&D for the work that he did in supporting R&D. R&D have no input into invoicing arrangements with Swansea University. Finance have ensured that the recharges have dropped to 0.1 now that the former director has dropped his sessions, and if he steps back fully from R&D we will ensure that the recharges stop. This is all managed internally within finance. Part of the ongoing control of this will also be the monthly finance file which is sent out to the Senior Research & Development Operations Manager and Deputy Director for Research & Innovation which will enable us to identify anyone who is being paid inappropriately.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Open	Medical	Medical Director	HDUHB 1920-09_004	R4. The Finance Department should ensure that an R&D financial position update should be reported to the R&D Sub-Committee on a regular basis.	A change in Finance Team and reporting arrangement and systems has meant that a written report has not gone to the last three Sub-Committee meetings. Finance have been working on a new finance report, which has now been completed. It will be brought to the R&D Senior team meeting on 17.2.20 for review and sign off, and an updated version (to year-end April 2020) brought to the next subcommittee. Circulation of the quarterly returns to the R&D Sub-Committee had been considered (so that they are aware of the figures being reported to WG), however the wide circulation of this and other reports is made difficult by the personal salary information and names contained within the reports. A process has now been developed to overcome this.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Open	Medical	Medical Director	HDUHB 1920-09_005	R5. Management should ensure that signed and dated copies of all grant submission documents are retained on file.	This is accepted. Management will ensure the documentation for all 'awarded grants' and live studies is held on file. All signed documents will be stored electronically and hard copies within a study specific Trial Master File or Grants Log.	Apr-20	Apr-20	Amber	In Progress

HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Open	Unscheduled Care	Director of Operations	HDUHB 1920-26_001	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.	On detailed review, in preparation for this submission, it is accepted that some adjustment of inherent risk score against risk treatment status was needed – this has now been addressed. The opportunity was also taken to update all actions for January 2020 and this should all now be satisfactory.	Jan-20	Jan-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Open	Unscheduled Care	Director of Operations	HDUHB 1920-26_001	R2. 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	Feb-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Open	Unscheduled Care	Director of Operations	HDUHB 1920-26_001	R3. 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 also noted that another corporate risk (696) was identified that is aligned to the Neurology Service – Specialist Epilepsy Nurse Service. This risk has also been accepted on to the BGH risk register.	Jan-20	Jan-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Open	Unscheduled Care	Director of Operations	HDUHB 1920-26_002	R4. 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	Mar-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Open	Unscheduled Care	Director of Operations	HDUHB 1920-26_003	R5. 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	Mar-20	Red	Not Implemented
HDUHB 1819-11	2019/20	Internal Audit - HDUHB	Integrated Care Fund – Follow Up	Internal Audit Report	Open	Carmarthenshire	Director of Operations	HDUHN 181-11_001	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	Not Implemented
HDUHB 1819-32	2019/20	Internal Audit - HDUHB	Radiology Directorate	Internal Audit Report	Open	Radiology	Director of Operations	HDUHB1819-32-001	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	Not Implemented
HDUHB 1819-32	2019/20	Internal Audit - HDUHB	Radiology Directorate	Internal Audit Report	Open	Radiology	Director of Operations	HDUHB1819-32-002	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	Not Implemented
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Open	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_003	R3. Management should ensure that consultant and SAS doctor DCC and SPA sessions are accurately recorded on the job plans and within the ESR system.	• New job plans not created using the online system will not be accepted/recorded • New System to be implemented for all job plan reviews. The nature of the online system and the way it needs to be used means that DCC & SPA can be clearly identified on job plans and thus make the transfer of information from the job plans job plans to other systems such as ESR more accurate.	Mar-21	Mar-21	Amber	In Progress
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Open	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_004	R4. Service Managers and Clinical Leads should ensure that consultant and SAS doctor expected outcomes are set out in all job plans.	• Medical Director to communicate the need to include expected outcomes, which are consistent with the needs of the service, in all job plans • Medical Director to recirculate Direct Clinical Care (DCC) Sessions Document (contained within the Job Planning Toolkit) to help inform and guide the expected outcomes which are set	Mar-20	Mar-20	Red	Not Implemented

HDUHB-1920-25	2019/20	Internal Audit - HDUHB	Estates Directorate Governance Review	Internal Audit Report	Open	Estates	Director of Operations	HDUHB-1920-25_002	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	Jan-20	Red	Not Implemented
HDUHB-1920-25	2019/20	Internal Audit - HDUHB	Estates Directorate Governance Review	Internal Audit Report	Open	Estates	Director of Operations	HDUHB-1920-25_005	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	In Progress
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Open	Estates	Director of Operations	SSU_HDU_1920_06.1_003	9. Financial vetting requirements should be defined where the anticipated aggregate value of work exceeds a pre-determined quantum over a predefined period	Agreed. A review of reactive maintenance expenditure, undertaken by external contractors, for the nine-month period to December 2019 will be undertaken. Where expenditure for that time-period, for any one contractor has exceeded £10k, management will undertake a financial vetting exercise [in consultation with NWSSP Procurement Services].	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Open	Estates	Director of Operations	SSU_HDU_1920_06.1_004	17. Following completion of the review, a robust stock count procedure should be embedded which includes evidence of review of relevant supporting information to confirm the accuracy of the reported figure.	Agreed. A stock count will be undertaken every two months, and at yearend, until the operation procedures [as per recommendation 18] have been embedded.	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Open	Estates	Director of Operations	SSU_HDU_1920_06.1_004	18. Operational procedures should be actioned for recording of issue and return of stock items; including physical access controls to the storeroom. The Health Board's 'Non Controlled Stores' procedure should be used as a basis for developing the required operational procedures	Agreed. An electronic fob system has been installed to monitor access to the storeroom. This went live on 11 November 2019. Operational policies have been re-introduced for issue and return of stock. The effectiveness of this process will be reviewed through the year-end stock count. The procedure will be further extended to ensure there is recording mechanism for all goods delivered to the storeroom to be logged accordingly to facilitate the reconciliation process.	Mar-20	Mar-20	Red	Not Implemented
HDUHB1819-27	2018/19	Internal Audit - HDUHB	IM&T Directorate	Internal Audit Report	Open	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	HDUHB1819-27_001	R8. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	This has been a long standing issue that I have been working with HR / Unions to ensure that the staff have their comfort breaks. Unfortunately, due to the nature of the work, structures etc we are not able to comply with this requirement. However, when the new switchboard technology is implemented it will allow this to occur. Staff have been made fully aware of their rights, and they have opted out of the ETWD around hours and breaks etc.	Mar-22	Mar-22	Amber	In Progress
HDUHB-1718-34	2017/18	Internal Audit - HDUHB	National Standards for Cleaning in NHS Wales	Internal Audit Report	Open	Estates	Director of Operations	HDUHB-1718-34_001	R4 • C4C audit methods and practices should be actioned by all Domestic Supervisors to ensure C4C are consistently thorough across all sites. • Audits should be planned ahead and noted on schedules and rotas to ensure audits are completed and do not get overlooked if a member of staff is away or on secondment. • If a member of staff is absent during the 48 hours following an audit, an alternative Domestic Supervisor should be deployed to check that the action plan arising from the cleaning audit has been completed in the functional area. • PMS should be asked to remap the rooms on the software and make amendments to the system so it accurately reflects the functional areas being audited. This will mean that the C4C system will be more user friendly and audits will be less time consuming to undertake.		Jun-18	N/K	Red	Not Implemented
HDUHB-1819-29	2018/19	Internal Audit - HDUHB	PC and Laptop Security (Follow-Up)	Internal Audit Report	Open	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	HDUHB-1819-29_001	R1. The original recommendation stands, whereby 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.	The Assistant Director of Informatics will work with the Health and Safety Group to identify and resolve the wider security of the Health Board sites. Where possible ICT solutions will be scoped to assist with the overall security of the Health Board, i.e. improved CCTV. Scoping – 1-2 months Action plan creation -2 months Resourcing gap analysis – 1 month Implementation – 10 months	Feb-20	N/K	Red	Not Implemented

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Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Status of report	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_001	The Health Board is required to provide HIW with details of the action it will take to ensure that: Resuscitation trolleys are replaced to provide appropriate storage for emergency drug boxes to prevent unauthorised access to the drugs they contain. The drawers on the trolleys are stocked in line with the Health Board Resuscitation policy (352) check list and documented as checked on a daily basis and after use. We identified that the trolleys on wards 7 and 11 are not fit for purpose. Emergency drug boxes should be marked for emergency use, unlocked and tamper-evident, in line with the Resuscitation Council guidelines. However they are stored on the top of the trolleys in full view of patients and the general public. Unauthorised access to emergency drugs could compromise patient and public safety. The drawers on the trolley in Ward 11 are untidy and cluttered and staff would not be able to locate the correct items in an emergency, or be able to adequately check the contents were in line with policy.	To monitor and follow up on delivery and seek support from Pharmacy & Resuscitation Officer for the changeover.	16/03/2020	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_002	The Health Board is required to provide HIW with details of the action it will take to ensure that: Keys to the controlled drugs cupboard on ward 7 are held in line with the Health Board Medicines policy. Controlled drugs on ward 7 and medication fridge temperatures on ward 11 are checked and evidenced as checked on a daily basis. A review of the daily checklist on ward 7 identified controlled drugs had not been evidenced as checked on 24th December 2019 and the 1st and 2nd January 2020. The key to the controlled drugs cabinet on ward 7 was kept in a separate cabinet and not on the person in charge of the ward or designated deputy as required in the Health Board Medicines policy. At the time of the inspection the lock on this cabinet had not been activated and could be accessed by all staff with access to the room. We identified that Ward 11 did not have documented checks on fridge temperatures for 6 days during the course of January 2020.	To remove the separate cabinet.	28/02/2020	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_003	The Health Board is required to provide HIW with details of the action it will take to ensure that: The Health Board has a system in place to ensure all patients have a patient identification band or risk assessed equivalent to ensure staff can correctly identify patients and provide the right care. We saw two patients on ward 7 and two patients on ward 11 that were not wearing patient identification wristbands. The absence of a patient identification wristband can result in misidentification and the compromise of patient care and safety.	To set up a Medicines Management Task & Finish Group across the Health Board to ensure safe Medicines Management processes are in place.	14/02/2020	N/K	Red	Not Implemented
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_004	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	Aug-21	Aug-21	Amber	In Progress
19097	2019/20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Immediate Improvement Plan	Draft	Unscheduled Care (WGH)	Director of Operations	19097IA_005	The Health Board is required to provide HIW with details of the action it will take to ensure that: An effective and traceable system is in place to ensure a servicing programme is followed and completed for patient beds on ward 11. An effective and traceable system is in place to ensure a servicing programme is followed and completed for clinical equipment including mattress pumps and an ECG machine on ward 11. A review of hi/low profile beds on ward 11 identified that some had no service records and others had not been serviced since 2017. A lack of, or infrequent servicing of beds may compromise the effective use the bed and in turn compromise patient safety. We saw examples of service records of mattress pumps on ward 11 that indicated the servicing period had expired and was overdue. We saw a service record for an Electrocardiogram machine on ward 11 that indicated the service was due 4/10/19. A lack of, or infrequent servicing of clinical equipment may compromise the effective use of the equipment and in turn compromise patient safety.	Across Health Board inpatient bed contract has recently commenced (03/02/2020) with an external company. To develop a service plan which will be overseen by the Clinical Engineering Department.	May-20	May-20	Amber	In Progress
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Immediate Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101IA_001	The health board is required to provide HIW with the actions it will take to meet the agreed and appropriate staffing levels in Llandovery Hospital to provide a service that ensures the delivery of safe and effective care.	Ongoing reviews and recalculation of nurse staffing levels, will be undertaken, in line with the principles set out in the All Wales Nurse Staff (Wales) Act. Which considers l the acuity, quality and 'professional judgement' data These reviews have commenced and aim to be completed by end March 2020.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Immediate Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101IA_001	The health board is required to provide HIW with the actions it will take to meet the agreed and appropriate staffing levels in Llandovery Hospital to provide a service that ensures the delivery of safe and effective care.	An experienced ward sister has been seconded to the ward to provide interim leadership (3 days per week pro tem). This arrangement will be reviewed on the 16th December 2019 as this is the anticipated date of the return of the ward sister and will be reviewed with the seconded ward sister remaining on site if necessary.	Dec-19	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_001	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 to be commenced to conceal gaps.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_001	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.	There are visitor toilets available in the Minor injuries unit, which can accommodate access for wheelchair users at all times. Signage to be updated in the unit to advise visitors of the location.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_001	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.	Estates department will complete an audit of draughts on all windows and address according to the result of the audit.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_001	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.	Estates department will complete an audit of draughts on all doors and address according to the result of the audit.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_002	The health board is required to provide HIW with details of the action it will take to ensure that: * Old and worn notice boards are replaced * Information relating to smoking cessation and health and well-being is presented on noticeboards in view of patients, visitors and staff * Carer's information is presented on a notice board on the ward and carers champion is nominated.	The service to identify funding mechanisms to enable replacement of the notice boards.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_002	The health board is required to provide HIW with details of the action it will take to ensure that: * Old and worn notice boards are replaced * Information relating to smoking cessation and health and well-being is presented on noticeboards in view of patients, visitors and staff * Carer's information is presented on a notice board on the ward and carers champion is nominated.	Lead for Investors in Carers to be contacted for relevant information to display on the notice boards.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_003	The health board is required to provide HIW with details of the action it will take to ensure that: * Information relating to advocacy support is made available to all patients * The ward introduces a confidential patient status at a glance board * A nurse recruitment and retention plan is provided to HIW, demonstrating how staff shortages will be addressed.	Nurse recruitment and retention plan to be developed and to be submitted to HIW on completion.	Mar-20	N/K	Red	Not Implemented

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19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_004	The health board is required to provide HIW with details of the action it will take to ensure that: * Both the date and the time of patient care is recorded in patient records * The appropriate number of registered nurses are available to provide safe and effective care to patients.	Relevant staff at the hospital to be reminded of the standards of documentation.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_004	The health board is required to provide HIW with details of the action it will take to ensure that: * Both the date and the time of patient care is recorded in patient records * The appropriate number of registered nurses are available to provide safe and effective care to patients.	Spot checks of audits on documentation will include checking that the date and the time of patient care is recorded in patient records.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_005	The health board is required to provide HIW with details of the action it will take to ensure that: * Discharge plans are completed in full, including the rehabilitation and discharge plans for each patient * The level of occupational therapy support available to patients is reviewed, and therapy is documented in full in the patient records.	Effective use of the discharge documentation will be monitored and staff to be instructed on the requirement to complete in full.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_005	The health board is required to provide HIW with details of the action it will take to ensure that: * Discharge plans are completed in full, including the rehabilitation and discharge plans for each patient * The level of occupational therapy support available to patients is reviewed, and therapy is documented in full in the patient records.	The rehabilitation goals / plans determined by the therapists, to be kept in the patients notes. This will be monitored with the monthly spot checks undertaken by the Clinical Lead Nurse.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_005	The health board is required to provide HIW with details of the action it will take to ensure that: * Discharge plans are completed in full, including the rehabilitation and discharge plans for each patient * The level of occupational therapy support available to patients is reviewed, and therapy is documented in full in the patient records.	Meeting scheduled for 06.02.2020 to review the level of provision with the lead for Occupational Therapy. The requirement to document the therapy requirement in notes will be discussed at the meeting and plan identified.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_006	The health board is required to provide HIW with details of the action it will take to ensure that: * The ward captures patient feedback and responds to patient and user experiences demonstrating learning and improvement made as a result * A Putting Things Right poster is placed on a notice board on the ward and is presented bilingually.	Patient Experience Team to be contacted and meeting to be arranged to identify plan as to how the team can support the service with gaining appropriate patient feedback, to support learning and improvement based on user feedback.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	The risk to monitored and updated based on assessment.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	The Head of Nursing to continue to work with the corporate nursing team to consider related issues, in respect to nurse staffing levels that affect the Directorates. Acuity and models of care to be reviewed and monitored through the nurse staffing work to ensure appropriate nursing care on the ward and minor injuries.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	The ward area has been decluttered. Storage space on the site to be reviewed. Estates department to complete a flooring audit review and replace marked or damaged flooring as recommended.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	All staff to be reminded of the procedure to follow for safe disposal and storage of sharps.	May-20	May-20	Amber	In Progress

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19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	A rolling refurbishment programme has commenced to redecorate the area.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_007	The health board is required to provide HIW with details of the action it will take to ensure that: * The local and corporate risk register reflect the limited availability of nursing staff in Llandovery hospital, and the impact of providing appropriate nursing care on the ward and in the minor injuries unit * The ward is de-cluttered and sufficient storage space provided * Damaged and marked flooring is repaired or replaced * Sharps boxes are closed when not in use * The therapy room is cleaned, decluttered, dirty therapy equipment cleaned or replaced and broken skirting boards repaired or replaced * Frozen food used for encouraging the rehabilitation of patients is stored appropriately, and regular checks are made on the use by dates, by nominated staff * All fire extinguishers are placed on stands or secured onto the wall * Doors to the ward, kitchen and staff room are adequately secured * The reception in the minor injuries unit is routinely locked and patient sensitive information is secured * The storage room is cleaned and locked when not in use * The sluice area and treatment room are routinely locked when not in use * An emergency buzzer is made available in the treatment room * Hot water is maintained at the correct temperature.	To confirm with Estates that all operational sinks have regulators, and are audited and control temperatures are monitored and recorded.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_009	The health board is required to provide HIW with details of the action it will take to ensure that: * Metal bins are replaced * The ward presents suitable and accurate evidence based information on infections on ward notice boards.	Infection control team to provide Hand Hygiene posters and other relevant infection control information to display on ward notice boards.	Jan-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_012	The health board is required to provide HIW with details of the action it will take to ensure that: * Alternative storage is provided for the equipment and furniture with a view to removing obstructions in a public area.	Alternative storage areas to be explored with estates department.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_013	The health board is required to provide HIW with details of the action it will take to ensure that: * All clinicians clearly date, time, print and sign their entries within patient records * The assessment of patient continence is recorded in patient records.	Relevant staff to be reminded of the need to comply with the sample signature profile, ensuring all signatures are legible and correlate to the date, time, and signature to be printed on all entries into the patient documentation. A signatory book to be established, for the GPs and all staff that document in the medical notes and to provide specimens of their signatures for cross referencing.	Feb-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_014	The health board is required to provide HIW with details of the action it will take to ensure that: * Senior Managers conduct a full risk assessment on the staffing levels in Llandovery hospital and ensure the correct number of registered nurses are rostered on all shifts to deliver safe and effective care to all patients * Staff team meetings have an agenda, minutes are circulated and staff are asked to confirm they have read the minutes * Senior Managers ensure all staff have the opportunity to take a break when on duty.	Number of beds have been reduced to support safe staffing levels. There will continue to be on-going assessment of staffing levels, with support from the corporate nurse staffing programme team.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_014	The health board is required to provide HIW with details of the action it will take to ensure that: * Senior Managers conduct a full risk assessment on the staffing levels in Llandovery hospital and ensure the correct number of registered nurses are rostered on all shifts to deliver safe and effective care to all patients * Staff team meetings have an agenda, minutes are circulated and staff are asked to confirm they have read the minutes * Senior Managers ensure all staff have the opportunity to take a break when on duty.	Alternative models of care to continue to be explored to ensure compliance with break periods for staff.	Mar-20	N/K	Red	Not Implemented
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_015	The health board is required to provide HIW with details of the action it will take to ensure that: * Robust safeguarding measures are in place and periodic background checks are made to ensure they prevent unsuitable people from working with vulnerable adults and children * Copies of staff appraisals are completed in full, signed, dated and placed on the appropriate member of staffs file.	A Task and Finish Group has been established, led by corporate workforce colleagues within the Health Board to identify a strategic approach to ensuring relevant background checks are undertaken. All staff identified as requiring a DBS check are completing the appropriate documentation to comply. All relevant staff to be reminded of the importance of completing staff appraisals in full, including signatures and dates. All staff appraisals once completed to be kept in staff files.	Apr-20	Apr-20	Amber	In Progress
19101	2019/20	HIW	Llandovery, 26-27 November 2019	Improvement Plan	Open	Community & Primary Care (Carmarthenshire)	Director of Operations	19101_015	The health board is required to provide HIW with details of the action it will take to ensure that: * Robust safeguarding measures are in place and periodic background checks are made to ensure they prevent unsuitable people from working with vulnerable adults and children * Copies of staff appraisals are completed in full, signed, dated and placed on the appropriate member of staffs file.	All relevant staff to be reminded of the importance of completing staff appraisals in full, including signatures and dates. All staff appraisals once completed to be kept in staff files.	Feb-20	N/K	Red	Not Implemented
19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_002	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	N/K	Red	Not Implemented
19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_003	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	May-20	Amber	In Progress
19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_003	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	N/K	Red	Not Implemented
19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_004	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	Not Implemented

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19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_007	The health board must ensure the following: ⍰ Consistent completion of cleaning schedules ⍰ Doors to the theatre department and all clinical areas are kept closed ⍰ Fabric curtains are replaced with disposable curtains ⍰ All staff are reminded of the bare below the elbow policy.	HOM to meet with Laundry Lead to explore purchasing of disposable Curtains for clinical areas	Dec-19	~~Mar-20~~ N/K	Red	Not Implemented
19127	2019/20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19127_012	The health board must ensure that: ⍰ A review of staffing rotas is undertaken to ensure that staffing levels are safe and effective to meet the needs of the service ⍰ The reasons for low morale and well-being amongst the staff teams are explored ⍰ A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication ⍰ Consideration is given to the provision of additional training for midwives.	Workforce Tool, Birthrate Plus to be undertaken in 2020 to review staffing requirements for maternity	Sep-20	Sep-20	Amber	In Progress
19257	2019/20	HIW	Withybush Hospital (Maternity), 3-4 December 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19257_002	The health board must ensure that information throughout the unit is made available bilingually	Audit to be undertaken to benchmark what bilingual information is available. Work in partnership with translation services to provide bilingual information.	Mar-20	N/K	Red	Not Implemented
19257	2019/20	HIW	Withybush Hospital (Maternity), 3-4 December 2019	Improvement Plan	Open	Women and Children's Services	Director of Operations	19257_007	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	Mar-20	Red	Not Implemented
18264	2019/20	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Improvement Plan	Open	Unscheduled Care (GGH)	Director of Operations	Cadog_001	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	Not known	Red	Not Implemented
18264	2019/20	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Improvement Plan	Open	Unscheduled Care (GGH)	Director of Operations	Cadog_002	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	Not known	Red	Not Implemented
18264	2019/20	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Improvement Plan	Open	Unscheduled Care (GGH)	Director of Operations	Cadog_003	R17:The health board must ensure that all doctors include their GMC registration number and their bleep number with their entries in to patient records.	Clinical Directors to discuss the need for improved documentation with medical staff.	Oct-19	Not known	Red	Not Implemented
19103	2019/20	HIW	Amman Valley Hospital, Cysgod Y Cwm Ward, 20-21 May 2019 (Community)	Improvement Plan	Open	Carmarthenshire	Director of Operations	19103_001	R1.The health board must provide HIW with a timescale for completion of planned works.	Work with the Estates support team to agree a suitable design for the wet room facility. T Schedule of work is agreed by the ward sister. Work to be completed and signed off by Estates and Service colleagues ready for commissioned use of the room.	Dec-19	~~Mar-20~~ N/K	Red	Not Implemented
No ref	2018/19	HIW	Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018	Improvement Plan	Open	Unscheduled Care (UHB Wide)	Director of Operations	PatientDischarge001	There has been an improvement in quality and timeliness where e-discharge is in operation. However, this is not in operation across many sites/hospitals with staff querying when rollout will be more widespread.	Roll out is over 50%, overall for the Health Board. With over 85% of medical wards now operating Medicines Transcribing and e-Discharge (MTeD). One hospital site is over 95% cover. Work is underway to improve the usage of MTeD within those wards that have the functionality available The MTeD facility is available across the Health Board (and ICT support) however further implementation is subject to agreement to increase pharmacy resource. This forms part of the Health Board IMTP.	Apr-20	Apr-20	Amber	In Progress
18262	2018/19	HIW	Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Improvement Plan	Open	Unscheduled Care (WGH)	Director of Operations	WGHUnannounced001	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-20	Red	Not Implemented
19102	2019/20	HIW	Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Immediate Improvement Plan	Open	Community & Primary Care (Pembrokeshire)	Director of Operations	19102I1_001	R7. The health board policy for the management and prevention of VTE finalised and disseminated to all appropriate staff.	The Health Board VTE policy to be completed and distributed to all appropriate staff.	Sep-19	Unknown	Red	Not Implemented
19105	2019/20	HIW	Ystwyth Ward, BGH 03-04 Sep19	Improvement Plan	Open	Unscheduled Care (BGH)	Director of Operations	19105_013	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	N/K	Red	Not Implemented
19105	2019/20	HIW	Ystwyth Ward, BGH 03-04 Sep19	Improvement Plan	Open	Unscheduled Care (BGH)	Director of Operations	19105_015	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	N/K	Red	Not Implemented
19105	2019/20	HIW	Ystwyth Ward, BGH 03-04 Sep19	Improvement Plan	Open	Unscheduled Care (BGH)	Director of Operations	19105_018	R18: The health board must ensure that the flooring by the nurses' station is repaired	To cost and arrange dates for replacement of the damaged floor	Feb-20	~~Mar-20~~ N/K	Red	Not Implemented

Healthcare Inspectorate Wales (Mental Health Learning Disabilities)

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
190417	2018/19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	190417_003	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	Not Implemented
190417	2018/19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	190417_010	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	In Progress
190417	2018/19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	190417_011	The health board should consider replacing the carpet and work surfaces in the staff offices. These pose a safety and infection control risk to staff and patients.	Submit Capital Bid of £7,750 for repairs to staff offices. (Subject to approval and availability of Capital)	Dec-20	Dec-20	Amber	In Progress
190417	2018/19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	190417_017	The health board must ensure that unmet needs are identified and recorded.	To develop a system for identifying and recording unmet needs.	Sep-19	Mar-21	Red	Not Implemented
190417	2018/19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	190417_018	The health board must ensure that patient capacity to consent is recorded on care plans	Develop and pilot an escalation process.	Mar-20	Sep-21	Red	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_021	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_021	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_021	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_022	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_022	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_026	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_027	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	Not Implemented
No ref	2019/20	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	Theme_YMH_032	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	Not Implemented
19009	2019/20	HIW MHLD	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	19009_007	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	Amber	In Progress
19009	2019/20	HIW MHLD	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	19009_008	The Health Board must ensure that capacity assessments are completed and recorded in patient records	Add to admission checklist – Where indicated complete decision specific capacity assessment and record in patients electronic records Communication to be sent to all Registered Nurses working within MH/LD inpatient services reminding them of the requirement that capacity assessments are completed and recorded in patient records. Review CTP audit and consider including monitoring component of capacity assessments in readiness for implementation of the audits within MH/LD inpatient settings	Sep-19	Sep-20	Red	Not Implemented
18173	2018/19	HIW MHLD	North Ceredigion Community Mental Health Team (Gorwellion) 20-21 Nov 2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	18173_015	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	Jun-20	Red	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_001	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	Amber	In Progress
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_002	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	In Progress
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_007	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	Mar-21	Red	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_008	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	Mar-21	Red	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_018	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	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_021	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	In Progress

Healthcare Inspectorate Wales (Mental Health Learning Disabilities)

No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_023	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	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_023	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	Not Implemented
No ref	2018/19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	JTR_023	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	Not Implemented

Audit Office

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
684A2014	2015/16	Wales Audit Office	A Comparative Picture of Orthopaedic Services - Hywel Dda	Improvement Plan	Scheduled Care	Director of Operations	684A2014_001	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 QIPP 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	2021/22	Red	Not Implemented
238A2017-18	2017/18	Wales Audit Office	Follow-up Outpatient Appointments: Update on Progress	Improvement Plan	Scheduled Care	Director of Operations	WAO_Outpatient_006	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	N/K	Red	Not Implemented
No ref	2019/20	Wales Audit Office	Integrated Care Fund (icf) Review Update (West Wales RPB)	Improvement Plan	Partnerships & Corporate Services	Director of Partnerships & Corporate Services	WAO_ICF_001	R1. Take a more regional approach to using the Integrated Care Fund and ensuring that projects support strategic objectives	• In 2019-20 the proportion of ICF funding that is retained at regional level was significantly increased, particularly in relation to the Learning Disability, carers and dementia elements • Where money has been allocated to local authority areas on a population basis (predominantly for older people), there is commonality of approach and local arrangements reflect regional models of delivery, for example in relation to front of hospital and home from hospital services • For 2020-21 the RPB is looking to further align local programmes, improve consistency and ensure that as far as possible, regional models of care are being implemented • The process and format for providing Project Initiation Documents (PIDs) for all funded projects has been improved to provide clarity on alignment between projects and strategic objectives set at national and regional level. There is still room for improvement in relation to this and reporting on delivery. Hence arrangements are being strengthened further for 2020-21 to ensure that comprehensive information is available for all projects and that robust quarterly reporting on all projects is in place. These strengthened arrangements will be set out in a revised Partner Agreement, signed by statutory and third sector partners and endorsed by the RPB at their meeting in March 2020.	Mar-20	Mar-20	Red	Not Implemented
No ref	2019/20	Wales Audit Office	Integrated Care Fund (icf) Review Update (West Wales RPB)	Improvement Plan	Partnerships & Corporate Services	Director of Partnerships & Corporate Services	WAO_ICF_005	R5. Strengthen project management arrangements across all Integrated Care Fund projects	• Project management of projects is improving, with PIDs submitted to all projects as part of the process of finalising the revenue investment plan – see above for further improvements being introduced for 2020-21. • Programme management of capital projects will be enhanced further through the appointment of a Capital Programme Manager.	May-20	May-20	Amber	In Progress
No ref	2019/20	Wales Audit Office	Integrated Care Fund (icf) Review Update (West Wales RPB)	Improvement Plan	Partnerships & Corporate Services	Director of Partnerships & Corporate Services	WAO_ICF_007	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	In Progress
No ref	2019/20	Wales Audit Office	Integrated Care Fund (icf) Review Update (West Wales RPB)	Improvement Plan	Partnerships & Corporate Services	Director of Partnerships & Corporate Services	WAO_ICF_008	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	In Progress
No ref	2017/18	Wales Audit Office	Radiology Service	Improvement Plan	Radiology	Director of Operations	WAO_Radiology_001	R7: Over the next year, increase mandatory training rates for all radiology staff to at least 85%.	Site lead superintendents to inform the radiology service manager of mandatory training rates and planned dates for appraisal (checked against ESR to ensure reliable recording). Monthly rates to be reported to RSM to ensure service is on target to achieve requirement with additional appraisal time arranged if required.	Mar-18	Mar-20	Red	Not Implemented
175A2019-20	2019/20	Wales Audit Office	Clinical coding follow-up review	Improvement Plan	Informatics	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_001	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. d) providing training for ward clerks and other staff in relation to their responsibilities for medical records. e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	b) 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 poly-pocket 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. d) 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 e) 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.	Dec-15	Mar-21	Red	Not Implemented
175A2019-20	2019/20	Wales Audit Office	Clinical coding follow-up review	Improvement Plan	Informatics	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_002	Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood. This should include: A) providing training for board members to raise their awareness of clinical coding and the extent to which it affects the quality of key performance information, other than mortality data.	A) There is no evidence of training for board members to raise their awareness of the importance of clinical coding	Dec-15	Mar-21	Red	Not Implemented
175A2019-20	2019/20	Wales Audit Office	Clinical coding follow-up review	Improvement Plan	Informatics	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_003	Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include: b) reinforcing the importance of completing timely discharge summaries	The Health Board has been slowly rolling out electronic patient discharge arrangements, although it is still only available in a limited number of areas. Coding teams said that where this is in place, the quality of information entered in to the system is generally poor. There is a cyclical issue which arises because of junior doctor intakes, which means that expected standards must be learned each time. Coding staff also indicated that electronic system updates can be problematic. Coding staff said that the timeliness and quality of written discharges is variable and has deteriorated over time. For example, they are often illegible or blank.	Dec-15	Mar-21	Red	Not Implemented

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603A2018-19	2018/19	Wales Audit Office	District Nursing: Update on Progress	Improvement Plan	Community and Primary Care (Ceredigion)	Director of Operations	WAO_DistrictNursing_001	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	Red	Not Implemented
No ref	2017/18	Wales Audit Office	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Improvement Plan	Informatics	Director of Planning, Performance & Commissioning	WAO_InfoBackUp_001	R5. Develop and document an ICT Disaster Recovery plan for all systems for which the Health Board has disaster recovery responsibility.		N/K	Mar-20	Red	Not Implemented
No ref	2017/18	Wales Audit Office	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Improvement Plan	Informatics	Director of Planning, Performance & Commissioning	WAO_InfoBackUp_002	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.		N/K	Mar-21	Red	Not Implemented
651A2015	2015/16	Wales Audit Office	Hospital Catering and Patient Nutrition Follow-up Review	Improvement Plan	Nursing	Director of Nursing, Quality and Patient Experience	WAO_Catering001	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	Not Implemented
380A2016	2016/17	Wales Audit Office	NHS Consultant Contract Follow Up	Improvement Plan	Medical	Medical Director	WAO_NHSConsultant001	R1: NHS bodies should ensure that all consultants have a job plan that is reviewed annually to ensure that it reflects the business needs of the NHS organisation and the continuous professional development of the consultant. (Auditor General Wales National Report, Rec 1a)	Current activities to resolve - The Medical Staffing Department scan all job plans and record job plan dates on the ESR system, helping to monitor percentage compliance across the Board. Future actions to prevent reoccurrence - Posts have been created to focus on monitoring and reviewing the job planning process throughout the Health Board. - Job plans to be recorded on a spreadsheet for ease of identifying those Doctors who require an up to date job plan. - Reminders to be sent to Doctors and Managers at regular intervals. - Monthly 'traffic light' scorecards to be produced detailing job plan compliance across the Health Board. Statistics to be split into site and specialty. - Compliance statistics to be reported to the Business Planning & Performance Assurance Committee on a monthly basis and the Workforce and OD committee on an annual basis. The Workforce and OD committee reports directly to the Board.	Mar-19	Dec-19	Red	Not Implemented
380A2016	2016/17	Wales Audit Office	NHS Consultant Contract Follow Up	Improvement Plan	Medical	Medical Director	WAO_NHSConsultant002	R2:Business processes should be reviewed to ensure that all consultants have an up-to-date job plan that accurately reflects the work that they do, and which is reviewed on an annual basis (Hywel Dda UHB Local Report, 2011, Rec 2a).	Current activities to resolve - The Medical Staffing Department scan all job plans and record job plan dates on the ESR system, helping to monitor percentage compliance across the Board. Future actions to prevent reoccurrence - Standard list of SPA activities and allocation to be created and used to help inform job plans. The SPA activities included should reflect organisational priorities and will require review on an annual basis to reflect any change in these priorities. - Doctors will be required to take evidence of how SPA allocation has been utilised to each job plan review meeting.	Mar-19	Dec-19	Red	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_001	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_002	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_003	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_004	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	Not Implemented
946A2018-19	2018/19	Wales Audit Office	Primary care services at Hywel Dda	Improvement Plan	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community and Long Term Care	WAO_PrimaryCare_005	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	Not Implemented
385A2016	2017/18	Wales Audit Office	Review of Estates	Improvement Plan	Estates	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	Red	Not Implemented
385A2016	2017/18	Wales Audit Office	Review of Estates	Improvement Plan	Estates	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	Red	Not Implemented
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual001	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	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual002	R3a. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should: a) Merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC; b) Ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee. c) Align all directorate level governance committees so they provide a report directly to the Operational QSESC. d) Introduce a standardised report template for all directorates to submit to the Operational QSESC, with a summarised version submitted to the QSEAC.	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. Transition arrangements for changes to Mental Health and Learning Disabilities quality report arrangements will be developed and worked through with the triumvirate team. Any specific exceptions requiring escalating to QSEAC escalated via OQSEAC, and appropriate staff asked to attend QSEAC as appropriate.	Apr-20	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality &	WAO_ReviewofQual003	R3b. To improve quality and safety assurance flows between the directorates and the Board, the Health Board should ensure that the Mental Health and Learning Disabilities directorate have a directorate level governance committee.	There is a Mental Health and Learning Disabilities directorate level governance committee. Work will be undertaken to strengthen and standardise the reporting arrangements to OQSEC (as recommendation 1)	Apr-20	Apr-20	Amber	In Progress

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xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual004	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.	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	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual005	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	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	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual006	R4. To improve the focus of the Operational QSESC, the sub-committee should incorporate within its activities assurance that learning from risks and action plans is being shared across directorates. Risks that should be discussed should include severe and high risks, as well as risks that are affecting a number of directorates.	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1). Agreement that risks and learning will be, embedded into the standard reporting templates. The templates will also advise on how learning from risks and action plans are being shared across Directorate and other areas. Deep dives are currently being discussed at each OQSESC meeting and will continue, these will support in-depth conversation required. The Risk Registers are to be used to inform these. A Listening and Learning Group is being established to facilitate shared learning across the organisation. Reporting arrangements for the group will be finalised and endorsed through QSEAC.	Apr-20	Apr-20	Amber	In Progress
xx2019-20	2019/20	Wales Audit Office	Review of operational quality and safety arrangements	Improvement Plan	Quality & Safety	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual007	R7. To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.	Task and finish group established which is jointly chaired by Director of Nursing and Director of Planning. The work of the task and finish group has been expedited. A project plan is in place including agreement of the priority indicators to be populated and rolled out to directorates.	Apr-20	Apr-20	Amber	In Progress
1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Governance	Board Secretary	WAO_SA_2018_001	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.	Jun-19	Apr-20	Red	Not Implemented
1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Governance	Board Secretary	WAO_SA_2018_002	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.	Sep-19	Apr-20	Red	Not Implemented
1033A2019-20	2018/19	Wales Audit Office	Structured Assessment 2018	Improvement Plan	Governance	Board Secretary	WAO_SA_2018_003	R4. Recommendation - Strategic planning To ensure the delivery of its health and care strategy, the Health Board should seek to resolve the outstanding request for funding from the Welsh Government to support the capacity needed to implement the strategy with the intended timescales.	The Health Board have identified that funding of £4.4m per annum is required in total in order to provide support to deliver the programme of change and to undertake work to develop the Programme Business Case. Welsh Government have confirmed that funding of £1.6m will be made available to the Health Board. This leaves a shortfall of £2.8m, which will need to be addressed as part of our planning deliberations.		Mar-20	Red	Not Implemented
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Governance	Board Secretary	WAO_SA_2019_001	R1. We found scope to reduce potential duplication of assurance between the Business Planning and Performance Assurance Committee (BPPAC) with the Health and Care Strategy Delivery Group (HCSDG). The Health Board should clarify the reporting lines of the Health and Care Strategy Delivery Group to ensure that the risk of duplication of assurance is mitigated.	The Board agreed the new governance arrangements at its meeting held on 30th January 2020. The paper clearly detailed the roles of the new BPPAC and the HCSDG (HCSDG will report to Executive Team instead of the Board which will reduce the risk of duplication with BPPAC). Terms of Reference and the Scheme of Delegation in terms of matters delegated to Committees will be reviewed and revised and presented to the Board in March 2020. The new arrangements will come into operation from 1st April 2020.	Apr-20	Apr-20	Amber	In Progress
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Governance	Board Secretary	WAO_SA_2019_002	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.	Apr-20	Apr-20	Amber	In Progress
1661A2019-20	2019/20	Wales Audit Office	Structured Assessment 2019	Improvement Plan	Governance	Board Secretary	WAO_SA_2019_003	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. • 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. • Prioritise the re-formation of a wider clinical reference group to support the clinically led delivery of the Strategy with a programme of regular workshops to test / challenge and inform the delivery of the strategic programmes. • Re-introduce workplace champions (developed during the Transforming Clinical Services programme Discover and Design phases) in 2020 for delivery of the Strategy. • 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. • Cohort 2 of the EQlip programme have ensured projects identified are supportive of teams delivering change projects in line with the Strategic direction. • 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. • 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 • Development of social media platform for the strategy delivery programmes and Transformation Programme Office to	Jul-20	Jul-20	Amber	In Progress

Internal Audit

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Assurance Rating	Service / Directorate	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
HDUHB1718-35	2018/19	Internal Audit - HDUHB	Theatres Directorate	Internal Audit Report	Reasonable	Scheduled Care	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 use.	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	Not Implemented
HDUHB1718-35	2018/19	Internal Audit - HDUHB	Theatres Directorate	Internal Audit Report	Reasonable	Scheduled Care	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 management.	Nov-17	N/K	Red	Not Implemented
HDUHB1819-33	2018/19	Internal Audit - HDUHB	Records Management	Internal Audit Report	Limited	Health Records	Director of Operations	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	TBC	Red	Not Implemented
HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Reasonable	Clinical Engineering	Director of Operations	HDUHB 1920-16_001	High	Management should put in place safeguards to ensure alerts and safety notices for all Health Board medical devices are fully captured.	TBC- The current procedure for the management of safety notices and alerts is under review. Following consultation it will be taken through Health Board processes for ratification and then implementation. The revised policy will ensure that the responsibility, for capturing all alerts received and actions taken is clear. With the introduction of the Once for Wales Concerns Management System which includes an alerts function, the Head of Quality and Governance has requested that an all Wales solution is considered. The Head of Quality and Governance will continue to the OfWCMS project to try and influence an all Wales solution. This will be done through the Programme Team and Programme Board.	Mar-20	Mar-20	Red	Not Implemented
HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Reasonable	Clinical Engineering	Director of Operations	HDUHB 1920-16_002	High	Management should review the current approach to medical devices training for clinical and nursing staff to ensure: all training is coordinated through a central point; training provided by external parties can be quality assessed; and training records can be accurately maintained.	TBC-The medical device trainer is currently undertaking a mapping exercise to prioritise the training in accordance to high medium and low risk devices. The initial training plan will focus on the high risk to identify the specific trainers (including external parties); assess that they are delivering a quality assured programme and identify records of training. The trainers that deliver aspects of the mandatory training programme i.e. resuscitation and moving and handling are already recording device training onto ESR. The work stream will also identify any gaps in provision of training. There is only one medical device trainer for the whole Health Board. At present, a large proportion of the time is dedicated to coordinating the cascade assessors' programme for infusion devices. There is currently no administrative support for the trainer. To ensure a timely delivery of all of the recommendations there will be a requirement to increase both trainer and administrative resources.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Reasonable	Clinical Engineering	Director of Operations	HDUHB 1920-16_003	Medium	Management should ensure the identified medical devices policies and procedures are promptly reviewed and submitted for approval.	TBC-The current procedure for the management of safety notices and alerts is under review. It will be issued for consultation early January 2020. Following consultation it will be taken through Health Board processes for ratification and then implementation.	Mar-20	Mar-20	Red	Not Implemented
HDUHB 1920-16	2019/20	Internal Audit - HDUHB	Medical Devices	Internal Audit Report	Reasonable	Clinical Engineering	Director of Operations	HDUHB 1920-16_004	Medium	Clinical Engineering Department should ensure that 'Equipment Status' tags for all returned medical devices to the inventory libraries are completed by the returning and receiving officers.	TBC-The new decontamination tags were introduced over the past six months as part of our ongoing continuous improvement exercise. During the initial stages of introduction these tags were incomplete due to a new process being implemented. We have since communicated with the Assistant Director of Nursing Quality and Safety and all General Managers / Heads of Nursing that we will not accept any equipment into the department without the tags being completed correctly. All equipment librarians have also been informed and this process will be monitored within our quality system.	Dec-19	TBC	Red	Not Implemented
HDUHB 1920-20	2019/20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Internal Audit Report	Reasonable	Informatics	Director of Planning, Performance & Commissioning	HDUHB 1920-20_001	Medium	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.	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 due to be advertised in March 2020, with an anticipated start date of May 2020.	Jul-20	Jul-20	Amber	In Progress
HDUHB 1920-20	2019/20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Internal Audit Report	Reasonable	Informatics	Director of Planning, Performance & Commissioning	HDUHB 1920-20_002	High	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.	Agreed. In conjunction with Recommendation 1, a detailed assessment of the gaps / tasks will be identified which in turn will form the work plan of the newly appointed cyber security resource. 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 esculation.	Jun-20	Jun-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_001	High	R1. The Research & Development Sub-Committee should ensure that the annual report for 2018/19 is submitted to the appropriate committee meeting and future reports should be submitted within six weeks of the end of the financial year.	The report is complete and will be circulated to Committee members, in advance of its formal agreement at the next R&D Sub-Committee on 20.4.20. A formal and time bound process of producing end of year reports as part of the Health Board planning arrangements is currently being produced to ensure timely future annual reports. This will be presented at the next Senior Management Team meeting on 17.2.20 for approval and once approved will be completed in time for the annual report completion for the year ending April 2020.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_002	High	R2. R&D Management should ensure individual researchers assigned investigation accounts promptly complete and submit their quarterly returns to Health & Care Research Wales via the Finance Department.	Information taken from the Hywel Dda UHB R&D Finance Process (Appendix 2) is as follows:- Spending plans (for amounts over £1,000) are to be provided to and reviewed by the R&D Senior Team at least 6 monthly. Spending plans must detail outline or planned spending / expenditure against income accrued, plus anticipated new income generated per annum. If income is less than anticipated (e.g. lower than expected recruitment), early discussion with the R&D Senior Team is essential. Any ad-hoc spend of £1,000 or more has to be approved by the R&D Senior Team. Failure to provide spending plans may result in the accrued income not being reinstated at the start of the new financial year. This income will be put into a general research support fund, managed by the R&D Department. While investigators are routinely asked to submit a spending plan for their 'investigator accounts', the response rate has been low. The Deputy Director for Research and Innovation issued a request for the return of spending plans, so that plans can be reviewed by the Research and Development Sub-Committee on 20.4.20. Where plans are not submitted, any money held on accounts will be added to the general research support fund, for which there is a plan. A revised plan for managing this process in the future will be presented by the finance lead at the next senior management team meeting on 17.2.20.	Feb-20	Feb-20	Red	Not Implemented

Internal Audit

HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_003	High	R3. The R&D, General Medicine and Finance Departments should come together and establish a reconciliation arrangement to ensure invoices received from Swansea University for the tenure of the former R&D Director are accurate and correct prior to payment by the Health Board.	The former R&D director is not paid directly by R&D. Invoices from Swansea University are received by Unscheduled Care and 0.2 sessions were recharged to R&D for the work that he did in supporting R&D. R&D have no input into invoicing arrangements with Swansea University. Finance have ensured that the recharges have dropped to 0.1 now that the former director has dropped his sessions, and if he steps back fully from R&D we will ensure that the recharges stop. This is all managed internally within finance. Part of the ongoing control of this will also be the monthly finance file which is sent out to the Senior Research & Development Operations Manager and Deputy Director for Research & Innovation which will enable us to identify anyone who is being paid inappropriately.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_004	High	R4. The Finance Department should ensure that an R&D financial position update should be reported to the R&D Sub-Committee on a regular basis.	A change in Finance Team and reporting arrangement and systems has meant that a written report has not gone to the last three Sub-Committee meetings. Finance have been working on a new finance report, which has now been completed. It will be brought to the R&D Senior team meeting on 17.2.20 for review and sign off, and an updated version (to year-end April 2020) brought to the next subcommittee. Circulation of the quarterly returns to the R&D Sub-Committee had been considered (so that they are aware of the figures being reported to WG), however the wide circulation of this and other reports is made difficult by the personal salary information and names contained within the reports. A process has now been developed to overcome this.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_005	High	R5. Management should ensure that signed and dated copies of all grant submission documents are retained on file.	This is accepted. Management will ensure the documentation for all 'awarded grants' and live studies is held on file. All signed documents will be stored electronically and hard copies within a study specific Trial Master File or Grants Log.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_006	Medium	R6. Management should ensure that only a formally approved Research & Development Strategy document is uploaded onto the Health Board's internet page.	The document in question (Strategy v4) has been uploaded into the document library on the internet site, however it has not been activated so is not visible to people viewing the page in the normal way. The version visible to people viewing the site is v3. Regarding the formal approval of v4: There is an email trail (dated 10.5.18) from the Policy Co-Ordination Officer to the Senior R&D Manager requesting that the document be reviewed by the R&D sub-committee following minor changes. These were to change any reference to the 'Data Protection Act' to 'the Data Protection Act/General Data Protection Regulations (2016) or any subsequent legislation to the same effect'. This was forwarded (10.5.18) to the Research Governance Officer who was servicing the R&D subcommittee. There is evidence that this item was on the agenda under AOB (Agenda item 11.1) for the sub-committee meeting dated 21.5.18. The table of actions following this meeting contain the entry (no.23) "Minor changes to R&D Strategy (GDPR) approved by Committee members. The Research Governance Officer to inform the Policy CoOrdination Officer". A further entry on this table of actions states "Complete 23.05.18. Action to be removed". The issue would therefore appear to be incorrect completion of the front section of the strategy v4 (referring to UPB approval rather than RDSC approval), and our failure to ensure that v4 is visible and v3 is removed. An email has been sent to the Policy Co-Ordination Officer asking her to revise the front page of v4 so that it is correct. Once this has been done v3 of the strategy will be removed from the internet and v4 used in its place.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_007	Medium	R7. R&D 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.	A process for routinely updating registers through the R&D SMT and management structures across research and development has now been introduced. In addition, the question will be added to the start of every meeting agenda (starting with Senior Management Team meeting on 17.2.20) to ensure it is a routine part of R&D business.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_008	Medium	R8. R&D Management should review the risk register to ensure all actions are updated on a regular basis and the application of risk treatment is accurate and correct.	A strengthened process of risk management has now been introduced. Management of individual risks have been re-assigned to ensure they are 'owned' by a named person. Risks and associated action plans to mitigate the risks will be reviewed monthly by the Senior Management Team, with escalation to the R&D sub-committee where necessary, and removal of the risk where appropriate.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_009	Medium	R9. Department managers and leads should ensure that the management of all periods of sickness complies with the NHS Wales Managing Attendance at Work Policy.	Management arrangements have been strengthened through an OCP and management gaps have been addressed. A team based structure is now in place with each team leader managing a maximum of 6 staff. An email has been sent to all team leaders reminding them of the NHS Wales Managing Attendance at Work Policy and requesting that they attend an update. This will be checked in their next 1:1s.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_010	Medium	R10. R&D Department 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 are captured on the latest approved PADR proforma.	PADRs are undertaken on a regular basis throughout the year. Figures from team leaders suggest that upwards of 90% of staff have a current PADR. Those PADRs which are out of date are planned. There are a number of new team leaders within the R&D department. A workshop on writing SMART objectives is planned for March. Line-managers will ensure that everyone has been on the Health Board PADR training session and this will be reviewed in 1:1s. Staff will be reminded to download the most upto-date version of the PADR form when preparing for their next PADR.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_011	Medium	R11. Management should ensure all R&D employees accurately maintain their diaries to enable line mangers to reconcile submitted travel claims.	All managers routinely check and reconcile claims but a reminder of the requirement to make sure calendars can be accessed by others has been issued. This will continue to be checked in 1:1s.	Apr-20	Apr-20	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_012	Medium	R12. Management should ensure that all extant Research & Development standard operating procedures are reviewed, submitted for approval and published on the organisation's intranet site.	A timeline for the review of SOPs has been prepared for discussion in the SMT on 17.2.20. This will ensure that all SOPs are reviewed on a rolling programme. All 16 outstanding SOPs will be reviewed, approved and published by January 2021.	Jan-21	Jan-21	Amber	In Progress
HDUHB 1920-09	2019/20	Internal Audit - HDUHB	Research & Development Governance Review	Internal Audit Report	Limited	Medical	Medical Director	HDUHB 1920-09_013	Medium	R13. Management should assess the need to maintain the research application documents and checklists given that evidence is captured and retained on the IRAS system.	As described in the 'finding' section above, all the information is captured electronically in ReDA, ie ReDA Cymru and in more recent months in ReDA3 (LPMS). The office checklist is not a requirement for good management of trials/research - it is in addition as an aide memoir for staff working on study set-up on a day to day basis to easily refer to when queries come in, therefore only limited information is completed e.g. outstanding issues, acronyms etc. In recent weeks, the Study Set Up Manager, as part of a task and finish group in HCRW has developed a new checklist for in-office assistance to be used as required (in paper or electronic format). It is not mandated, nor is there a need for it to be fully completed as the ReDA3/LPMS system is used for this purpose (our current data completeness is recorded as 100% in LPMS).	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	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.	On detailed review, in preparation for this submission, it is accepted that some adjustment of inherent risk score against risk treatment status was needed – this has now been addressed. The opportunity was also taken to update all actions for January 2020 and this should all now be satisfactory.	Jan-20	Jan-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_001	High	R2. 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	Feb-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_001	High	R3. 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 also noted that another corporate risk (696) was identified that is aligned to the Neurology Service – Specialist Epilepsy Nurse Service. This risk has also been accepted on to the BGH risk register.	Jan-20	Jan-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_002	High	R4. 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	Mar-20	Red	Not Implemented

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HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_003	High	R5. 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	Mar-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_004	Medium	R6. 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	Mar-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_005	Medium	R7. Management should ensure all BGH Management Committee agendas, minutes and papers are made readily accessible.	BGH has been subject to an extraordinary situation where the only two members of the admin support team were absent long term for different reasons. The Management PA post has been re-appointed and going forward this individual will maintain a full document record, including version control, in a shared area that allows managed access.	Mar-20	Mar-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_006	Medium	R8. Management should ensure that approved terms of reference are in place for all supporting groups and forums of the BGH Management Committee.	The Quality Forum will agree the TOR at the first meeting in January 2020, whilst the TOR of the Professional Nursing Forum was recently updated. However, due to an oversight, the date was not changed on the document – this has been rectified. The Theatre User Group TOR and membership were reviewed and ratified by the HMC.	Jan-20	Jan-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_007	Medium	R9. Bronglais Hospital Management should ensure the Health Board registers of gifts, sponsorship and hospitality are accurate and up-todate, 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 registers.	Feb-20	Feb-20	Red	Not Implemented
HDUHB 1920-26	2019/20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Internal Audit Report	Limited	Unscheduled Care	Director of Operations	HDUHB 1920-26_008	Medium	R10. 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	Apr-20	Amber	In Progress
HDUHB 1819-11	2019/20	Internal Audit - HDUHB	Integrated Care Fund – Follow Up	Internal Audit Report	Reasonable	Carmarthenshire	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	Not Implemented
HDUHB 1819-32	2019/20	Internal Audit - HDUHB	Radiology Directorate	Internal Audit Report	Reasonable	Radiology	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	Not Implemented
HDUHB 1819-32	2019/20	Internal Audit - HDUHB	Radiology Directorate	Internal Audit Report	Reasonable	Radiology	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	Not Implemented
HDUHB-1920-34	2019/20	Internal Audit - HDUHB	Environmental Sustainability Report	Internal Audit Report	Reasonable	Estates	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	May-20	Amber	In Progress
HDUHB-1920-34	2019/20	Internal Audit - HDUHB	Environmental Sustainability Report	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB-1920-34_002	Medium	R2. Management should provide progress updates of previous year's initiatives and reference to finite resources that has material impact within the Sustainability Report.	Water meters (AMR's) are being installed following award of a five-year contract with ADSM, targeting March 2020. Performance of water reduction measures will be reported annually thereafter.	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-34	2019/20	Internal Audit - HDUHB	Environmental Sustainability Report	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB-1920-34_003	Medium	R3. Management should ensure the explanation narrative regarding energy consumption and financial indicator estimates for Greenhouse Gas table is completed and sufficient detail to explain the use of estimates for business travel and miles is included.	A few words had been deleted in error, so the narrative explaining Greenhouse Gas Emissions did not read correctly, this will be reviewed and amended in next year's report to ensure sufficient detail is included when estimated figures have to be used.	May-20	May-20	Amber	In Progress
HDUHB-1920-34	2019/20	Internal Audit - HDUHB	Environmental Sustainability Report	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB-1920-34_004	Medium	R4. Management should ensure the documented procedures are complete and approved for staff use.	Documented procedures will be reviewed and completed as part of the ISO 14001 accreditation.	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-34	2019/20	Internal Audit - HDUHB	Environmental Sustainability Report	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB-1920-34_005	Medium	R5. Management should ensure that invoice consumption costs are accurately input into the supporting spreadsheets.	All staff carrying out data inputting will be reminded of the importance of accurately inputting data into spreadsheets. The verification process will be reviewed to minimise the chances of input errors occurring.	Mar-20	Mar-20	Red	Not Implemented
HDUHB1819-17	2019/20	Internal Audit - HDUHB	Charitable Funds	Internal Audit Report	Substantial	Finance	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	Apr-20	Red	Not Implemented

Internal Audit

SSU_HDU_1819_11	2019/20	Internal Audit - SSU	Cardigan Integrated Care Centre	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	SSU_HDU_1819_11_001	Medium	R8. The UHB should obtain the surety bond for the foul drainage.	Agreed. Legal advice will be sought on any potential liability/ recourse post completion.	Jun-20	Jun-20	Red	Not Implemented
SSU_HDU_1819_11	2019/20	Internal Audit - SSU	Cardigan Integrated Care Centre	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	SSU_HDU_1819_11_002	Medium	R9. The UHB should identify appropriate resolution for the storm drainage.	Agreed. Legal advice will be sought on any potential liability/ recourse post completion.	Jun-20	Jun-20	Red	Not Implemented
SSU_HDU_1819_11	2019/20	Internal Audit - SSU	Cardigan Integrated Care Centre	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	SSU_HDU_1819_11_003	Medium	R10. The UHB should review the advice provided at the time of procuring the land to determine whether there is any recourse from the advice provided.	Agreed. Legal advice will be sought on any potential liability/ recourse post completion.	Jun-20	Jun-20	Red	Not Implemented
SSU_HDA_1819_01	2019/20	Internal Audit - SSU	Capital Follow Up (W&C Phase 2, and Bronglais Front of House)	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	SSU_HDA_1819_01_001	Medium	Bronglais Front of House R1. 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 assessed.	Both elements of the 'wider' scheme need to be complete beforethe PPE is undertaken. There have been some delays encountered and work was due to complete end January / beginning of February. As such, completion of the PPE is now anticipated during 2019/20.	Sep-19	Jun-20	Red	Not Implemented
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Limited	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_003	High	R3. Management should ensure that consultant and SAS doctor DCC and SPA sessions are accurately recorded on the job plans and within the ESR system.	• New job plans not created using the online system will not be accepted/recorded • New System to be implemented for all job plan reviews. The nature of the online system and the way it needs to be used means that DCC & SPA can be clearly identified on job plans and thus make the transfer of information from the job plans job plans to other systems such as ESR more accurate.	Mar-21	Mar-21	Amber	In Progress
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Limited	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_004	High	R4. Service Managers and Clinical Leads should ensure that consultant and SAS doctor expected outcomes are set out in all job plans.	• Medical Director to communicate the need to include expected outcomes, which are consistent with the needs of the service, in all job plans • Medical Director to recirculate Direct Clinical Care (DCC) Sessions Document (contained within the Job Planning Toolkit) to help inform and guide the expected outcomes which are set	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Limited	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_004	Medium	R6. Management should ensure that the Job Planning Tool Kit for SAS doctors is submitted to the LNC for approval, published and made available to employees as soon as possible.	• Include SAS Doctor toolkit on the agenda for LNC Meeting on the 22/01/2020 • Consider any amendments requested by LNC members and amend document accordingly • Medical Director to circulate approved document to all those involved with the job planning process • Toolkit to be uploaded on to the Health Board intranet	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-29	2019/20	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Internal Audit Report	Limited	Medical	Medical Director & Director of Clinical Strategy	SSU_HDU_1920_29_004	Medium	R7. Service Managers and Clinical Leads should ensure they attend the Allocate training sessions to enable them to use the e-job planning system that has been rollout across all directorates and services.	• Workshop dates to be re-circulated • Medical Director to send formal notification of compulsory use of e-job planning system via letter and email to all those involved with the job planning process • Register of workshop attendance to be maintained • Deputy Medical Director of Acute Hospital Services to be notified of any managers who have not attended a session and are not engaging with the transition from paper to electronic job planning format	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-25	2019/20	Internal Audit - HDUHB	Estates Directorate Governance Review	Internal Audit Report	Limited	Estates	Director of Operations	HDUHB-1920-25_001	Medium	R3: Estates and Facilities Management should ensure that the accountability and reporting arrangements of supporting groups and committees are defined and documented in the Directorate of Facilities Team Meeting terms of reference.	Agreed. The ToRs for the DFTM will now be reviewed to incorporate formal reporting and accountabilities. The other supporting groups will develop their own specific ToRs confirming reporting arrangements. This will be undertaken at the same time as the next review of the ToRs for the DFTM, which is scheduled on the work plan for March 2020.	Mar-20	Mar-20	Red	Not Implemented
HDUHB-1920-25	2019/20	Internal Audit - HDUHB	Estates Directorate Governance Review	Internal Audit Report	Limited	Estates	Director of Operations	HDUHB-1920-25_002	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	Jan-20	Red	Not Implemented
HDUHB-1920-25	2019/20	Internal Audit - HDUHB	Estates Directorate Governance Review	Internal Audit Report	Limited	Estates	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	In Progress
SSU_HDU_1819_01	2019/20	Internal Audit - SSU	Estates Follow Up (Residential Accommodation/ Backlog Maintenance/ Fire Precautions Follow Up)	Internal Audit Report	Reasonable	Finance	Director of Finance	SSU_HDU_1819_01_001	Medium	Residential Accommodation R10: Management will consider the viability of accommodation both with and without SIFT monies.	Work is ongoing regarding the utilisation of SIFT, with the potential that SIFT is held centrally, in the future, by Medical Education.	Jun-19	Mar-20	Red	Not Implemented
SSU_HDU_1819_04	2019/20	Internal Audit - SSU	Data Centre Project	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	SSU_HDU_1819_04_001	Medium	R1. At the WGH solution, a business case should be prepared.	Agreed – a business justification case will be prepared for the next phase of the Data Centre containerised solution.	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Limited	Estates	Director of Operations	SSU_HDU_1920_06.1_003	High	9. Financial vetting requirements should be defined where the anticipated aggregate value of work exceeds a pre-determined quantum over a predefined period	Agreed. A review of reactive maintenance expenditure, undertaken by external contractors, for the nine-month period to December 2019 will be undertaken. Where expenditure for that time-period, for any one contractor has exceeded £10k, management will undertake a financial vetting exercise [in consultation with NWSSP Procurement Services].	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Limited	Estates	Director of Operations	SSU_HDU_1920_06.1_004	Low	12. In accordance with the Operational Maintenance Policy, reporting should be undertaken to the appropriate forum to allow routine assessment of the reactive maintenance contract arrangements.	Agreed. The Quality, Safety and Experience Assurance Committee currently receives data on reactive maintenance. However, this is for information purposes only and is not scrutinised. The monthly Operational Management team meetings will now receive performance reporting on reactive work with exceptions to be brought to the attention of the Operational Delivery Group. Interim	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Limited	Estates	Director of Operations	SSU_HDU_1920_06.1_004	High	17. Following completion of the review, a robust stock count procedure should be embedded which includes evidence of review of relevant supporting information to confirm the accuracy of the reported figure.	Agreed. A stock count will be undertaken every two months, and at yearend, until the operation procedures [as per recommendation 18] have been embedded.	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.1	2019/20	Internal Audit - SSU	Financial Safeguarding – Maintenance Team Led Work	Internal Audit Report	Limited	Estates	Director of Operations	SSU_HDU_1920_06.1_004	High	18. Operational procedures should be actioned for recording of issue and return of stock items; including physical access controls to the storeroom. The Health Board's 'Non Controlled Stores' procedure should be used as a basis for developing the required operational procedures	Agreed. An electronic fob system has been installed to monitor access to the storeroom. This went live on 11 November 2019. Operational policies have been re-introduced for issue and return of stock. The effectiveness of this process will be reviewed through the year-end stock count. The procedure will be further extended to ensure there is recording mechanism for all goods delivered to the storeroom to be logged accordingly to facilitate the reconciliation process.	Mar-20	Mar-20	Red	Not Implemented
SSU_HDU_1920_06.2	2019/20	Internal Audit - SSU	Financial Safeguarding: Design Team Led CRL Projects	Internal Audit Report	Reasonable	Estates	Director of Operations	SSU_HDU_1920_06.2_001	Low	4) Management should review the detail of the current procurement activity reporting for Design-led procurement and strengthen where appropriate	The suite of information presented to the Capital Monitoring Forum has been updated to include the appointed contractor. Internal Audit has provided examples of additional information to be presented in the annual report which will be considered accordingly.	Mar-20	Mar-20	Red	Not Implemented
HDUHB 1617-08	2016/17	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB 1617-08_001	Medium	R4: A systematic approach to inspections and risk assessments should be established, which would provide a more proactive approach to identifying potential areas of risk within the Health Board.	Based upon the resource available, a realistic planned H&S inspection programme will be introduced. This will involve visiting various departments and examine their H&S arrangements and compliance.	Nov-16	Mar-20	Red	Not Implemented
HDUHB 1617-08	2016/17	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB 1617-08_002	Medium	R5: A structured approach to the review of risk assessments should be adopted. Where risk assessments are undertaken by the Health & Safety department, a log of all actions should be maintained and regularly reviewed to ensure actions are completed/followed-up, as appropriate. Individual departments undertaking risk assessments should be reminded of the correct process.	A log of actions will be introduced and will become a key performance indicator by the Health and Safety Team. These will be discussed at Monthly Team meetings and where appropriate brought to the attention of the Health and Safety and Emergency Planning Sub Committee.	Oct-16	Mar-20	Red	Not Implemented
HDUHB1819-27	2018/19	Internal Audit - HDUHB	IM&T Directorate	Internal Audit Report	Reasonable	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	HDUHB1819-27_001	High	R8. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	This has been a long standing issue that I have been working with HR / Unions to ensure that the staff have their comfort breaks. Unfortunately, due to the nature of the work, structures etc we are not able to comply with this requirement. However, when the new switchboard technology is implemented it will allow this to occur. Staff have been made fully aware of their rights, and they have opted out of the ETWD around hours and breaks etc.	Mar-22	Mar-22	Amber	In Progress
HDUHB 1636	2017/18	Internal Audit - HDUHB	Low Vision Service Wales - Review of New Arrangements	Internal Audit Report	Reasonable	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community & Long Term Care	HDUHB 1636_001	Medium	R2. The wording and details need clarifying and strengthening to make clear what will happen when funding from the general allocation has been spent. Furthermore, the TOR's appear to conflict with the Directions as they state the Service cannot be diluted.	Subject included on Joint Committee risk register in order to stimulate discussion.		N/K	Red	Not Implemented
HDUHB 1636	2017/18	Internal Audit - HDUHB	Low Vision Service Wales - Review of New Arrangements	Internal Audit Report	Reasonable	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community & Long Term Care	HDUHB 1636_002	Medium	R3. The MOU requires reviewing and updating.	Currently under review.		N/K	Red	Not Implemented

Internal Audit

HDUHB 1636	2017/18	Internal Audit - HDUHB	Low Vision Service Wales - Review of New Arrangements	Internal Audit Report	Reasonable	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community & Long Term Care	HDUHB 1636_003	Medium	R5. The TOR's should be reviewed in line with the Directions to ensure the two documents do not conflict.	This is to be addressed by the Joint Committee and risk register.	Jul-17	N/K	Red	Not Implemented
HDUHB 1636	2017/18	Internal Audit - HDUHB	Low Vision Service Wales - Review of New Arrangements	Internal Audit Report	Reasonable	Primary Care, Pharmacy (community), LTC & LVWS	Director of Primary, Community & Long Term Care	HDUHB 1636_004	Medium	R6. The issues arising with the lack of growth forecast built into the budget allocation should be added to the risk register that is currently being developed, and closely monitored and brought up for discussion at the Joint Committee meetings.	Ongoing – the LVSW Joint Committee and Jill Paterson continue to highlight this to WG. This is suggested to be included on the Joint Committee risk register on 8th June 2017 at the Joint Committee meeting.	Ongoing	N/K	Red	Not Implemented
HDUHB-1718-34	2017/18	Internal Audit - HDUHB	National Standards for Cleaning in NHS Wales	Internal Audit Report	Reasonable	Estates	Director of Operations	HDUHB-1718-34_001	High	R4 • C4C audit methods and practices should be actioned by all Domestic Supervisors to ensure C4C are consistently thorough across all sites. • Audits should be planned ahead and noted on schedules and rotas to ensure audits are completed and do not get overlooked if a member of staff is away or on secondment. • If a member of staff is absent during the 48 hours following an audit, an alternative Domestic Supervisor should be deployed to check that the action plan arising from the cleaning audit has been completed in the functional area. • PMS should be asked to remap the rooms on the software and make amendments to the system so it accurately reflects the functional areas being audited. This will mean that the C4C system will be more user friendly and audits will be less time consuming to undertake.		Jun-18	N/K	Red	Not Implemented
HDUHB-1819-29	2018/19	Internal Audit - HDUHB	PC and Laptop Security (Follow-Up)	Internal Audit Report	Limited	Planning, Performance & Commissioning	Director of Planning, Performance & Commissioning	HDUHB-1819-29_001	High	R1. The original recommendation stands, whereby 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.	The Assistant Director of Informatics will work with the Health and Safety Group to identify and resolve the wider security of the Health Board sites. Where possible ICT solutions will be scoped to assist with the overall security of the Health Board, i.e. improved CCTV. Scoping – 1-2 months Action plan creation -2 months Resourcing gap analysis – 1 month Implementation – 10 months	Feb-20	N/K	Red	Not Implemented
HDUHB-1819-25	2019/20	Internal Audit - HDUHB	Review of Discharge Processes (Follow-up)	Internal Audit Report	Reasonable	Unscheduled Care	Director of Operations	HDUHB-1819-25_001	Medium	R1. Management should ensure the current draft Complex Discharge Standards are formally approved and communicated to staff.	The standards were not originally developed and signed off by local authority partners, therefore it is the health board's intention to review the standards, in partnership with local authority colleagues and then refresh the standards, in particular the timescales associated with the pathways. These will then be fully approved by all parties. This is part of a larger piece of work where the health board is implementing the All Wales Discharge to Assess pathways. Alongside this the health board's informatics department are working on a set of performance measures against these, with the aim to start to have some clearer accountability for discharge to complement the existing front door measures.	Sep-19	Jan-20	Red	Not Implemented
HDUHB-1819-24	2019/20	Internal Audit - HDUHB	Preparedness & Compliance with the Nurse Staffing Act	Internal Audit Report	Substantial	Nursing	Director of Nursing, Quality & Patient Experience	HDUHB-1819-24_001	Medium	R1. Management must ensure that nurse staffing level information is visibly displayed and made available for all patients and visitors.	a) Printed copies of the FAQ leaflet (taken from the NHS Wales Nurse Staffing levels (Wales) Act (2016) Operational Guidance) in both English and Welsh were issued to all wards covered by Section 25B in April 2018. Further copies are being reissued immediately (May 2019) pending receipt of the revised Operational Guidance (which contains a refreshed Patient FAQ sheet) which is due to be issued from WG in July 2019. When this document is received, Patient Information leaflets will be printed to ensure a supply of the leaflets are available to all appropriate wards at all times. The revised Guidance will also contain an 'easy read' version of the Patient FAQ and this will also be printed and made available on each ward. b) In addition, the posters showing the planned roster and calculated nursing establishment for each of the Section 25B wards, which the HB is required to display outside each ward once the establishment is provided to the Board, will be refreshed and reissued in June 2019. This timing is to ensure that the most recent calculations have been noted through the agreed governance structures within the Health Board and the date that this has occurred is then recorded on the posters as is part of the information required within the patient poster template.	Aug-19	Jan-20	Red	Not Implemented
HDUHB 1819-12	2019/20	Internal Audit - HDUHB	Savings Planning & CIP	Internal Audit Report	Reasonable	Finance	Director of Finance	HDUHB 1819-12_001	Medium	R1. Consideration should be given to providing CIP management training within the Health Board.	Actions 1. Review the content of the Health Board's Managers Passport programme and in particular the finance module to ensure it adequately covers CIP management. 2. Identify the cohort of managers in the Health Board that would benefit from bespoke CIP management training, and scope from other organisations the best way to deliver this. 3. Review and where necessary refresh, before re-issuing the Workforce and non-pay checklists and ask managers to sign to say they have received and reviewed them. 4. Scope and implement a programme of development that runs alongside the Turnaround programme's more informal approach learning in action, to ensure there is a system that starts to embed the approach to CIP management that has longevity beyond the existing Turnaround Programme.	Jul-19	Mar-20	Red	Not Implemented
HDUHB-1920-05	2019/20	Internal Audit - HDUHB	Welsh Language Standards Implementation	Internal Audit Report	Reasonable	Partnerships and Corporate Services	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	Not known	Red	Not Implemented
HDUHB-1920-05	2019/20	Internal Audit - HDUHB	Welsh Language Standards Implementation	Internal Audit Report	Reasonable	Partnerships and Corporate Services	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	Not known	Red	Not Implemented
HDUHB-1920-05	2019/20	Internal Audit - HDUHB	Welsh Language Standards Implementation	Internal Audit Report	Reasonable	Partnerships and Corporate Services	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	Not known	Red	Not Implemented
HDUHB-1920-05	2019/20	Internal Audit - HDUHB	Welsh Language Standards Implementation	Internal Audit Report	Reasonable	Partnerships and Corporate Services	Director of Partnerships and Corporate Services	HDUHB-1920-05_004	Medium	R4. Management should ensure all directorate Readiness Assessments include a responsible officer(s) and deadline date for non-compliant standards that require addressing.	This will be implemented during this quarter.	Dec-19	Not known	Red	Not Implemented
HDUHB-1920-15	2019/20	Internal Audit - HDUHB	Annual Quality Statement	Internal Audit Report	Reasonable	Quality	Director of Nursing, Quality and Patient Experience	HDUHB-1920-15_001	Medium	R1. Management should ensure that the Welsh version of the AQS 2018/19 is published and uploaded on the Health Board website as a matter of priority.	This will be clearly accounted for in the timetable for the production of the next report. It is accepted that due to the very challenging timescales involved in this year's process and the requirement to produce the AQS by end of May, the welsh translation of the AQS was delayed.	Oct-19	Jan-20	Red	Not Implemented
SSU HDU 1920 07	2019/20	Internal Audit - SSU	Water Safety – Additional Sampling	Internal Audit Report	Limited	Estates	Director of Operations	SSU HDU 1920 07_001	Medium	R7: Management should review the cost / benefit of an enhanced BMS provision.	Agreed. We will review the cost / benefit of an enhanced BMS at the Water Safety Group.	Mar-20	Mar-20	Red	Not Implemented
SSU HDU 1920 07	2019/20	Internal Audit - SSU	Water Safety – Additional Sampling	Internal Audit Report	Limited	Estates	Director of Operations	SSU HDU 1920 07_002	Medium	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of; • the Authorised Engineer; • Welsh Water (infringement notices); and • site survey risk assessment.	Agreed. The Welsh Water infringement notices will be concluded by November 2019, with longer time frames required for certain others (noting that some NWSSP: SES recommendations relate to removal of redundant pipework following accurate drawings). Time frames for these are as advised at recommendations 5 & 6.	Mar-20	Mar-20	Red	Not Implemented

Community Health Council

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_001	R1. The Health Board needs to keep people up to date on their waiting times and plans for their care. This will lead to less worry, frustration and isolation.	New patients - will be sent an acknowledgement letter upon receipt of referral. Existing patients – Audiology will develop patient information leaflets that explain relevant timescales for care so that patients are aware of their pathway timescales.	Aug-20	Aug-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_002	R2. The Health Board needs to give people clear explanations about what is available and reasons why other options are not readily available.	Audiology to develop a staff standard operating procedure (SOP) document which defines the types of hearing aid provided by the NHS based on clinical need. Contents of SOP once developed to be disseminated to staff at staff meeting, this will ensure that staff disseminate correct information to patients.	Jul-20	Jul-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_003	R3. Staff need to remember that the people they see may be worried or anxious about their NHS appointment. It is important that staff remember to try to put people at their ease and give people sufficient time even though they may feel under pressure. This includes clear introductions, explanations and making sure that people know what is happening next and when.	Audiology staff to be reminded of the need to: 1. Be empathetic towards patients. 2. To ensure that agreed individual management plans continue to be discussed, and printouts offered, to all patients who are issued with hearing aids.	May-20	May-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_004	R4. The Health Board needs to consider that telephone communication can be a problem for people.	Staff will be reminded to 1. Advise people using the service of the different ways of contacting the service (ie: phone / text / letter / generic email). 2. The patient information leaflet being devised (action Point recommendation1 .) will include the different ways that patients can contact the department	Jul-20	Jul-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_005	R5. There may be a need to consider how much can be communicated in written pamphlets, by letter or email. It can sometimes be easier for patients to read information rather than struggle on the phone.	1) There is a need for the service to develop (and standardise existing)patient information leaflets so that they provide all relevant information. 2). There is a need for ongoing liaising with the Health Board's Communications Team to review/ update the Audiology webpage.	Aug-20	Aug-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_006	R6. Different people have different communication needs and it would be helpful if staff could try to find out from patients what suits them best.	Staff to be reminded of the utilisation (and monitoring) of the Audiology patient management system to highlight if patients have a preferred communication need	Aug-20	Aug-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_007	R7. The Health Board needs to remember that whilst people with a hearing loss have a hidden disability that impacts on their lives, people do not want to be treated as if they are ill.	Staff to be reminded of the importance of treating patients with dignity and respect.	Aug-20	Aug-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_008	R8. People feel more in control when they know what is happening and this also stops them feeling like a burden or a nuisance.	See actions listed in recommendations 1 and 3	Aug-20	Aug-20	Amber	In Progress
CEO2526	2019/20	CHC	Audiology (Hearing) Services November 2019	Improvement Plan	Scheduled Care	Director of Operations	CEO2526_009	R9. There may be a need to consider how communication can be improved. This might involve giving better information to individuals or by looking at technology to assist eg appointment screens or website updates.	1. The service to work with the Health Board's Communications team to review/ update the Audiology webpage.	Aug-20	Aug-20	Amber	In Progress
CHC Llandovery	2019/20	CHC	Llandovery Hospital August 2019	Improvement Plan	Carmarthenshire	Director of Operations	Llandovery_002	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-20	Red	Not Implemented
CHC Llandovery	2019/20	CHC	Llandovery Hospital August 2019	Improvement Plan	Carmarthenshire	Director of Operations	Llandovery_003	R3.The Health Board could promote the hospital more to let people know that a relatively small hospital can provide a range of services and take pressure off bigger, busier hospitals.	1.To provide advice on potential patients who could be admitted to Llandovery Hospital to the weekly patient flow meetings at Glangwili General Hospital.	Jan-20	N/K	Red	Not Implemented
CHC Llandovery	2019/20	CHC	Llandovery Hospital August 2019	Improvement Plan	Carmarthenshire	Director of Operations	Llandovery_006	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	N/K	Red	Not Implemented
CHC Llandovery	2019/20	CHC	Llandovery Hospital August 2019	Improvement Plan	Carmarthenshire	Director of Operations	Llandovery_007	R7.The Health Board could canvas patients to identify if the television in the open ward environment is a concern from their perspective.	To continue with existing review process undertaken on a regular basis which ensures that staff actively discuss what can be done to make patients stay more comfortable. Options being explored.	Jan-20	N/K	Red	Not Implemented
No ref	2019/20	CHC	Women and children's services Visit report March 2018	Improvement Plan	Women and Children's Services	Director of Operations	CHC_W&C_001	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	TBC	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_001	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	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_002	R2. HB needs to consider ways that people can more easily access mental health support at times of crisis.	To implement a streaming service prior to registration in ED. To progress the collaborative (ED and MH&LD) work reviewing the ability for patients known to secondary mental health services to be able to refer directly to CRHT.	Dec-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_003	R3. HB needs to review ways of making sure that people who are unwell have some privacy and dignity within the department.		Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_004	R4. 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	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_005	R5. HB needs to continue to explore ways of achieving reductions in waiting times.		Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_006	R6. HB needs to provide information about waiting times	To improve the utilisation of the electronic display system in the waiting room; To work with reception staff and the triage nurse to ensure waiting times are being accurately reflected to the public	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_007	R7. HB electronic signs need to be regularly updated	To put in place clear processes to ensure waiting times are accurately captured, being clear about the different streams and how waiting times may differ	Oct-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_008	R8. HB needs to find ways of addressing people's basic requirements when waiting for long periods of time. For example, food, drink.	To discuss with catering department the re-introduction of snack packs; To agree and implement a robust process for wellbeing 'rounds' within the Department; To agree a daily schedule with Red Cross volunteer service to support patients within the Department	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_009	R9. HB needs to find ways of addressing people's basic requirements when waiting for long periods of time. For example, Medication	To implement a robust system to ensure patients medications are prescribed and administered in a timely way, where a long stay in the department is experienced	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_010	R10. HB needs to find ways of addressing people's basic requirements when waiting for long periods of time. For example, Sleep	To explore the options for provision of eye masks and ear plugs to patients	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_011	R11. HB needs to find ways of addressing people's basic requirements when waiting for long periods of time. For example, Calling for a nurse	To explore with the estates department the installation of additional call bells	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_012	R12. HB needs to find ways of addressing people's basic requirements when waiting for long periods of time. For example, where to keep their belongings	To explore the provision of (bedside) lockers	Nov-19	N/K	Red	Not Implemented

Community Health Council

No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_013	R13. Consider giving priority attention to children and the elderly while waiting	To reinforce these aspects when undertaking triage (These aspects are contained within The Manchester Triage system) To explore implementation of frailty screening into the Emergency Department to support appropriate streaming of elderly patients	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_014	R14. There should be an appropriate quiet waiting area for people who are in a distressed state or suffering from a mental health crisis	The design of the department does not allow for a separate waiting area however if patients present in a distressed state. We do use the small waiting area behind the reception desk for them to wait. This area is more private and staff are able to observe patients more closely in this area. If relatives present in a distressed state we do have a relative's room that we are able to take them to.	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_015	R15. A&E staff to have timely access to be able to link with the mental health crisis team	To implement a streaming service prior to registration in ED To ensure that all staff are aware of how to refer patients to the CRHT.	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_016	R16. Nurses and Doctors to ensure patients are informed and involved in their NHS care by improving communication.	To implement a version of the '4 questions' which is appropriate for an ED to ensure all patients understand why they are there, what is wrong with them and their plan of care.	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_017	R17. Ensure patients in reception are accurately informed how long they will wait to be seen.	To improve the utilisation of the electronic display system in the waiting room; To work with reception staff and the triage nurse to ensure waiting times are being accurately reflected to the public	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_018	R18. Consider using a tannoy system or names to appear on the electronic board when calling for patients	To explore the purchase and installation of a tannoy system to call patients	Nov-19	N/K	Red	Not Implemented
No ref	2019/20	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Improvement Plan	Unscheduled Care	Director of Operations	A&EWGH_019	R19. Patients are concerned about the change of the A&E location and would find it hard to get to hospital.	To link with the 'A Healthier Mid & West Wales' plan and the Transforming Hospitals, Communities and Mental Health work streams	Nov-19	N/K	Red	Not Implemented
No Ref	2019/20	CHC	Bronglais Hospital, Dyfi ward and Clinical Decisions Unit, 21 November 2018 and 24 January 2019	Improvement Plan	Unscheduled Care (BGH)	Director of Operations	BGH_Dyfi&CDU_001	R5.Staff do not always have access to a quiet area when sensitive information needs to be shared	Ongoing work on Meurig ward to establish a quiet room for hospital use	Oct-19	Apr-20	Red	Not Implemented
No Ref	2019/20	CHC	Bronglais Hospital, Dyfi ward and Clinical Decisions Unit, 21 November 2018 and 24 January 2019	Improvement Plan	Unscheduled Care (BGH)	Director of Operations	BGH_Dyfi&CDU_002	R7. Suitable arrangements not always in place for dementia	To trial of Registered Mental Nurse (RNM) formal out reach	Mar-20	Mar-20	Red	Not Implemented

Health and Safety Executive

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
JHET/HD/0410 2019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/01_ 001	1. 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.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/01_ 002	2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/01_ 003	3. Identify sources of information on violence and aggression incidents and near misses, to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded b. Records of the number and type of incidents at each site where porters are called to deal with violence and aggression; c. Records of restrictive physical interventions related to violence and aggression; d. Referrals to Occupational Health related to violence and aggression; e. Information from employee groups who do not have access to Datix; f. Information from employee representatives; g. Information from those providing training under the All Wales Violence and Aggression Passport.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/01_ 004	4. Identify how the findings from monitoring, audit and review will be considered and consulted on, and responsibilities allocated to ensure that suitable and timely action is taken and completed.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/01	2019/20	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/01_ 005	5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/02_ 001	1. 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.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/02_ 002	2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/02_ 003	3. Identify sources of information on manual handling incidents and near misses, and use these to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded; b. Referrals to Occupational Health related to musculoskeletal disorders; c. Sickness absence records related to musculoskeletal disorders; d. Information from employee groups who do not have access to Datix; e. Information from employee representatives; f. Information from those providing training under the All Wales Manual Handling Training Passport.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/02_ 004	4. 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.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/02	2019/20	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/02_ 005	5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/03	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/03_ 001	1. 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	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/03	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/03_ 002	AND 2. 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.	May-20	Jul-20	Amber	In Progress

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JHET/HD/0410 2019/04	2019/20	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/04_ 001	1. 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	May-20	Jul-20	Amber	In Progress
JHET/HD/0410 2019/04	2019/20	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/04_ 002	AND 2. 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	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/05_ 001	1) With the assistance of a competent person assess all risks that involve manual handling of loads with the Laundry at Glangwili Hospital.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/05_ 002	From the findings of your assessment; 2) 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/05_ 003	3) 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/05	2019/20	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/05_ 004	4) 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/06_ 001	1. In consultation with employees and with assistance of a competent person, critically review the implementation and effectiveness of your current arrangements for assessing risks and learning from incident investigation outcomes for managing and reducing those risks.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/06_ 002	2. 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/06_ 003	3. 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/06_ 004	4. 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/06	2019/20	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/06_ 005	5. 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/07_ 001	EITHER 1) Avoid hazardous manual handling operations 'so far as is reasonably practicable', by redesigning the task to avoid moving the load or by automating or mechanising the process.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102 019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/07_ 002	OR 2) 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.	May-20	Jul-20	Amber	In Progress

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LPJ/HD/04102019/07	2019/20	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/07_003	3) 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 4) Implement any other equally effective measures to remedy the said contraventions.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/08	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/08_001	EITHER 1. 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.	May-20	Jul-20	Amber	In Progress
LPJ/HD/04102019/08	2019/20	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Legislative requirements	Estates	Director of Operations	JHET/HD/04102019/08_002	AND 2. 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.	May-20	Jul-20	Amber	In Progress

Mid and West Wales Fire and Rescue Service

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00113573_001	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughtout 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 compramise strips and seals of fire doors.	Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00113573_002	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00113573_003	R3. St Nons. Ensure the certificates showing testing of emergency lighting systems are provided via email at the earliest opportunity.	Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00113573_004	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.	Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00113573	2019/20	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)	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00113573_005	R2. Bro Cerwyn. Reinstate the fire resistance in the following locations: Holes in ceiling areas of offices, water leaking onto electrical appliances and sockets.	Mar-20	Mar-20	Red	Not Implemented
BFS/KBJ/SJM/00115068	2019/20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. South Pembs Hospital	Legislative requirements	Estates	Director of Operations	BFS/KBJ/SJM/00115068_001	3. 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.	Dec-19	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_001	R1. All items identified in the significant findings of your Fire Risk Assessment will need to be completed within the identified time scales.	Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered EN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_002	R2. 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 & Waldo Suite (Mental Health Department) 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. 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.	Mar-20	Mar-20	Red	Not Implemented

Mid and West Wales Fire and Rescue Service

ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered FN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_003	R3. Ensure that the escape route next to staff room G16, which leads into a small yard area, is cleared of all obstructions and remains available for escape purposes at all times. Wheeled bin compound, electrical appliances and combustible items in escape route will need to be removed.	Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered FN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_004	R4. Reinstate the fire resistance in the following location(s) • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devises are functioning in line with its design specifications and manufacturer's instructions	Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered FN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_005	R5. Reinstate the fire resistance in the following location(s) • Fire resisting Glazing removed from main corridor of St Caradogs & replaced with thin plywood boarding.	Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered FN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_006	R6. The fire alarm system will need to be inspected by a qualified fire alarm engineer to ensure the system is fit for purpose and repaired/upgraded as necessary.	Mar-20	Mar-20	Red	Not Implemented
ED/KJ/00113573	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30. St Caradogs, WGH. The serving of this Notice dated 6th December 2019 and numbered FN/262/08	Legislative requirements	Estates	Director of Operations	ED/KJ/00113573_007	R7. Ensure that all doors on exit routes are available and can be easily and immediately opened in an emergency by anyone who might need to use them.	Mar-20	Mar-20	Red	Not Implemented
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	R1. •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.	Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	R2. 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.	Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	R3. 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	Jul-20	Amber	In Progress

Mid and West Wales Fire and Rescue Service

BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_004	R4. Ensure that everyone can evacuate quickly and safely by details. • Removing the photocopier to a safe location off the means of escape (within the Sealyham block) • Keeping all escape routes clear of all items Namely file cabinets and combustibles. (office Areas Kensington, Sealyham) • Notice boards should be placed behind a lockable screen if erected on a means of escape.	Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_005	R5. Ensure that escape lighting on all escape routes in all five locations mentioned above are operating to the standard required and in accordance with BS 5266 the emergency lighting should operate if the local lighting circuit fails. The system should be tested monthly and inspected bi-annually.	Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_006	R6. 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.	Jul-20	Jul-20	Amber	In Progress
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	2019/20	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.	Legislative requirements	Estates	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_007	R7. Upholstered furniture is to comply with British Standard 7176 or the equivalent European Standard. • Pembroke county community room.	Jul-20	Jul-20	Amber	In Progress
BFS/KS/SJM/00114719	2019/20	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	Legislative requirements	Estates	Director of Operations	BFS/KS/SJM/00114719_001	R1. 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.	Sep-20	Sep-20	Amber	In Progress
BFS/KS/SJM/00114719	2019/20	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	Legislative requirements	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R2. 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.	Sep-20	Sep-20	Amber	In Progress
BFS/KS/SJM/00114719 - KS/890/03	2019/20	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	Legislative requirements	Estates	Director of Operations	BFS/KS/SJM/00114719_001	R1. 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.	Aug-21	Aug-21	Amber	In Progress
BFS/KS/SJM/00114719 - KS/890/03	2019/20	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	Legislative requirements	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R2. 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.	Aug-21	Aug-21	Amber	In Progress

Mid and West Wales Fire and Rescue Service

BFS/KS/SJM/00114719-KS/890/04	2019/20	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	Legislative requirements	Estates	Director of Operations	BFS/KS/SJM/00114719_002	R1. 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	Apr-22	Amber	In Progress

Public Service Ombudsman (Wales)

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
201901989	2019/20	Public Service Ombudsman (Wales)	201901989 (13248)	Ombudsman Report	Scheduled Care	Director of Operations	201901989_003	R3. Review the pathway for the management of such cases to ensure that it is robust, clinically sound yet patient centred.	Mar-20	Mar-20	Red	Not Implemented
201901989	2019/20	Public Service Ombudsman (Wales)	201901989 (13248)	Ombudsman Report	Scheduled Care	Director of Operations	201901989_004	R4. Introduce a more robust pathway for these situations (if deemed necessary following the above review). The Health Board said that this will take 1 further month to implement if this is required.	Mar-20	Mar-20	Red	Not Implemented
201806908	2019/20	Public Service Ombudsman (Wales)	201806908 (7793)	Ombudsman Report	Scheduled Care	Director of Operations	201806908_002	R2. Makes a redress payment to Mr Q of £650 due to the injustice as outlined in paragraphs 33 and 34	Mar-20	Mar-20	Red	Not Implemented
201806908	2019/20	Public Service Ombudsman (Wales)	201806908 (7793)	Ombudsman Report	Scheduled Care	Director of Operations	201806908_004	R4. Reviews its pooled patients waiting list procedure, alongside the BOA position statement, to ensure it is patient focused and mitigates the risks of poor practice as outlined above.	May-20	May-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_001	R1. Within 1 month, the Health Board will provide you a letter of apology for the extended time taken to respond to your original complaint and for having to bring your further dissatisfaction to the Ombudsman. It will also apologise that its original letter was not as comprehensive as it would have liked and that it did not fully address your complaint.	Apr-20	Apr-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_002	R2. Within 1 month, the Health Board will make a payment of £750 in recognition of the above shortfalls in its concerns handling process.	Apr-20	Apr-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_003	R3. The Health Board will instruct an appropriate independent clinical expert to review the clinical aspects of your complaint within 1 month. The expert will not have been involved in Mrs B's care and treatment and will not be employed by the Health Board. The expert will provide a written report within 3 months of instruction. Their report will include, where relevant, recommendations for: a. Mrs B's future care and treatment (including recommended timescales for implementing the care and treatment recommendations). b. Any reimbursement of private consultation costs incurred by Mrs B in relation to her left hip. c. Improvements to practice.	Jul-20	Jul-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_004	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.	Aug-20	Aug-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_005	R5. The Health Board will implement any future care and treatment recommendations made by the expert in line with the timescales recommended by them.	Date not yet known	Date not yet known	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_006	R6. Within 1 month of the receipt of the expert report, the Health Board will implement any improvements in practice recommended by the expert.	Aug-20	Aug-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_007	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 and responses as well as timeliness for replies.	Jun-20	Jun-20	Amber	In Progress
201905316	2019/20	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Scheduled Care	Director of Operations	201905316_008	R8. The Health Board will submit evidence of completion of all these measures to the Ombudsman.	Date not yet known	Date not yet known	Amber	In Progress
201904831	2019/20	Public Service Ombudsman (Wales)	14088	Ombudsman Report	Unscheduled Care (BGH)	Director of Operations	201904831_001	R1. Within one month the Health Board will: a) apologise to you and your husband for the failure to consider an alternative diagnosis and inadequate complaint handling	Apr-20	Apr-20	Amber	In Progress
201904831	2019/20	Public Service Ombudsman (Wales)	14088	Ombudsman Report	Unscheduled Care (BGH)	Director of Operations	201904831_002	R2. Within one month the Health Board will: b) share this case with those involved in your husband's case as reflective learning.	Apr-20	Apr-20	Amber	In Progress
201904831	2019/20	Public Service Ombudsman (Wales)	14088	Ombudsman Report	Unscheduled Care (BGH)	Director of Operations	201904831_003	R3. Within three months the Health Board will: c) provide training to all its medical staff in the ED on diagnosis and management of headaches – using an anonymised version of this case as an example as part of the training.	Apr-20	Apr-20	Amber	In Progress
201902238	2019/20	Public Service Ombudsman (Wales)	12260	Ombudsman Report	Unscheduled Care (PPH)/ Cancer	Director of Operations	201902238_001	R1. Within 1 month the UHB should send a written apology to Mrs H which acknowledges the failings identified in the report.	Apr-20	Apr-20	Amber	In Progress
201902238	2019/20	Public Service Ombudsman (Wales)	12260	Ombudsman Report	Unscheduled Care (PPH)/ Cancer	Director of Operations	201902238_002	R2. Within 1 month the UHB should review communication practices regarding patient's outcomes and options for end of life care and identify any relevant training needs.	Apr-20	Apr-20	Amber	In Progress
201902238	2019/20	Public Service Ombudsman (Wales)	12260	Ombudsman Report	Unscheduled Care (PPH)/ Cancer	Director of Operations	201902238_003	R3. Within 1 month the UHB should share this report with all relevant medical staff and confirm to the Ombudsman that the report has been used for critical reflection.	Apr-20	Apr-20	Amber	In Progress

Coroner Regulation 28

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
Reg 28 EKI	2019/20	Coroner Regulation 28	Regulation 28 inquest touching the death of Emily Katherine Inglis	Coroner Report	Mental Health & Learning Disabilities	Director of Operations	CoronerEKI001	R2.The inquest further identified that there were deficiencies in record-keeping, both in terms of ensuring that risk management strategies remained up-to-date and in preserving handover records.	Unclear what action to be taken - no clarification from service to date.	Not Known	Not Known	Red	Not Implemented

Delivery Unit

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
No ref	2018/19	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-PlannedCare_002	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	Red	Not Implemented
No ref	2018/19	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-PlannedCare_004	R4i. The UHB should ensure that contacts and appointments with patients facilitate patients' feedback.	Current systems of letters, telephone and text reminders all include points of contact for further information for reassurance. Implementation of the Health Board Patient Feedback System	Mar-20	Mar-20	Red	Not Implemented
No ref	2018/19	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-PlannedCare_004	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	Mar-20	Red	Not Implemented
No ref	2018/19	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-PlannedCare_004	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	May-20	Red	Not Implemented
No ref	2018/19	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-PlannedCare_009	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-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_002	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_003	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_004	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_005	R5. Ensure there is an appropriate mechanism to connect monitoring to ophthalmic delivery plans with monitoring of progress with eye care measures delivery.	Identified processes within WPAS to enable monitoring mechanisms.	Mar-20	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_006	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_007	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Improvement Plan	Scheduled Care	Director of Operations	DelUnit-EyeCare_008	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	Mar-20	Red	Not Implemented
No ref	2017/18	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	AWR_QCTP_001	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.	Mar-23	Mar-23	Amber	In Progress
No ref	2017/18	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	AWR_QCTP_002	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	In Progress
No ref	2017/18	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	AWR_QCTP_005	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.	N/K	N/K	Amber	In Progress
No ref	2018/19	Delivery Unit	National report- The Quality of Care and Treatment Planning - Assurance Review of Adult MH&LD Services	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	NR_QCTP_003	R3. HBs, LAs and NHS Wales Informatics Service (NWIS) should review assessment and review processes ensuring that they align to the Measure and the requirements of the SSWBA as the Wales Community Care Information System (WCCIS) is rolled out across LAs. These processes should support proportionate approaches to care and treatment planning and review, reduce bureaucratic burden and overlap, and empower service users and their families to contribute to the planning of their care.	Interim Head of Nursing, Mental Health & Learning Disabilities believes Director of Operations should be leading this piece of work as it is wider than the service and involves NWIS and WCCIS system to be rolled out which is out of her control . Currently outside the girst of the HB to control	Mar-23	Mar-23	Amber	In progress
No ref	2018/19	Delivery Unit	All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Improvement Plan	Mental Health & Learning Disabilities	Director of Operations	AWAR_PCCAMHS_005	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	Mar-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Cardiology	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	Apr-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Cardiology	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	Jul-20	Red	Not Implemented

Delivery Unit

No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Cardiology	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	Jul-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Unscheduled Care (GGH)	Director of Operations	AllWalesCardiology002	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	Apr-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Unscheduled Care (GGH)	Director of Operations	AllWalesCardiology003	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	Jul-20	Red	Not Implemented
No ref	2019/20	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Unscheduled Care (GGH)	Director of Operations	AllWalesCardiology003	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	Jul-20	Red	Not Implemented

Peer Review

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
No ref	2016/17	Peer Review	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-CYPDiabetes001	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.	2015/16	TBC	Red	Not Implemented
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH001	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	Sep-20	Sep-20	Amber	In Progress
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH002	R2. High dependency unit (HDU) – lack of space There is a concern that the physical space of the unit is inadequate to accommodate 4 HDU cots.	As part of Phase 2 redevelopment of neonatal and maternity services in Glangwili General Hospital -the Neonatal Unit will be relocated to a temporary facility from January 2020 pending -the redevelopment of the current unit by summer 2020. Both of the above solutions will facilitate an appropriate high dependency facility	Nov-20	Nov-20	Amber	In Progress
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH003	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	In Progress
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH004	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	Mar-20	Red	Not Implemented
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH005	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.	Nov-20	Nov-20	Amber	In Progress
No ref	2019/20	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Women and Children's Services	Director of Operations	PeerReview-GGH006	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	In Progress
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH001	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	TBC	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH002	R2. Sustainability of service A critical decision is urgently required to consolidate bases across Hywel Dda	The existing model is no longer sustainable based on current and predicted fill rates/demand but will require executive and clinical leadership to resolve ET have agreed to a proposal to rationalise bases at PPH and Llandysul. Engagement timelines are currently being agreed . The provisional date for rationalisation is in March 2020	Dec-19	Mar-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH003	R3. Multi-Disciplinary Workforce Review what additional APP resource is required to support the Carmarthenshire team particularly at weekends to ensure a consistency of service across all bases	To review as part of winter plans (Short Term) and IMTP investment (medium term). This should be part of the longer term strategy for the service This action is dependent on education of staff, the aim is to increase to 3 WTE in Q1 2021/22	ASAP	Jun-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH003	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	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH005	R5. Service Delivery For short notice cancellations, GPs should be issued with a letter from the AMD/MD noting impact on the service and patient care.	Clinicians electing to work part sessions and leaving the shift with no notice must be addressed. Possible wider links with revalidation and GMC. Letter not yet issued. GPs are challenged on notice cancellations and the UHB is seeing an improvement on notice provided. Timescale currently unclear. Action requires input from Medical Director .	Nov-19	TBC	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH005	R5. Service Delivery Joint Mental Health triage practitioners should be considered on a regional basis and could be piloted with Swansea Bay this winter	Utilising learning from AB model. Initial conversations have taken place in UHB with Mental Health service but no agreement currently made. Joint pilot with Swansea Bay requires CEO approval for sign off.	Jan-20	Jan-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH006	R6. Wider Workforce Planning The c 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	Not known	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH006	R6. Wider Workforce Planning Healthcare Support workers supporting GPs on visits as part of the driver role has been successfully introduced and should be expanded as part of existing roles.	The Job description has recently been amended (Jan 2020) and new staff recruited will have the HCSW element assigned as part of this role. Not currently expanded to existing roles, will be reliant on Workforce contracts and willingness of staff. Christine Davies to help to support cultural change within the workforce.	Ongoing	Ongoing	Amber	In Progress
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH011	R11. 111 Service Review the clinical communication between the clinical support hub and OOH team regarding shift fill rates.	Joint communication and escalation plan required – particularly for weekends. Escalation is subject to review at present on a regional basis between the UHB and Aneurin Bevan University Health Board. Discussions needs to be held on how this will feed into the UHB and assess the risk associated with patients assigned to the UHB when the service is escalated and timely care cannot be provided. These conversations are taking place as part of the Exec Team project group.	Jan-20	Apr-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH012	R12. Finance Finance should urgently reconsider the £500,000, 13% efficiency saving that has been directed to the OOH team and the wider impact that this may be having on the service and unscheduled care demand	This is having a detrimental impact on service delivery and potentially leading to increased cases attending ED.	Urgent	Not known	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH013	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	Mar-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH014	R14. Specific Operational Issues IT issues relation to the prescription printers continue to frustrate clinical staff. This needs to be addressed as a matter of urgency.	New printers have been procured for WGH treatment centre and effort is now being focused on the other bases where equipment has been purchased but local problems are preventing the systems from being operational.	Dec-19	Apr-20	Red	Not Implemented
No ref	2019/20	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Out of Hours	Director of Operations	PeerReview-OOH014	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	Red	Not Implemented

Welsh Language Commissioner

Reference Number	Financial Year	Report issued by	Report Title	Type of Plan	Service / Directorate	Director	Recommendation Reference	Recommendation	Management Response	Completion Date	Revised Completion Date	Status (RAG)	Implementation Status
CSG584	2019/20	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Welsh Language	Director of Partnerships and Corporate Services	CSG584_001	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	Apr-20	Amber	In Progress
CSG584	2019/20	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Welsh Language	Director of Partnerships and Corporate Services	CSG584_002	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	Apr-20	Amber	In Progress
CSG584	2019/20	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Welsh Language	Director of Partnerships and Corporate Services	CSG584_001	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	Apr-20	Amber	In Progress
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_001	R1. The Welsh Government, health boards and primary care clusters need to work together to develop ways of assessing the linguistic needs of the population.	Welsh Language Officer to contact the Welsh Government to establish if an All Wales approach to working together is likely on the implementation of the Welsh Language Commissioner's report (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Feb-20	Feb-20	Red	Not Implemented
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_002	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. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Mar-20	Red	Not Implemented
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_003	R3. Health Education and Improvement Wales, higher education institutions and health boards should work together and strategically plan on the basis of the above information, in order to ensure that specific training courses recruit Welsh speakers according to need.	The HB will engage and contribute to joint working where requested. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-21	Mar-21	Amber	In Progress
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_008	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. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Mar-20	Red	Not Implemented
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_009	R9. Higher education establishments and health boards should increase the opportunities for Welsh medium students to gain work experience in areas where the use of the Welsh language is required professionally.	The HB will engage and contribute to joint working where requested. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-21	Mar-21	Amber	In Progress
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_013	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 (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Mar-20	Red	Not Implemented
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_014	R14. In addition to recommendations 3 and 4, the Welsh Government, Health Education and Improvement Wales and local health boards need to offer students an incentive to stay and study in Wales, and also to attract those who have trained outside Wales to return to Wales to work having qualified as primary care workers.	(RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-21	Mar-21	Amber	In Progress
No ref	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language	Improvement Plan	Director of Workforce & OD	Director of Workforce & OD	PCTWL_015	R15. All of the recommendations in this report should be considered as part of the development of a workforce strategy for the health service in Wales in order to develop a bilingual health service.	HB Director of Workforce & OD will work with WG and HEIW and contribute to any All Wales Workforce Strategy. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-21	Mar-21	Amber	In Progress