Bundle Audit & Risk Assurance Committee 23 June 2020

6.3 Audit Tracker

Presenter: Joanne Wilson

SBAR Audit Tracker ARAC June 2020

Appendix 1 - High Priority Recommendations

Appendix 2 - Other Recommendations

Appendix 3 - Reports Opened & Closed Since February 2020

Appendix 4 - Reports with Recommendations that have Exceeded Original Completion Date

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	UHB Central Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Rachel Williams, Assurance and Risk Administrator Claire Bird, Assurance and Risk Officer Charlotte Beare, Head of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit and Risk Assurance Committee (ARAC) with progress of the work agreed by the Board in April 2020 in respect of the implementation of high priority recommendations from audits and inspections during COVID-19, and also provide an update of the review and assessment of all other recommendations as to whether they can be implemented within timescales as previously outlined.

Cefndir / Background

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

All reports from audits, reviews and inspections carried out across the UHB are logged onto the UHB central tracker and progress on implementing recommendations was collated from services on a quarterly basis in preparation for the Executive Performance Reviews (EPRs) (these have been suspended since March 2020 to allow services to respond to COVID-19 and there are no plans at present to resume these).

Asesiad / Assessment

Management of outstanding recommendations during COVID-19

Following agreement at the Board on 16 April 2020 that governance was as important in times of national crisis, a directive was sent to Executive Directors (Corporate functions) and General Managers (Operations Directorates) to ask that all outstanding recommendations are reviewed and assessed as to whether they can be implemented within planned timescales taking into account the current and ongoing impact of COVID-19.

The assurance and risk team contacted services directly for updates, and for recommendations that would not be implemented by the original date, services were asked to provide clear

reasoning for the delay, an explanation of how the risk would be managed in the interim, and a provisional timescale.

The Board also agreed that the following recommendations must be progressed, as a minimum, as planned or in line with revised timescales:

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

The table below sets out a summary of the current status of the high priority recommendations outlined above since the Board in April 2020. Appendix 1 provides an individual breakdown of each high priority recommendation.

External Body	**No. of recs deemed still to be implemented by original timescales, or new date agreed by regulator**	**Update summary**
HIW Immediate Assurance	3 Immediate improvement recommendations (6 recommendations reported to ARAC April 2020, 3 of which have since been implemented)	2 of the 3 immediate improvement recommendations have gone beyond their original timescales. These recommendations relate to the update of the Venous Thromboembolism (VTE) policy and Disclosure and Barring Service (DBS) certificates. Further details can be found in Appendix 1.
HSE	22 recommendations from 8 improvement notices (including the 13 material breaches) (28 recommendations reported to ARAC April 2020, 6 of which have since been implemented)	8 of the 28 recommendations have revised timescales that pass the compliance date of 31/07/20, or have timescales of 'ongoing'. The assurance and risk team have requested clarification of timescales against all actions and are awaiting confirmation of any correspondence from HSE that confirms their agreement to the revised timescales. Further details can be found in Appendix 1. These will be discussed and reviewed by the Health and Safety Assurance Committee on 22 June 2020.
MWWFRS	32 items (12 items reported to ARAC April 2020, this was in error and should have been reported as 25. Since the 25 items in April 2020: • New Enforcement notice for St Caradogs (KS/890/05) supersedes previous notice (EN/262/08) resulting in a decrease of 4 items against the new notice.	Clarity is being sought from the service on which items have been fully implemented and timescales of those currently outstanding. This information has not been clear from the Fire Enforcement Programmes shared with the assurance and risk team by the service. Further details can be found in Appendix 1. The service is currently in discussion with the MWWFRS regarding appropriate timescale extensions in light of COVID-19, however nothing official has been received and therefore the timescales from the current Enforcement Notices/ Letters of Fire Safety

	• 2 items implemented from Letter of Fire Safety Matter, WGH, January 2020. • New enforcement notice for GGH, April 2020, which includes 13 out of 14 items still to be implemented.	Matters still remain on the audit tracker. Once official correspondence is received from MWWFRS these timescales will be amended on the audit tracker to reflect the new position.
Audit Wales (AW) and Internal Audit (IA)	All 'high' priority recommendations AW – 12 (18 'high' priority recommendations reported to ARAC April 2020, 5 of which have since been implemented). IA - 33 (27 'high' priority recommendations reported to ARAC April 2020. A high volume of IA activity has taken place since April 2020, including a number of IA reports closed, and new reports opened).	11 of the 12 AW recommendations are behind schedule or no update has been received by the services (red RAG status). Of these 11, 7 already had red RAG status at the last ARAC in April 2020. 14 of the 33 IA recommendations are behind schedule or no update has been received by the service (red RAG status). Of these 14, 13 were already red RAG status at the last ARAC in April 2020. Further details can be found in Appendix 1.

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

To provide the Committee with a status report, as agreed by the Board in April 2020, the assurance and risk team has contacted all services over a 5 week period to obtain updates. Whilst there has been good engagement with services, it has been challenging to obtain revised timescales for all recommendations. There are 45 recommendations that do not have revised timescales. This may be due to the service not providing a clear enough response, which is currently being followed up, staffing pressures from responding to COVID-19 or staff have been redeployed, or due to COVID-19 the service may not be in a position to provide a revised timescale at this point in time. The unpredictability of the pandemic makes it difficult to predict when some services will resume and the UHB is following a quarterly planning process directed by Welsh Government which directs which services will resume and when.

There has been no response from services in the following areas, this has resulted in 13 recommendations having no update provided on the audit tracker. For those that have not responded these will be escalated to the Executive Director of Operations as appropriate.

The assurance and risk team will continue to engage with these services to obtain updates/ clarify timescales as these become known. The assurance and risk team will also work with services over the coming months to establish how risks relating to delayed recommendations will be managed in the interim and ensuring these are added onto the Datix risk module (as appropriate).

UHB Central Tracker
The audit tracker paper reported to ARAC in April 2020 advised how the outstanding recommendations from auditors, inspectorates and regulators should be managed by the Health Board during the Covid-19 pandemic and did not provide an update of activity.

Since February 2020, a further 20 reports have been closed or superseded, with 36 new reports received by the UHB. These are listed in Appendix 3.

As of 9 June 2020, there are 116 reports currently open, 77 of which have recommendations that have exceeded their original completion date (see Appendix 4 for the list of reports). The number of recommendations where the original implementation date has passed has increased from 136 to 182. Of the 182 recommendations that are overdue, 77 have gone beyond six months of the original completion date.

Of the 182 overdue recommendations 7 have been highlighted on the tracker as an 'external recommendation' whereby the recommendation is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

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

	No of reports open at ARAC Feb-20	**No of reports received since ARAC Feb-20**	**No of reports closed since ARAC Feb-20**	**No of reports open at ARAC Jun-20**	**No of reports that have passed their original implement-ation date**	**No of red recommend-dations i.e., Original implementat-ion date has passed or will not be met**	**No of red recommend-ations beyond 6 months of original completion date**
AW	12	3	0	15	13	29	20
CHC	8	2	4	6	5	11	5
CHC / HIW Contractors	6	2	2	6	4	9	0
Coroner Reg 28	1	0	0	1	0	0	0
DU	6	0	0	6	6	15	9
HEIW	0	0	0	0	0	0	0
HSE	8	0	0	8	0	4	0
HIW (Acute & Community)	8	3	1	10	9	16	5
HIW (MH&LD)	6	1	1	6	6	19	13
IA	30	12	8	34	21	44	18
MWWFRS	6	5	3	8	4	9	0
Peer Reviews	3	0	0	3	3	11	2
PSOW - S16	0	0	0	0	0	0	0
PSOW - S21	5	6	1	10	3	4	0
Royal Colleges	0	0	0	0	0	0	0
Other	0	1	0	1	1	6	0
WLC	1	1	0	2	2	5	5
TOTAL	**100**	**36**	**20**	**116**	**77**	**182**	**77**

Plan of Work

The assurance and risk team will:

- Escalate non-responses to relevant Executive Director.
- In the absence of the EPRs, implement a rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Committee.
- Work with services to establish how risks relating to delayed recommendations will be managed in the interim and ensuring these are added onto the Datix risk module (as appropriate).

Argymhelliad / Recommendation

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

- Executive Directors and lead Officers understand that there is still the expectation that outstanding recommendations from auditors, inspectorates and regulators should continue to be implemented during COVID-19, to ensure services are safe and the risk of harm to patients and staff is managed and minimised
- The progress made on the implementation of high priority recommendations from audits and inspections, in line the agreed timescales.
- The review and assessment of all other recommendations as to whether they can be implemented within timescales as planned.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
Gweithlu: **Workforce:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: **Risk:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and identified risks are not being managed.
Cyfreithiol: **Legal:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.

Enw Da: **Reputational:**	As above.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	No direct impacts from this report

Appendix 1: high priority recommendations

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress update
19102	Aug-19	HIW	Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Open	N/A	Community & Primary Care (Pembrokeshire)	Sonia Hay / Ceri Griffith	Director of Operations	19102I1_001	High	R7. The health board policy for the management and prevention of VTE finalised and disseminated to all appropriate staff.	The Health Board VTE policy will be disseminated once approved by MMSC, to be completed and distributed to all appropriate staff.	Sep-19	N/K	Red	The HB is to adopt the All Wales policy once this has been approved at the All Wales level., delays due to Covid 19. An All Wales meeting is planned June 16th.
19097	Feb-20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Open (COVID-19)	N/A	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	19097IA_004	High	R4. The Health Board is required to provide HIW with details of the action it will take to ensure that: Fire doors are fitted to the entrance of ward 7 in line with the requirements of the Enforcement notice issued by the Mid and West Wales Fire and Rescue Service to ensure the Health Board adequately protects patients, staff and the general public in the event of fire. We were informed that the doors to the entrance of ward 7 were not fire doors. An Enforcement Notice was issued by the Mid and West Wales Fire and Rescue Service requiring action to fit fire doors by the 30th November 2019. We were informed the doors were due to be replaced in September 2020 at the earliest as part of phase 2 of improvement work.	The Health Board has a fully structured plan for fire safety at WGH developed in response to the Mid and West Wales Fire and Rescue Service Enforcement Notice (MWWFRS). The plan presented to MWWFRS is a staged approach allowing us to undertake advance works very promptly with the substantive element of work progressed via a Business Case process. Within this plan all fire requirements to escape routes identified within the above Enforcement Notice will be undertaken at WGH between May 2020 and August of 2021. This programme is currently being considered by the MWWFRS and we are awaiting further clarity from them on the agreed timelines on this work. The Welsh Government are also fully engaged in this process and are supportive of the approach being taken by the Health Board. This work will include doors at the entrance to Ward 7 and any other Fire Doors necessary within the escape routes in this Hospital. The MWWFRS have recommended that the remaining works within Wards and Departments will be undertaken as a second stage to the above.	Aug-21	Aug-21	Amber	
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Director MH&LD	Director of Operations	19106IA001	High	During the inspection, we found that three members of staff employed by the health board, and working at the Brynmair Clinic, did not have a current Disclosure and Barring Service (DBS) certificates in place. This meant that we could not be assured that the staff members were suitable to work with vulnerable adults .We consider the above practice to be unsafe and increases the risk of harm to patients. Improvement needed The Health board must ensure all staff (where applicable), have DBS checks completed with a record of completion kept on file.	With advice and input from the central Resourcing Team, to undertake an audit of the DBS status of all staff within the MH&LD Directorate	Jan-20	Jul-20	Red	Delayed to Covid-19. Work is being undertaken by New Manager and awaiting a response
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_Primary Care_001	High	R3a. Calculate a baseline position for its current investment and resource use in primary and community care.	The Health Board need to set the baseline for expenditure in primary and community care based on the information used to produce its audited annual accounts. A plan for implementation of the baseline needs to be compiled and implemented to reflect services at 31st March 2019. Changes will then be measured relative to this baseline annually.	Apr-19	N/K	Red	Assurance and Risk Officer requested update from Finance Senior Business Partner on behalf of reporting officer. No update received.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_Primary Care_002	High	R3b. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.	The shift of resources into primary and community care can be monitored on an annual basis using the information that forms the basis of the Health Board's audited accounts. The shift of resources needs to be measured in accordance with the national paper dealing with the transfer of services and resources to primary care.	Apr-19	May-20	Red	Assurance and Risk Officer requested update from Finance Senior Business Partner on behalf of reporting officer. No update received.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_Primary Care_003	High	R5b. Revisit its primary care workforce plans to ensure they take account of the issues arising from the Transforming Clinical Services programme.	Work is ongoing to understand the current staffing within primary care across the contractor professions to ensure that the Primary Care Model for Wales is implemented.	Oct-19	N/K	Red	Response from Director of Primary Care, Community and Long Term Care- it should ultimately align to our strategy and what we want to see from Practices in that context. However where it becomes challenging is that whether or not we were linking nationally or locally, we still need to access the data and the only way in which we can get the accurate workforce data is through the national reporting tool which will then allow us to align our plans with our local Strategy. No revised timescale provided.
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_Primary Care_004	High	R7b. Subject to positive evaluation, begin to fund new models from mainstream funding rather than the Primary Care Development Fund.	To be considered in line with the Primary Care Model for Wales, the IMTP and the shift of funding within the system to support service change and remodelling.	Oct-19	N/K	Red	No update provided
946A2018-19	Nov-18	Audit Wales	Primary care services at Hywel Dda	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Director of Primary, Community and Long Term Care	WAO_Primary Care_005	High	R7c. Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments.	Public engagement plan regarding access to all primary care services to be developed and implemented.	Oct-19	N/K	Red	No update provided
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Quality & Safety	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual001	High	R1. To improve consistency, the Health Board should introduce a standardised approach to the quality and safety arrangements within the operational directorates. The standardisation should apply to structures, core membership, frequency of meetings and core agenda items for discussion. The county director arrangements must include consideration of primary care quality and safety matters.	Options for standardising the approach to quality and safety arrangements have been agreed. This includes templates for terms of reference, agendas for meetings and standardised reporting. Templates will be developed in collaboration with the Corporate Governance Team. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. Quality and safety matters are included in the county directors meetings and this will be monitored.	Apr-20	Sep-20	Red	Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements to ensure agreed core agenda items are discussed. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Monthly focused QSEAC meetings have been scheduled during the COVID-19 pandemic to deal with urgent Q&S issues/risks. As a result OQSESC meetings are temporarily on hold to reduce the burden on operational staff dealing with the pandemic. This will be monitored through the standardised reporting arrangements put in place.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress update
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Quality & Safety	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual003	High	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. 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. 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. 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	R3a. 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. R3b. 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). R3c. Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports. Operational Quality, Experience Sub-Committee (OQSEC) will be the overarching sub-committee for operational quality and safety issues, both specialist, primary and acute services, with cross-organisational groups reporting to OQSEC. R3d. Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1).	Apr-20	Sep-20	Red	R3a.1 - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements, including the Mental Health & Learning Disabilities Directorate. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. R3b –Monthly focused QSEAC meetings have been scheduled during the COVID-19 pandemic to deal with urgent Q&S issues/risks. As a result OQSESC meetings are temporarily on hold to reduce the burden on operational staff dealing with the pandemic. Once these meetings are re-instated, the MHLD Directorate will report directly into OQSESC and work will be undertaken to strengthen and standardise the reporting arrangements to include standard agendas, terms of reference, etc. R3c - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements to ensure all directorate level governance committees report in a standardised way to OQSESC. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. R3d - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Standardised reporting templates will be introduced for all Directorates to submit to the Operational QSESC, with a summarised version submitted to QSEAC. Revised timescales of Sept 2020 provided.
xx2019-20	Jun-19	Audit Wales	Review of operational quality and safety arrangements	Open	N/A	Quality & Safety	Sian Passey	Director of Operations/ Director of Nursing, Quality & Patient Experience	WAO_ReviewofQual004	High	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	Sep-20	Red	R4.1 - Templates for terms of reference and agendas for meetings are in place, however these are not standardised across operational directorates quality and safety arrangements in order to consider risks and learning from these. Standard reporting templates are under development however this has been put on hold due to the current COVID-19 pandemic. Risks and learning will be embedded into standardised reporting templates to advise on how learning from risks and action plans are being shared across Directorates and other areas. In the meantime, monthly focused QSEAC meetings have been scheduled during the pandemic to deal with urgent Q&S issues/risks. As a result OQSESC meetings are temporarily on hold with risks and issues being reported directly to the OQSESC Chair.
1033A2019-20	Jan-19	Audit Wales	Structured Assessment 2018	Open	N/A	Governance	Board Secretary	Board Secretary	WAO_SA_2018_003	High	R3a. Recommendation - Operational meetings To free up capacity for both executive and operational teams, and to enable a more joined up focus on the use of resources, the Health Board should streamline the number of holding to account (HTA) or performance review meetings with operational teams by: (a) reviewing the frequency and timing of these meetings;	Ensure the Holding To Account (HTA) meetings merge with the Executive Team Performance Reviews (ETPR) from April 2020 as this will reduce the burden on service leads and will make it more feasible for medical leads to attend (see R3c below for further details). Consideration to be given to the scheduling of the new meetings. ETPR meetings are currently held on Wednesday mornings to protect Wednesdays as a corporate day, with Executive Team meetings scheduled on Wednesday afternoons. However, Clinical Directors have since advised their attendance at the ETPRs will be increased if the reviews are scheduled for Thursday mornings to coincide with their protected time for managerial meetings (see R3c below). The Executive to continue to have ongoing discussions relating to performance management arrangements as part of the Board governance review and review of managerial arrangements in the Operations Directorate. A new Performance Management Assurance Framework will be presented to Board for approval on 26th March 2020. A schedule and agenda outline will be developed for the new combined meetings by 31st March 2020. The Principal Project Manager for Turnaround and the Performance Manager will lead on developing the new performance review schedule and agenda.	Jun-19	~~Apr-20~~ N/K	Red	• On 17 February 2020, the CEO led a workshop with Executive Team members/nominated deputies and presented a proposed new operating model for 2020/21. The new model was structured around our three year plan actions, organisational risks and performance management. The new model looked to merge HTA and EPR meetings into the same process to reduce the burden on service leads. Executive Directors would be given greater responsibility for performance management within their directorate. Service areas would only be seen by the CEO twice a year (ahead of JET meetings) or if a performance trigger was met. Following the workshop, work began on scoping performance triggers and what groups were already in place and new ones needed to oversee the key elements of the new operating model i.e. plan actions, risks and performance management. • In early March the scoping work for the new operating model was put on hold to allow staff time to prepare for and manage the COVID pandemic. • Alongside this, the EPR meetings were also stood down to give staff more time to focus on COVID related tasks. At present, there are no plans to resume the EPR meetings. • A new Transformation Steering Group has been established, with the first meeting held on 8 June 2020. This group will refresh our thinking and determine what our priorities will now be for the new operating model, in light of COVID.
1033A2019-20	Jan-19	Audit Wales	Structured Assessment 2018	Open	N/A	Governance	Board Secretary	Board Secretary	WAO_SA_2018_003	High	R3c. Recommendation - Operational meetings To free up capacity for both executive and operational teams, and to enable a more joined up focus on the use of resources, the Health Board should streamline the number of holding to account (HTA) or performance review meetings with operational teams by: (c) aligning these meetings with management sessions contained within job plans for clinical directors to enable them to participate fully.	The Deputy Medical Director for Acute Hospital Services is now in post and has been working to fill vacancies within the clinical leadership structure, which will help to strengthen medical representation at operational meetings. The Deputy Medical Director for Acute Hospital Services will communicate the need for job plans for those clinicians holding managerial and leadership positions to be robust and for protected time to be allocated to enable clinical director engagement with relevant executive and operational meetings. The job plans of clinical leads need to ensure that leadership responsibilities can be managed and prioritised accordingly. Details of meetings requiring attendance need to be regular and consistent with sufficient advance communication to be provided of any changes to meeting arrangements (at least 6 weeks if the change results in a clash with clinical commitments) to enable clinicians/medical leads to attend without the risk of any disruption to service provision.	Sep-20	~~Apr-20~~ Dec-20	Red	The review of all job plans in the current and post-CV19 period is being agreed with Clinical Leads/Hospital Directors. The allocation of time to allow Clinical Directors and Senior leaders to attend management meetings (including ETPR's) will be included within this process.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress update
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Board Secretary	Board Secretary	WAO_SA_2019_002	High	R2. We found that the Executive Performance Reviews (EPRs) do not apply to corporate directorates, with the exception of Estates. The Health Board should apply EPRs to corporate directorates not already covered within the process.	The Health Board agrees corporate directorates should also be included in the EPRs. The Executive continue to have discussions relating to performance management arrangements as part of the Board governance review and review of managerial arrangements in the Operations Directorate. A new Performance Management Assurance Framework will be presented to Board for approval on 26th March 2020, this will include the merger of the existing EPRs and Holding To Account meetings as well as the inclusion of corporate teams in the performance review process. A schedule and agenda outline will be developed for the new meetings by 31st March 2020. The Principal Project Manager for Turnaround and the Performance Manager will lead on developing the new performance review schedule and agenda.	Apr-20	N/K	Red	• On 17 February 2020 the CEO led a workshop with Executive Team members / nominated deputies and presented a proposed new operating model for 2020/21. The new model was structured around our three year plan actions, organisational risks and performance management. The model was health board wide i.e. included corporate directorates. Following the workshop, work began on scoping performance triggers plus what groups were already in place and what new groups were needed to oversee the key elements of the new operating model i.e. plan actions, risks and performance management. • In early March the scoping work for the new operating model was put on hold to allow staff time to prepare for and manage the COVID pandemic. Alongside this, the EPR meetings were also stood down to give staff more time to focus on COVID related tasks. At present there are no plans to resume the EPR meetings. A new Transformation Steering Group has been established, with the first meeting scheduled for 8 June 2020. This group will refresh our thinking and determine what our priorities will now be for the new operating model, in light of COVID.
1661A2019-20	Dec-19	Audit Wales	Structured Assessment 2019	Open	N/A	Governance	Board Secretary	Board Secretary	WAO_SA_2019_003	High	R3. We found that there is scope to empower the wider workforce to contribute to the transformational change agenda. The Health Board should implement practical solutions to engage the wider workforce in the change programme, for example by identifying change champions within individual services.	• Through the appointment of the clinical team within the TPO there is a focused direction of reaching the workforce to become engaged in delivering the Strategy. Leads are attending meetings within service areas to increase awareness, understanding and help staff to become involved. • 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	Jul-20	Jul-20	Amber	No update received.
JHET/HD/04102019/01	04/10/2019	Health and Safety Executive	Improvement notice - Violence and Aggression 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/01_001	High	R1. Establish a management system to monitor and review the implementation of your Violence and Aggression Policy number 285. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	Outstanding action- Further improvements are being made to the Datix recording system in terms of V&A, with a Case Management module currently being developed.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track to be completed by June 2020.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experiencens	JHET/HD/04102019/02_001	High	R1. Establish a management system to monitor and review the implementation of your Manual Handling Policy number 273. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	Critically review the Manual Handling Policy to ensure that it is fit for purpose. Request assistance of General Managers in achieving aims. Increase moving and handling risk assessments where required. Introduction of new Moving & Handling risk assessment paperwork to standardise nursing documentation across Wales. Link to Incident Investigation Control Group.	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sough from the reporting officer.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_002	High	R2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sough from the reporting officer.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_003	High	R3. 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.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sough from the reporting officer.

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JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/02_004	High	R4. Identify how the findings from monitoring, auditing and review will be considered and consulted on, and responsibilities allocated to ensure that suitable and timely action is taken and completed.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sough from the reporting officer.
JHET/HD/04102019/02	04/10/2019	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/02_005	High	R5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sough from the reporting officer.
JHET/HD/04102019/03	04/10/2019	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/03_001	High	R1. In consultation with employees or their representatives, and with the assistance of a competent person, assess the risk from violence and aggression in the Accident and Emergency Department. In order to be suitable and sufficient the risk assessment should include consideration of the following: a. Information on the number and nature of recent previous incidents and near misses, and learning from these. b. The physical layout and design of the department, and how it is currently used at different times of day and night. c. Different groups who may be harmed e.g. agency staff, porters, students, visitors. d. Alarm systems and the response to these e. Sharing of risk information between agencies and between employees, e.g. patient history f. Lone working or isolation within the department g. Information, instruction and training for employees h. Communication with patients and relatives	Various actions notes under this recommendation.	~~May-20~~ Jul-20	Jan-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer. One action under 'Consideration of g). Information, instruction and training for employees' has a timescale of 2021. Clarity is being sought from the reporting officer if this revised timescale has been agreed with the HSE.
JHET/HD/04102019/03	04/10/2019	Health and Safety Executive	Improvement notice - Accident and Emergency Department, Withybush Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/03_002	High	AND R2. Identify and prioritise the measures you need to take as a result of the risk assessment in order to comply with health and safety law.	Various actions notes under this recommendation.	~~May-20~~ Jul-20	Jan-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer is unclear if this recommendation will be implemented by July 2020, or if the HSE have agreed to an extension to January 2021. Clarity is being sought from the reporting officer.
JHET/HD/04102019/04	04/10/2019	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/04_001	High	R1. In consultation with employees or their representatives, and with the assistance of a competent person, assess the risk to employees of musculoskeletal disorders from moving and handling health records. In order to be suitable and sufficient the risk assessment should be done using the MAC, ART and RAPP tools or other similar relevant risk assessment systems. The assessment of each task should include but may not be limited to: a. Weight and size of notes, boxes, crates and trolleys b. The number of times employees have to pick up, carry, push or pull c. The route and distance they are carrying or moving it, including steps, ladders, floor surfaces etc d. Where they are picking it up from or putting it down (e.g. emptying the bottom of a trolley, putting it on a shelf above shoulder level) e. Any twisting, bending, stretching or other awkward postures	Risk assessments have commenced on all moving and handling activities involving health records. A company was engaged to monitor push/pull force for manual trolleys and link to Health & Safety limits for the NHS. It was discovered that it was more to do with how the trolleys were handled rather than the weight so training was identified as more the issue. However if the trolleys were to be powered then the issue would be eliminated	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
JHET/HD/04102019/04	04/10/2019	Health and Safety Executive	Improvement notice - Withybush Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/04_002	High	AND R2. Identify and prioritise the measures you need to take as a result of the risk assessment in order to reduce the risk and comply with health and safety law, for example by making changes to the task, the load, providing suitable equipment and changing the working environment	Various actions notes under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experiences	JHET/HD/041020 19/05_001	High	R1. With the assistance of a competent person assess all risks that involve manual handling of loads with the Laundry at Glangwili Hospital.	Main issues identified by the report and the M&H Team were the weight of the load on the cages / trolleys and the impaired vision caused by overloading. Risk assessments have commenced for key moving and handling tasks. A company was engaged to monitor push/pull force for manual trolleys and link to Health & Safety limits for the NHS.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/05_002	High	From the findings of your assessment; R2. Consider avoiding hazardous manual handling operations 'so far as is reasonably practicable', by redesigning the tasks to avoid moving the load or by automating or mechanising the process and produce a timetabled schedule for implementation of the chosen automated / mechanised process.	Various actions noted under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/05_003	High	R3. Where mechanical assistance is not reasonably practicable to achieve then initiate changes to the tasks, the load and the working environment and produce a timetabled schedule for implementation of the identified control measures.	Various actions noted under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/05	04/10/2019	Health and Safety Executive	Improvement notice - Laundry at Glangwili Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/05_004	High	R4. When looking at an individual operation, consider in turn the task, the load, the working environment and individual capability as well as other factors and the relationship between them. Try to fit the operations to the individual, rather than the other way round. OR Implement any other equally effective measures to comply with the said contravention.	Various actions noted under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/041020 19/06_002	High	R2. Having reviewed your arrangements, develop an effective system for investigating incidents to determine their immediate and underlying causes to ensure lessons are learnt. This system should enable the identification of any necessary remedial action and its implementation.	Various actions noted under this measure.	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sought from the reporting officer.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress update
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_003	High	R3. Design the system to effectively capture the accurate recording of incident details including the clear setting out of responsibilities for those expected to use this system.	Various actions noted under this measure.	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sought from the reporting officer.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_004	High	R4. Determine how the system will be monitored by senior managers to ensure that follow-up action is carried out, and how it will be audited and reviewed.	Various actions noted under this measure.	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sought from the reporting officer.
LPJ/HD/04102019/06	04/10/2019	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_005	High	R5. Implement a programme for making available the relevant information, instruction and training to those required to investigate and record incidents. OR Implement any other equally effective measures to remedy the said contravention.	Various actions noted under this measure.	~~May-20~~ Jul-20	Ongoing	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Update provided by reporting officer but recommendation is stated as 'ongoing'. Clarity on timescale is being sought from the reporting officer.
LPJ/HD/04102019/07	04/10/2019	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/07_002	High	R2. Where such manual handling operations cannot be avoided you should in consultation with the Health Board's health & safety competent persons, and with their employee representatives, assess the risks and identify additional controls for all manual handling activities in theatres: You should take into consideration the following: a) Identifying all of those activities which pose a risk to employees' health and are not included in the All Wales Manual Handling Passport including: static support of patients' limbs, moving and handling patients into the prone position, repositioning patients during surgery. b) Developing systems to carry out suitable and sufficient risk assessments c) Identifying changes in processes to avoid manual handling or additional controls to reduce the risk to employees' health. d) Providing suitable and sufficient information, instruction and training to those who will be carrying out the patient handling e) Providing suitable and sufficient information, instruction and training to those who will be carrying out inanimate load risk assessments including wheeled operations. f) Developing a system to communicate the findings of the assessments and controls identified to eliminate or reduce the risk.	Various actions noted under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/07	04/10/2019	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/07_003	High	R3. From the findings of your assessment provide a timetabled programme for implementing the necessary controls identified to reduce the risk of injury so far as is reasonably practicable. OR R4. Implement any other equally effective measures to remedy the said contraventions.	Various actions noted under this measure.	~~May-20~~ Jul-20	Jul-20	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. On track for July 2020.
LPJ/HD/04102019/08	04/10/2019	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries)	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_001	High	EITHER R1. Implement an effective management system to ensure all incidents where employees and others (such as Agency staff) have suffered an injury from a medical sharp are fully recorded and investigated. This system should also be used to manage any remedial actions required to ensure ongoing risks are mitigated.	Action plan not shared with Assurance and Risk Officer.	~~May-20~~ Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Action plan from reporting officer shows recommendation will not be implemented by April 2021. Clarification being sought from reporting officer if this has been officially agreed with the HSE.
LPJ/HD/04102019/08	04/10/2019	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries)	Open	N/A	Health and Safety	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_002	High	AND R2. Implement a suitable follow up monitoring system for managing employees and others (e.g. Agency workers) post injury (caused by a medical sharp) that exposed, or may have exposed, the person to a biological agent, to ensure they receive appropriate medical advice, treatment and counselling. OR Implement any other equally effective measures to remedy the said contraventions.	Action plan not shared with Assurance and Risk Officer.	~~May-20~~ Jul-20	Apr-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Action plan from reporting officer shows recommendation will not be implemented by April 2021. Clarification being sought from reporting officer if this has been officially agreed with the HSE.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_001	High	R1. Bronglais General Hospital Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are considered for inclusion on the directorate registers.	We are also undertaking a review to ascertain if any other corporate or Scheduled Care risks exist which relate to BGH theatres which should be admitted and referenced to a generic theatres risk on the BGH Directorate Risk Register (but will remain the property of the Scheduled Care Directorate).	Feb-20	Feb-20	Red	No update received in May 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_002	High	R2. Department managers and leads should ensure that the management of all periods of sickness complies with the NHS Wales Managing Attendance at Work Policy.	The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including sickness management.	Mar-20	Mar-20	Red	No update received in May 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_003	High	R3. Bronglais General Hospital Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy; and all employees on the Ystwyth Stroke Ward receive an annual personal development appraisal review that should be documented and retained on file.	The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including PADRs. BGH also has three inexperienced development Band 7 Ward Managers who are receiving support and are also cohorted on to the STAR leadership programme to aid in the development of their management skills.	Mar-20	Mar-20	Red	No update received in May 2020.

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HDUHB 1920-20	Feb-20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Paul Solloway/ Anthony Tracey	Director of Planning, Performance & Commissioning	HDUHB 1920-20_002	High	The Health Board ICT department should formally define the cyber security tasks that cannot be undertaken within the current resource envelope and the associated risks. This should be reported through the organisational governance structure so that a decision on risks and priorities can be made.	Management response to be agreed at ARAC June 2020: Agreed In conjunction with Recommendation 1, a more detailed assessment of the gaps / tasks from the Stratia report action plan will be undertaken by the Band 6 Cyber Security once they are in post. It is envisaged that the Stratia report action plan will be fully implemented by March 2021, providing the post holder will be in place by September 2020. In the meantime the UHB are still undertaking all the necessary patching on the Desktops / Laptops and Server Infrastructure as previously agreed, as well as prioritising the removal of legacy equipment and systems to further reduce our exposure to cyber-attacks. The majority of the remaining actions from the Stratia report relate to the need to implement the nationally available products which will be undertaken by the Band 6 Cyber Security once in post. These products will allow at a national and local view to investigate any specific issues that arise from a cyber-attack. A cyber security risk is already included Corporate Risk Register (Risk Ref. 451). This risk is reviewed on a monthly basis and any additional mitigations or actions are updated accordingly. As revised and new risks	Mar-21	Mar-21	Amber	ARAC has requested that the management response be revisited/updated to provide further detail on whether plans are in place to address the audit findings. Revised management response to be reported to ARAC in June 2020.
HDUHB-1920-25	Oct-19	Internal Audit - HDUHB	Estates Directorate Governance Review	Open	Limited	Estates	Rob Elliott	Director of Operations	HDUHB-1920-25_004	High	R4: Estates Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are included on the directorate registers.	A full review is underway of all Directorate, Corporate and Service Risks within the FM team. It is planned to do this review in line with the agreed work plan by the end of Jan 2020. We intend to work closely with the Governance Team and Internal Audit within this review to ensure clarity on the recommendation.	Jan-20	Oct-20	Red	27/05/2020- Follow up report HDUHB-1920-39 shows this recommendation as only partially addressed; 'We noted the positive steps taken by the directorate to address the original finding, whilst acknowledging that continued actions are needed to be undertaken to ensure the risk register allows for the effective and robust management of risks'. Recommendation changed back to red on the audit tracker, to be confirmed when final report is agreed by ARAC. Recommendation being tracked by this original report.
HDUHB-1920-25	Oct-19	Internal Audit - HDUHB	Estates Directorate Governance Review	Open	Limited	Estates	Rob Elliott	Director of Operations	HDUHB-1920-25_005	High	R7: Estate Directorate Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy.	Agreed. The FM team have made substantial efforts in delivering a formal PADR process to significant staff numbers (circa 86% of staff). This has been well received by the staff involved and acknowledged internally by members of the Executive team. A review will be needed to ensure the PADR process is consistently applied across all staff. We will work to identify exemplar examples within our workforce and ensure that there is learning delivered throughout our supervisory team to improve standards. This review will be undertaken on each PADR as it becomes due for each member of staff.	Oct-20	Oct-20	Amber	27/05/2020. Due to COVID-19 constraints this recommendation was not included in the HDUHB - 1920-39 follow up report, therefore this recommendation remains open on the tracker. Still on track for October 2020 as of May 2020.
HDUHB1819-27	Nov-18	Internal Audit - HDUHB	IM&T Directorate	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Director of Planning, Performance & Commissioning	HDUHB1819-27_008	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	Report to be superseded by HDUHB_1920_40 IM&T Assurance – Follow Up, still in draft as of 28/04/2020. Update June 2020- this is currently going through full OCP for Switchboards. Estimated delivery now July 2021.
HDUHB 1819-11	May-19	Internal Audit - HDUHB	Integrated Care Fund – Follow Up	Open	Reasonable	Community & Primary Care (Carmarthenshire)	Peter Skitt / Martyn Palfreman	Director of Operations	HDUHN 181-11_001	High	R2. Management must ensure that quarterly ICF reports are submitted to Welsh Government no later than the designated submission dates set out in the Written Agreement.	Late submissions of quarterly reports have been due largely to delays in receiving activity and financial data from partners. Welsh Government has been fully informed of anticipated delays and the reasons for them on all occasions. The Written Agreement will be updated by the end of June 2019 and will provide an opportunity for re-emphasising quarterly reporting deadlines in advance. Increased capacity within the Regional Collaboration Unit will be deployed to support partners in the retrieval and collation of data for inclusion in the reports.	Jul-19	N/K	Red	WG reduced the requirements in response to C-19, so only financial reporting was essential however, there was still impact across the board in terms of timely financial reporting..
HDUHB 1920-16	Jan-20	Internal Audit - HDUHB	Medical Devices	Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_001	High	R1: Management should put in place safeguards to ensure alerts and safety notices for all Health Board medical devices are fully captured.	To review current procedure for the management of safety notices and alerts and issue for consultation (Complete) To present the revised procedure to the appropriate committee for ratification (June 2020)	Jun-20	Jun-20	Amber	Revised management response to be reported to ARAC June 2020.
HDUHB 1920-16	Jan-20	Internal Audit - HDUHB	Medical Devices	Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_002	High	R2: Management should review the current approach to medical devices training for clinical and nursing staff to ensure: ▪ all training is coordinated through a central point; ▪ training provided by external parties can be quality assessed; and ▪ training records can be accurately maintained.	Undertake mapping exercise to prioritise the training in accordance to high medium and low risk devices. (complete) To map the high risk devices across acute and community areas to identify which devices are used in each area and the number of staff in each area that will require training. (August 2020). To complete training needs analysis. The training needs analysis when completed will identify the initial training resource to deliver training on the high risk devices. (October 2020) Business case to be prepared for training resources. (November 2020). To transfer historical medical devices training records on to ESR (Temporary administrative support has been provided to start the	Nov-20	Nov-20	Amber	Revised management response to be reported to ARAC June 2020.

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HDUHB-1718-34	Feb-18	Internal Audit - HDUHB	National Standards for Cleaning in NHS Wales	Open (external rec)	Reasonable	Estates	Rob Elliott	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.	inspecting C4C Audits across the Health Board in order to ensure that consistency is appropriately applied. Due to the imminent release of the new MICAD System and C4C upgrade along with the revised National Cleaning Standards for Wales 2009, planned for April 2018, all domestic supervisors will be retrained which will present an opportunity to address any non-consistency in audits and reduce any subjectivity. It is also planned to implement rotation audits across sites and comparison made to further assure consistency by the Soft FM Compliance Manager. Careful planning will ensure Nursing and Estates staff are advised in advance of the audit times and dates to ensure they are able to attend. Supervisory cover will be allocated in the period following the audit, to ensure all relevant action plans are developed and implemented. PMS have proposed as part of the implementation programme of the new version of MICAD Software, for them to verify and amend the	Jun-18	Requesting approval to close report.	Red	As required the audit check list is amended to the current use on the Estate. Any additional elements are added so that the area is scored as if it was already on the system. The information on the existing system has been amended to reflect the functional use of areas to make more user friendly/less time consuming. Some areas have now moved priority ratings from Very High to High Risk and vice versa as the use of areas has now changed. The full remap of areas would be part of the updated system which is still pending.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_001	High	R1: Management should ensure wards maintain a Pharmacy agreed stock list of controlled drugs that are either used regularly on that ward or are required in case of an emergency.	Historically controlled drugs have not been part of the stock list controls and therefore have not routinely been included. However, it is accepted that the policy does not differentiate between CDs and non-CDs and it is good practice to have an agreed stock list for CDs for reference. In response to this recommendation: ▪ CD stock lists agreed for all wards. Reconfiguration of wards due to COVID has delayed implementation.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	Ward Sisters to provide up to date Signature lists and copies forwarded to the Pharmacy Department. Pharmacy department secretary to maintain a log of signature list received.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	A programme of Medicines Management workshops to be developed to re-enforce the procedures within the Medicines Management Policy (to be included in the medication safety days).	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002b	High	R2b: Ward managers should ensure that authorised signatories lists for drug requests are regularly reviewed and updated, and a copy submitted to the Pharmacy Department.	Issues to be discussed with ward sisters at professional meetings and scrutiny reviews	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
HDUHB-1819-29	Feb-19	Internal Audit - HDUHB	PC and Laptop Security (Follow-Up)	Open	Limited	Planning, Performance & Commissioning	Tim Harrison / Rob Elliott / Anthony Tracey	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	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	May-21	Red	This was put on hold due to COVID, but will be picked up again and progressed with estates colleagues. Estimated completion of May 2021
HDUHB 1819-32	Oct-19	Internal Audit - HDUHB	Radiology Directorate	Open	Reasonable	Radiology	Amanda Evans	Director of Operations	HDUHB1819-32-001	High	R3: A review of on-call arrangements across the Health Board sites would be beneficial in order to ensure standardised procedures to enable efficient and economic working practices and staffing arrangements. The benefits and cost savings of introducing a shift system should be considered.	On call arrangements within the Health Board are complex and historic, appearing to have evolved with demands of service and staffing levels. Furthermore the 'on call' has been seen as a recruitment incentive as it is financially lucrative and may attract new staff to the Health Board. In addition some arrangements and rotas have been in place since prior to the merger and have not been updated. It has been difficult to obtain written signed off documentation to support the current agreements but there is uniformity across the Health board in the amounts that are paid. There is in place an All Wales On Call agreement which staff have utilised to draw up the agreements. The interpretation of this agreement seems to vary from site to site in particular to the suggested 'compensatory rest'. The on call agreements have not been reviewed since this agreement was drafted in 2012. The on call arrangements review are part of the workforce IMTP of the	Apr-19	~~Aug-20~~ To be confirmed in June 2020	Red	A transformation project team has been established between the Head of Radiology, Workforce and OD and the Project Management Office (PMO) which met in February 2020 and devised a transformation project plan in relation to Radiology staffing levels including on-call arrangements. A second meeting was due to take place in March 2020 but was suspended due to COVID-19. The project plan was discussed with the executive team in the March 2020 Holding to Account meeting for Radiology where it was agreed Radiology would present new costings for improved staffing levels to the Executive Team. A model was developed and costed although due to COVID-19 this has not been presented to the Executive Team. Currently, during the pandemic, staff have been working differently to accommodate the patient flow and it is anticipated that some of the adjustments will continue when returning to what will be a new normal. The transformation project plan is currently a minimum of 3 months behind schedule. It is anticipated for a further meeting to be arranged in June 2020 to establish revised timescales against the remaining actions.
HDUHB 1819-32	Oct-19	Internal Audit - HDUHB	Radiology Directorate	Open	Reasonable	Radiology	Amanda Evans	Director of Operations	HDUHB1819-32-002	High	R8: It should be ensured that staff work on call or overtime hours in addition to their basic hours and not instead of. The full number of basic hours should be worked prior to receiving any payments for additional hours.	As per previous response, the on call arrangements are historic with the reasoning for this being the need to sustain out of hours services with the levels of staff available. However it is noted key staff are often away from the department on rest days and this is acknowledged as a significant issue with efficiency. Compensatory rest days count towards the basic hours with the current on call arrangements and as per previous response the system is to be reviewed with the task and finish group and staff consultation. Please note any staff member that works less than full time hours does not receive overtime payments until they reach normal working hours.	Apr-19	~~Aug-20~~ To be confirmed in June 2020	Red	A transformation project team has been established between the Head of Radiology, Workforce and OD and the Project Management Office (PMO) which met in February 2020 and devised a transformation project plan in relation to Radiology staffing levels including on-call arrangements. A second meeting was due to take place in March 2020 but was suspended due to COVID-19. The project plan was discussed with the executive team in the March 2020 Holding to Account meeting for Radiology where it was agreed Radiology would present new costings for improved staffing levels to the Executive Team. A model was developed and costed although due to COVID-19 this has not been presented to the Executive Team. Currently, during the pandemic, staff have been working differently to accommodate the patient flow and it is anticipated that some of the adjustments will continue when returning to what will be a new normal. The transformation project plan is currently a minimum of 3 months behind schedule. It is anticipated for a further meeting to be arranged in June 2020 to establish revised timescales against the remaining actions.

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HDUHB1819-33	Feb-19	Internal Audit - HDUHB	Records Management	Open	Limited	Health Records	Sarah Brain	Director of Planning, Performance & Commissioning	HDUHB1819-33_002	High	R2. Identified Service and Departmental Managers should ensure a Paper Health Records Inventory Form is completed, regularly reviewed and forwarded to the Head of Health Records as set out in the Health Records Management Policy.	(a) All Information Asset Owners (IAO's) have been identified via the Information Asset Owners Group which is organised by the Health Boards Information Governance Team. The IAO's have clear responsibility for completing an Information Audit Template. Some of the information requested on the template includes: • Type of information held • Where the information is held • Legal requirements and classification of the information • How is the information shared • How is the information distributed Effectively over time the information gathered will support or potentially replace the inventory form as the list will be a Health Board wide database containing all IAO's and the relevant information. The Information Governance Manager is working directly with Directorates and lead IAO's to ensure the information is completed as quickly as possible. To date approximately 50% of responses have been received and the IG Manager will continue to work with individual leads to ensure those currently outstanding are completed as soon as possible. (b) This work is being supported by the Electronic Records Group which is being led by the Deputy Director of Operations. This group is looking at	May-19	Nov-20	Red	Recommendation had previously been closed but is now re-opened after being reported to ARAC in April 2020 as outstanding with the progress below: In order to better track and monitor progress with the individual IARs and put more responsibility on the IAOs to drive this work, a template IAO Work Plan was circulated. Based on the most recent RAG update, 70% of IAOs have engaged in the process and are working towards compliance (31/44). The Information Governance Sub-Committee (IGSC) requested that the 13 IAO that have not engaged is escalated to the Executive Team. The compliance has now been included within the Executive Performance Reviews, and a number of IAOs have already begun to engage following the recent round of performance meetings A programme of in-depth refresher training is being rolled out for all IAO/IAAs to ensure they fully understand their information assets and the responsibilities that entails, including records management. This is being carried out in conjunction with ongoing work between IG and IAOs in developing a GDPR compliant Information Asset Register for each service area of responsibility. At the time of writing this update 65% of all IAO/IAAs (62/97) have undertaken the training It is anticipated that there will be a delay of 3-4 months and a revised date will be November 2020
HDUHB-1920-32	Mar-20	Internal Audit - HDUHB	Rostering	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_001	High	The required staffing skill mix should be maintained at all times. When a shift cannot be suitably filled, ward staff should ensure that senior management are fully informed as per policy.	Reinforce through senior nurse management structure the importance of maintaining the required staffing skill mix, unfilled shifts to be recorded and reported through risk assessment for regular review. Roll out of allocate E-Roster system will improve real-time visibility of skill mix, this will enable managers to intervene in a timely manner.	Jun-20	Mar-21	red	(a)Nursing Workforce Management group was temporarily stood down to support COVID 19 response however discussions about rostering and shift management have continued through the following: Senior Nurse & Midwifery Team meetings- monthly. Heads of Nursing calls with the Director of Nursing- weekly Staffing calculation work in line with COVID staffing planning (b)Discussions have taken place at an all-Wales level regarding development of the HCSM system to enable enhanced capture of any reasons for variation in rosters. It is expected that this work will commence in July 2020 and be available to implement in the UHB during 20/21. (c)A decision was taken to pause the work on the introduction of Allocate (new e-rostering system) due to the requirements for social distancing. A response is awaited from the company to confirm the approach and timescales.
HDUHB1718-35	Apr-18	Internal Audit - HDUHB	Theatres Directorate	Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_001	High	R4. The practice of claiming enhanced hours for the whole period of an on-call shift should be officially reviewed, as a matter of urgency, with appropriate personnel involved in the process. Any decision made on the future payment of enhanced provision should be made in line with the Agenda For Change On-Call Agreement. The decision should be fully documented and appropriately approved for 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	The recommendations cannot be addressed until grievance process is complete
HDUHB-1920-38	May-20	Internal Audit - HDUHB	Review of PADR Process (Follow Up)	Open	Reasonable	Workforce & OD	TBC	Director of Workforce & OD	HDUHB-1020-38_001	High	R1. Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy. Personal Appraisal Development Review - Follow Up Comments A review of personal appraisal development reviews (PADRs) undertaken since June 2019 were tested within six departments (three new departments and three revisited departments) to ensure the quality of reviews complied with the SMART principles set out in the PADR Policy. Concluding our review of the revisited departments, we noted the positive impact of objectives meeting the SMART principles since the introduction of the new PADR form – see Table A for breakdown. Whilst noting the improvement in the quality of PADRs within the revisited departments, instances of objectives not meeting the SMART principles (explicitly the Specific, Measureable and Timely principles) were evident in a sample of PADR forms tested within three new departments.	Management response from original report: Following receipt of this audit, the Director of Workforce and OD has reviewed and inspected all 56 PADRs audited as part of this review. In response, the Organisational Development team has already begun to review the PADR Policy, process and training provision. Specifically the layout of the documentation will be reviewed as reflecting on the audit findings the layout is not conducive to the recording of SMART objectives as per the Policy. Having reviewed all PADRs 89% are of very good quality with a high level of detail around objectives however to comply with the policy they must be documented differently.	Nov-19	No timescales included in follow up report.	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales.
HDUHB-1920-29	Dec-19	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Open	Limited	Medical	Helen Williams	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	The online Allocate electronic system is now the only acceptable format for job planning and the system requires detailed DCC/SPA information. Once the system is fully operational and all job plans have been reviewed using Allocate, there will no longer be a requirement to transfer the information on to ESR.
HDUHB-1920-29	Dec-19	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Open	Limited	Medical	Helen Williams	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-21	Red	The system requires further detail in terms of expected outcomes and once all job plans are reviewed using Allocate this recommendation will be fully met.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_002	High	R2: Management should request, and retain in a centralised location, the required data providing assurance of the competency of appointed contractors. A 'valid for' period should be included to ensure that, upon expiration, up to date information is requested rather than reliance placed on historic data.	Accepted. The data will be obtained through completion of the pre-qualification questionnaires [as per the new policy]. Initially, it will be logged on a centrally maintained spreadsheet with a view to investigate databases available to the UHB. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.

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SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_005	High	R5a: Formal inductions should be completed by all contractors engaged by the UHB and attendance recorded and reviewed appropriately on a centralised UHB database.	Agreed. Plans had been made for all current contractors to receive the induction by 31 March 2020 with a log of attendance maintained. However, in light of the current unique times the country is faced with, these plans have been postponed. Appropriate arrangements will be made to roll out the induction through an appropriate means for existing contractors and any new appointments. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_005	High	R5b: Job and location specific risks should be discussed and formally documented by relevant competent staff in addition to the induction via the new Job Registration and Authorisation form.	Agreed. Plans had been made for all current contractors to receive the induction by 31 March 2020 with a log of attendance maintained. However, in light of the current unique times the country is faced with, these plans have been postponed. Appropriate arrangements will be made to roll out the induction through an appropriate means for existing contractors and any new appointments. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_007	High	R7a: A permit to work procedure should be developed, ratified and communicated to all relevant officers.	Agreed. A procedure will be drafted to address the different types of permits that may require issue for work on UHB sites. As noted through a recent CDM course attended, when Estates Officers are signing the RAMS, they are accepting that the content appears reasonable. They do not have the expertise to confirm that the content is correct. This will be addressed accordingly. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All ecommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_007	High	R7b: Appropriate permits to work for different high risk types of work must be High issued by Estates staff in line with HSE guidance and the new Control of Contractors policy.	Agreed. A procedure will be drafted to address the different types of permits that may require issue for work on UHB sites. As noted through a recent CDM course attended, when Estates Officers are signing the RAMS, they are accepting that the content appears reasonable. They do not have the expertise to confirm that the content is correct. This will be addressed accordingly. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All ecommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_001	High	R1. Forecasting should be undertaken for each contract by the Finance Business Partners as the identified (Finance) Contract Leads to ensure the financial needs of the Health Board are met.	The Contracting Team will work closely with Finance Business Partners to support this work. As this recommendation is accepted, the contracting team have identified a resource to undertake this work with Business Partners moving forward.	Jan-21	Jan-21	Amber	New report approved at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_002	High	R2. SLA Contract monitoring and budget reviews of services both provided and accessed, need to be undertaken by management to ensure the standards of service meet the requirements of the Health Board.	The Contracting Team have identified a full time resource to support this work.	Nov-20	Nov-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_003	High	R3. Management need to ensure that LTA contracts are signed by the appropriate authorised signatory, in accordance with the agreed Health Board Scheme of Delegation.	All LTAs will now follow the scheme of delegation, with all contracts over £10m being reported to the Board following CEO approval, and those below £10m being reported for information.	Jul-20	Jul-20	Amber	New report approved at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_004	High	R4. Management should ensure that the terms and conditions set out in SLA contracts are adhered to at all times.	All contract meetings involving the contracts team will be documented moving forward. These will of course include any actions arising. This will demonstrate the requisite compliance around roles and responsibilities as set out in the contact.	Jun-20	Jun-20	Amber	At ARAC 27/05/2020 where report was approved, members noted the management response doesn't answer the question around the quality of the SLAs. The Director of Finance responded that Finance is doing a piece of work with the Value Based Outcomes team.
BFS/KS/SJM/001 13573-KS/890/05 (supersedes EN/262/08)	2/4/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_001	High	R1. Fire Risk Assessment According to your action plan dated 02 December 2019 V2 there are still a small number of significant findings of your Fire Risk Assessment that need to be completed. These need to be confirmed once completed.	Actions have not been provided by the service.	Oct-20	Dec-21 (allowing for impact of COVID 19)	Red	Some fire risk assessments have been completed with the exception of those assessments which is part of stage 2 WGH Fire Enforcement Programme. This recommendation is currently ragged as red as the original date of October 2020 is sited on the enforcement notice from Mid and West Wales Fire and Rescue Service (MWWFRS). Estates colleagues are meeting with MWWFRS on 06/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KS/SJM/001 13573-KS/890/05 (supersedes EN/262/08)	2/4/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_002	High	R2. Fire Resisting Doors Ensure that door-sets that can resist fire and smoke for 30 minutes are provided in the following locations: • All identified fire resisting doors throughout St Caradogs Unit and Waldo Suite (Mental Health Department) Any self-closing device fitted to doors and must not compromise the effectiveness of any intumescent strips and smoke seals forming part of the door set. As stated in your action plan dated 02 December 2019 V2 the works are on schedule to be completed by 04 September 2020.	Actions have not been provided by the service.	Oct-20	Dec-21 (allowing for impact of COVID 19)	Red	The priority doors have been verbally agreed with MWWFRS to be be completed by December 2020 (rapid progress has been made, with the remaining items to be completed by December 2021 (delayed by 4 months due to impact of COVID-19). Estates colleagues are meeting with MWWFRS on 06/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.

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BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	2/4/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_003	High	R3. Compartmentation / Dampers Reinstate the fire resistance in the following location: • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devices are functioning in line with its design specifications and manufacturer's instructions. According to the action plan dated 02 December 2019 V2 these ongoing works are to be completed in the timescale of this Enforcement Notice	Actions have not been provided by the service.	Oct-20	Dec-21 (allowing for impact of COVID 19)	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 06/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_001	High	R1. Compartmentation - All Horizontal and Vertical Breaches and / or Penetrations. •To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the wards, theatres, plant rooms, offices, surgeries, specialist units and any other compartmented spaces within the Glangwili Hospital site are addressed. • Any contractual work undertaken to install services through a fire resisting barrier should be quality assured to ensure that the fire resistance is reinstated on completion. • Any room that is made into a hazard room / area should comply with WHTM 0502 5.40 & Table 6	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_002	High	R2. Fire Damper Systems Ensure that the fire damper systems are properly tested and maintained. Following completion of testing of these systems, documentation needs to be sent to my office confirming this. Fire damper systems should be tested as per British Standard 5588-9 Code 9, with a maximum testing interval of two years.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_003	High	R3. Fire Resisting Corridors and Doors Ensure that the escape routes are kept free from fire and smoke by making sure all fire doors are fit for purpose and protect the means of escape as they are intended to do so. 1. A number of fire resisting doors throughout the premises were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm. Any damaged fire resisting glazing needs to be replaced. 2. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position, if this is a requirement then the doors should be linked into the fire alarm system to allow them to positively close fully into their frame on the activation of the fire alarm. 3. Ensure that all doors on exit routes are available and can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency. 4. Doors to rooms that have no public access should be locked when not in use. 5. All fire doors should have identification showing the fire-rating of the door. 6. All transom lights above all doors and enclosures within the hospital	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_004	High	R4. Fire Risk Assessment • Ownership needs to be taken of the significant findings of the Fire Risk Assessment. Those items highlighted within the fire risk assessments need to be completed within the identified time scales. • Departments within the hospital that are not operated by the Hywel Dda University Health Board also have a duty to comply with this item and all other items relevant to them within this enforcement notice.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_005	High	R5. Add Device to and Update the Fire Alarm 1. Extend the smoke detection within the corridor of the Tyssul ward (adjacent to the Laser treatment room) and link it to the existing fire alarm system. 2. Exchange the smoke detection for a heat detection within the staff room Block 32FF. 3. A large number of Detector heads were seen to be outdated, this was also noted within the risk assessments, the fire detection needs to be updated in accordance with BS 5839 part 1. 4. There needs to be fire alarm repeater panels available for both wards within Block 2 FF. All of the above points should comply with WHTM 05 03, part B and BS 5839 Part 1. The changes should be carried out and commissioned by a competent person.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.

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BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_006	High	R6. Escape Lighting Ensure that the emergency lighting is tested and in good working order so that it will operate if the local lighting circuit fails. The system should conform to BS 5266.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_007	High	R7. Training for Own Staff Provide your employees with instruction and training so that they know the fire precautions you have put in place. They must also be familiar with what they need to do in case of fire to ensure that they are safe and can keep other people safe.	Actions have not been provided by the service.	Oct-20	Dec-20	Red	As an interim measure e-learning module will be in place by December 2020, instead of face to face training. Delay to December 2020 due to COVID-19. Verbal discussion has taken place between Head of Fire Safety Management at UHB and Mid and West Wales Fire and Rescue Service. MWWFRS have agreed verbally with Head of Fire Safety Management at UHB that they are happy with this arrangement but no formal correspondence received to confirm.
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_008	High	R8. Cooperation/Coordination Effective systems of communication must be established with those who are responsible for all departments to ensure all relevant persons are provided with suitable and sufficient information in respect of the fire safety measures implemented. The cooperation must ensure that the shared fire safety measure(s) protect you all.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_009	High	R9. Alternative Escape Route (Distance) Do not alloaw the adjoining door within Room 32 X-Ray Department GF Block 6 and room 26 to be locked with a key. A push pad or similar device should be installed to the door which complied with BS EN 179 (for emergency exit devices) or BS EN 1125 (for panic hardware). Signage indicating the need to use this door as a fire exit should also be displayed on both sides of the door from room 26 to room 32.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/001 07739-	17/04/2020	Mid and West Wales Fire and	Enforcement Notice	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_010	High	R10. Obstruction of Escape Routes Ensure that everyone can evacuate quickly and safely.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_010	High	1. Cabinets and lockers should be stored in areas that do not impede escape in the event of an emergency these items should be removed from the corridors. 2. Remove fridge stored within staircase Block 8 FF. 3. Remove items stored in lift lobby 2/B within CCU. 4. Remove Bins Store within staircase Block 32 GF. 5. Remove Bins Stored at the entrance to SCBU					
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_011	High	R11. Fire Fighting Equipment Remove the existing Dry Powder Extinguishers from within all of the departments of the hospital site.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/001 07739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/0 0107739_012	High	R12. Storage of Refuse Manage all waste on site responsibly. Your refuse bins sited at the rear of the Renal unit are overflowing and combustible material is accumulating around this area. This is also the case in the courtyard of Block 32 and within the maintenance yard. If not carefully managed and controlled, rubbish stacked in a haphazard fashion in unsightly piles outside premises can lead to more rubbish being dumped or fly tipped. Graffiti, vandalism and arson may then follow in quick succession. When there is no segregated bin storage, wheeled bins should be chained together and to an immobile object such as a metal stake, at least 10 metres away from any building.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.

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BFS/KS/SJM/00107739-KS/890/06	17/04/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_014	High	R14. Access Particular attention needs to be taken regarding the access for fire service vehicles in the event of a fire at the Glangwili site. Whilst visiting the site to conduct the inspections over a week period, it was noted that the car parks were heavily overcrowded with vehicles parking in unauthorised areas, as a result the attending fire appliances would not be able to access all parts of the hospital. Access to all parts of the building should be available for the fire service at all times as mentioned in WHTM - 0502 Chapter 7 and Part B of Schedule 1 of the Building Regulations 2010.	Actions have not been provided by the service.	Oct-20	Oct-20	Amber	Awaiting clarification from service on when this recommendation will be fully completed.
BFS/KS/SJM/00114719-/KS/890/02	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_02_001	High	R1. Compartmentation – All Vertical Escape Routes. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Vertical Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Actions have not been provided by the service.	Sep-20	Sep-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KS/SJM/00114719-/KS/890/02	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_02_002	High	R2. Fire Damper Systems - Maintenance Ensure that the fire damper systems are properly tested and maintained. Following completion of testing of these systems, documentation needs to be sent to my office confirming this. Fire damper systems should be tested as per British Standard 5588-9 Code 9, with a maximum testing interval of two years.	Actions have not been provided by the service.	Sep-20	Sep-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KS/SJM/00114719 - KS/890/03	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Actions have not been provided by the service.	Aug-21	Aug-21	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KS/SJM/00114719 - KS/890/03	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.	Actions have not been provided by the service.	Aug-21	Aug-21	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KS/SJM/00114719- KS/890/04	09/02/2020	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/04	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Actions have not been provided by the service.	Apr-22	Apr-22	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: 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.	Actions have not been provided by the service.	Mar-20	Awaiting clarification from service	Red	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.

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BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Actions have not been provided by the service.	Mar-20	Awaiting clarification from service	Red	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_003	High	R3. St Nons. Ensure the certificates showing testing of emergency lighting systems are provided via email at the earliest opportunity.	Actions have not been provided by the service.	Mar-20	Awaiting clarification from service	Red	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_004	High	R1. Bro Cerwyn. Ensure that everyone can evacuate quickly and safely by removing the combustibles from the escape routes- outside kitchen area and dead-end corridor to offices.	Actions have not been provided by the service.	Mar-20	Awaiting clarification from service	Red	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS/KBJ/SJM/00113573	10/12/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_005	High	R2. Bro Cerwyn. Reinstate the fire resistance in the following locations: Holes in ceiling areas of offices, water leaking onto electrical appliances and sockets.	Actions have not been provided by the service.	Mar-20	Dec-21 (allowing for impact of COVID 19)	Red	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 06/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber.
BFS/KBJ/SJM/00115068	29/05/2019	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. South Pembs Hospital	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00115068_003	High	R3. Ensure that door-sets that can resist fire and smoke for 30 minutes are provided in the following locations: • Compartment double doors in main ward on 1st floor. The term 'door-set' refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set. 3 x hinges • Intumescent seals and smoke sealing devices/Self closure.	Actions have not been provided by the service.	Dec-19	Oct-20	Red	Not yet complete, bigger piece of work than originally thought. Capital money has now been confirmed and work to be undertaken, revised date October 2020. Unclear if MWWFRS have agreed to this extension
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Actions have not been provided by the service.	Jul-20	Jul-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Actions have not been provided by the service.	Jul-20	Jul-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426_005	High	R5. Escape Lighting 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.	Actions have not been provided by the service.	Jul-20	Jul-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.

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BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_006	High	R6. Establish Emergency Procedures Establish procedures to be followed in case of fire and nominate people to put those procedures into effect. Ensure that there are enough competent people to successfully implement an evacuation. Where premises are occupied on a shared basis, effective systems of communication must be established with those responsible for other premises to ensure all relevant persons are provided with suitable and sufficient information in respect of the fire safety measures implemented. All five blocks but namely the Kensington, Sealyham Blocks.	Actions have not been provided by the service.	Jul-20	Jul-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.
BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425	07/01/2020	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_007	High	R7. Reduce Fire Spread Upholstered furniture is to comply with British Standard 7176 or the equivalent European Standard. • Pembroke county community room.	Actions have not been provided by the service.	Jul-20	Jul-20	Amber	Requested clarification from service on when this recommendation will be completed by and if MWWFRS have agreed to any extensions if applicable.

Appendix 2: Recommendations in progress / overdue

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
651A2015	Feb-16	Audit Wales	Hospital Catering and Patient Nutrition Follow-up Review	Open (external rec)	N/A	Nursing	Sharon Daniel	Director of Nursing, Quality and Patient Experience	WAO_Catering 001	Not stated	R4b: We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	Introducing a computerised catering system will incur additional revenue costs as the inputting of live data is key to providing timely and accurate information. The costs associated with such systems would ordinarily need to be sourced from Capital funding. • A review of cost benefits will be undertaken during 2016 as part of the work on the Catering Business case development , with a view to including in the Outline Business case if the review demonstrates it to be appropriate to do so	Dec-16	N/K	Red	No update provided.
380A2016	Jun-16	Audit Wales	NHS Consultant Contract Follow Up	Open	N/A	Medical	Helen Williams	Medical Director	WAO_NHSCon sultant001	Not stated	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-20	Red	Per April 20 ARAC, WAO progress states: "Based on end of year figures the target of 90% set for the completion of up to date Consulatant and SAS Doctors would have been exceeded in the absence of the Covid 19 pandemic". WAO have coded the rec green as completed
380A2016	Jun-16	Audit Wales	NHS Consultant Contract Follow Up	Open	N/A	Medical	Helen Williams	Medical Director	WAO_NHSCon sultant002	Not stated	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-20	Red	Per April 20 ARAC, WAO progress states: "Based on end of year figures the target of 90% set for the completion of up to date Consulatant and SAS Doctors would have been exceeded in the absence of the Covid 19 pandemic". WAO have coded the rec green as completed
385A2016	May-17	Audit Wales	Review of Estates	Open	N/A	Estates	Rob Elliott	Director of Operations	WAO_Estates0 01		R6: Widen the range of performance management KPI to include: ▪ time; ▪ cost; ▪ productivity; ▪ non-productive time; ▪ quality; ▪ service; and ▪ customer feedback.	Establish a Working Group to set out the IT requirements to capture this range of KPIs Implement any changes necessary to ensure these KPIs are reported. Actions/Timescales to be progressed during 2016/17 with reports to be provided to CEIMTSC as part of agreed work plan	Sep-19	~~May-20~~ Sept-20	Red	Likely to be pushed back as delivery of replacement of RAM4000 has been delayed- can't do any onsite installations at the moment due to members of staff currently working on COVID related work. Feb 20 ARAC TOA requested an update be provided Oct 2020.
385A2016	May-17	Audit Wales	Review of Estates	Open	N/A	Estates	Rob Elliott	Director of Operations	WAO_Estates0 02		R8: Ensure the right number of people with the right skills are available now and in the future by developing fully funded plans for workforce and training.	Review to be undertaken of workforce plans to identify:- ▪ Existing resources/ age profile This is updated annually Currently working with Workforce and OD to develop an "apprentice academy" ▪ To consider all Investment plans and any subsequent resource impact within Estates.. ▪ Action plan to address identified gaps.	Dec-16	~~Apr-20~~ Sep-20	Red	Most of the work on this has been completed but has now been knocked back due to COVID. A 'work in progress' type paper on future training of workforce has been shared with the CEO. Feb 20 ARAC TOA requested an update be provided Oct 2020.
No ref	Mar-18	Audit Wales	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Director of Planning, Performance & Commissioning	WAO_InfoBack Up_006		Disaster Recovery & Business Continuity. R8. Design and implement a schedule of regular back-up media and disaster recovery testing to provide assurance that applications and data can be successfully restored in the time required after the loss of a system.	No revised management response provided in this follow up report.	N/K	Mar-21	Red	As of May 2020 still in line for March 2021 deadline.
603A2018-19	Jun-18	Audit Wales	District Nursing: Update on Progress	Open (external rec)	N/A	Community and Primary Care (Ceredigion)	Tracey Evans / Sharon Daniel	Director of Operations	WAO_DistrictN ursing_001	Not stated	R6. Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the casemix between teams compared with team resources.	The Health Board said that it expects this issue to be definitively addressed through the publication of the All Wales dependency tool, currently expected in 2020.	Jan-19	~~Mar-20~~ Nov-20	Red	28/05/2020- The National District Nursing Project Officer appointment was made in February 2020, however, this work stream has been delayed due to COVID-19. The development of the national patient acuity/dependency tool for District Nursing services was reviewed on 7th May 2020 by the AW Nurse Staffing Levels programme Lead and remains one of the priority developments for 2020. The patient case mix and the resources within each of the DN teams in Hywel Dda was, reviewed, pre COVID, and was ready for presentation to the Director of Nursing, Quality and Patient Experience at the end of March 2020. However, due to the plans to support District Nursing services during COVID this review is on hold. The aim is to re-visit this work stream in September 2020 and will be aligned to the National work plan. Further update therefore to be provided after November 2020.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalC oding_001b		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: b) removing the use of temporary records, including poly-pockets and ensure files are merged into the master patient record.	Temporary notes and poly-pockets are still in use across the organisation. The Health Board's self-assessment response indicated that the numbers received into coding offices are not high. However, clinical coders across the Health Board told us that the situation had deteriorated over the period since our last review. There has been a decline in the organisation, maintenance and condition of individual patient case note folders because of greater movement of patients around the Health Board and shorter lengths of stay. Both factors add to the challenge of ensuring the notes are maintained in line with standards, and available when needed by clinical coding teams as well as clinicians. A note is entered in Medicode whenever a polypocket is used as the source for coding. If an audit of the full case note is subsequently carried out, there will then be a flag to indicate that it was not available at the time of coding.	Sep-19	Oct-20	Red	An action plan has been developed via the Health Records Group. The Health Records Group has agreed to focus on the correct Tracking of Patient Records, with Temporary notes and poly-pockets looking to be addressed following this work. Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalC oding_001d		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: d) providing training for ward clerks and other staff in relation to their responsibilities for medical records	There is no ongoing programme of training to ensure that ward clerks maintain records in line with professional standards. Coding staff said that the standard of practice amongst ward clerks is highly variable, and there is no real ownership of the notes in some wards. Ward clerks are managed by individual specialties and wards. This increases the need for ongoing communication (with ward staff in general as well as with ward clerks) about the importance of maintaining standards of practice and for the provision of training.	Sep-19	Oct-20	Red	IThe Head of Information Governance and Head of Health Records have agreed that joint IG and Health Records training will commence from January 2020. Rooms are currently being secured at each site to allow staff to attend. Staff will be trained in IG at the same time to improve the IG compliance. We anticipate this work will take 4-6 months to complete with a number of sessions being held in all sites. ARAC April2020 update: Revised Timescale – Training to begin December 2019 for 4-6 months Progress has been delayed (3-4 months) due to the COVID pandemic, with a newly revised completion date of October 2020
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalC oding_001e		R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	All the clinical coding teams are asked to track case notes correctly using the Myrddin Patient Administration System. The Health Board's self-assessment indicated that this always happens, except for when case notes are collected from a ward in the morning and returned that afternoon. However, coding staff indicated that case note tracking is generally poor, except at Withybush Hospital.	Aug-20	No new timescale received from service.	Red	An action plan has been developed via the Health Records Group. The Tracking of Records will be the focus of the Health Records Group for the next 6 months with a review at the end of this period along with lessons learned. The work plan suggests a number of phases to the work, ensuring that there are feedback loops and reviews. Timescale – 16 months, based around 4 x 4 month PDSA cycles. The first PDSA cycle was undertaken and lessons learned have been feed into the next PDSA cycle, which unfortunately was paused due to the COVID outbreak. It is anticipated that there will be a delay of 3-4 months. Assurance and risk officer requested clarification of revised date. Response from service- Health Records Group is leading on this chaired by Assistant Director of Informatics. This action needs to be reviewed as part of the work of the group.

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175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey / Gareth Beynon	Director of Planning, Performance & Commissioning / Director of Operations	WAO_ClinicalCoding_002c		R2. Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include: c) ensuring all staff receive consistent feedback on issues raised through validation and audit from all sites.	None of the coders are currently qualified to audit coding work. In 2017-18 it was decided to have a supervisor and a coder carry out an audit of 30 case notes each month and to feedback the results directly to individual coders. The arrangement was suspended so that all coding team resources could be directed towards clearing the coding backlog. At the time of our fieldwork the situation had not changed. The Coding Manager carries out data quality checks when time allows. However, his time has been heavily committed to providing a presence on each site to mitigate for the long-term sickness absence of one of the two coding team supervisors.	Original completion date not stated in report	Action is currently on hold until addition resource is available	Red	Until additional resources are made available this recommendation will be placed on hold. If the Executive Team wish this to be progressed, there will be effect on the coding completeness. As an estimate, in total each day a coding supervisor and a coder undertake audit work would account for 12,000 cases not being coded. Based on each coder having feedback and partaking in 1 audit day per month. This equates to a 1- 2% effect on the completeness. Apr 20 ARAC update: The Clinical Coding Team are undertaking minimal audits in line with NWIS, and these are being feedback to coders when available. Action is currently on hold until addition resource is available
684A2014	15-Jun	Audit Wales	A Comparative Picture of Orthopaedic Services - Hywel Dda	Open		Scheduled Care	Lydia Davies	Director of Operations	684A2014_001	Not High	R10. Operating theatres: The rate of cancelled operations made by the Health Board was five per cent compared with the Welsh Government target of two per cent.	A theatres improvement programme is being formalised as part of the HB 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	Mar-22	Red	Currently outstide the gift of the UHB to implement this recommendation due to COVID-19. Plan is being put in place re-start operating theatres with a paper being provided to the Acute Bronze Committee In June 2020 to agree steps required for operations to take place (e.g. pre-assessment appointment, COVID-19 risk assessment, 2 week patient isolation prior to surgery day, etc.) and decision will need to be made on which site will be safest for routine operations to take place. Currently a lot of questions still to be answered. Assurance and risk officer to review recommendation with reporting officer in September 2020.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_001		R1: Long term Set out a vision and plan for the future of the EPP to: • prioritise future developments; • establish the capacity of existing staff resources; and • identify the resources that would be needed to realise the vision for the service.	A new plan to address multi-mobility rehabilitation is being developed which includes EPP. Staffing resource and future developments for EPP will be covered as part of this. A workshop will be held in November 2019 to commence engagement activities with a view to finalising the plan in 2020/21.	Mar-20	Sep-21	Red	A paper had been completed for Executive discussion as COVID 19 crisis happened. Since the learning has started to evolve for COVID 19 patents and the fact we may not be able to do face to face group sessions for a prolonged period of time the relevant teams have begun discussions with how to deliver and support rehabilitation remotely Elements that are being tested include Attend Anywhere by the physiotherapists Patient Knows Best by difficult asthma and home oxygen teams. Digital films like Pocketmedic 2 new members of staff have been seconded for a year into the EPP team to support delivery of programmes and plan and prioritise need starting on 01/06/2020
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_003		R3: Address the barriers to promoting the EPP.	A bid for funding to undertake specific research to understand the barriers to engagement and take-up of the programme is being developed. The aim would be to complete the research by Feb 2021. Work is also on-going to develop a bespoke programme to reflect cultural and language needs in order to further support the Syrian Vulnerable Persons Resettlement Programme. A bid is being developed to seek funding to support this innovation through the Self-management and Well-being Fund. Bid submission date is Nov 2019 and if successful work will be completed by April 2020.	Feb-21	Dec-21	Red	All bids were unsuccessful. A new plan has yet to be discussed on how to deliver this work.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_004		R4: Include EPP web-links on information sent out by the team and on Health Board waiting list letters and holding letters.	EPP is represented on a Quality Improvement Communication Team project which will incorporate this action. This project will be completed by July 2020.	Jul-20	Jul-21	Red	Unable to complete project due to COVID 19 as yet change completed date to July 2021.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_005		R5: Involvement Work with patient experience staff to capture the experiences of patients who have moved on.	The EPP Team is working with the Patient Experience Team to develop a Family and Friends feedback tool. Plans are in place to hold an annual update event in each county to which all previous programme participants are invited to attend. The EPP Team are continuing to gather participant and tutor stories in order to promote the benefit of attending the programmes. This work is on-going throughout 2019/20.	Mar-20	Mar-22	Red	Unable to progress this work as yet but continues to be a priority.
1496A2019-20	19-Oct	Audit Wales	Implementing the Well-being of Future Generations Act- Hywel Dda Health Board	Open	N/A	Partnerships & Corporate Services	Claire Hurlin	Director of Partnerships and Corporate Services	WAO_Futuregenerations_006		R6: Look for opportunities to involve younger people in the design and delivery of EPP courses, possibly through schools and colleges.	The EPP are planning to start working with sixthform schools and other settings alongside the Welsh Baccalaureate. Initially the Team will work with Bro Dinefwr School to develop this initiative by April 2020.	Apr-20	Dec-21	Red	Started to look at delivering a healthy eating session, have been unable to link into the Welsh Baccalaureate as the school had already set specifics for this, now on hold due to COVID 19 but will continue as soon as possible
238A2017-18	Not known	Audit Wales	Follow-up Outpatient Appointments: Update on Progress	Open		Scheduled Care	Keith Jones	Director of Operations	WAO_Outpatient_006	Not High	R6: Put in place systems and processes that will allow the Health Board to identify patients with these conditions.	Robust quality controlled systems to be developed across the process for the usage of outcome forms to ensure reduce errors.	Mar-18	Jun-20	Red	A revised outcome form has been developed and created to ease the completion of the form and emphasise the directive to ensure the that the clinical conditions are updated. The is currently in the testing phase with two specialties to ensure it meets the needs of the clinical team and medical records staff. Testing and required changes to surgical specialities should be completed and ready for rollout by end of June 2020.
No ref	Not known	Audit Wales	Integrated Care Fund (icf) Review Update (West Wales RPB)	Open		Partnerships & Corporate Services	Anna Bird	Director of Partnerships & Corporate Services	WAO_ICF_007	Not stated	R7. Rollout the use of the regional outcomes framework to all projects if the pilot is successful	• A new outcomes and benefits framework is being developed at regional level, for application initially against transformation fund projects and extension thereafter to cover the ICF programme.	Dec-20	Dec-20	Amber	On-going discussions taking place and the timescales may need to shift but will be reviewed again at the end of Quarter 1 2020/21
No ref	Not known	Audit Wales	Integrated Care Fund (icf) Review Update (West Wales RPB)	Open		Partnerships & Corporate Services	Anna Bird	Director of Partnerships & Corporate Services	WAO_ICF_008	Not stated	R8. Develop exit strategies for all Integrated Care Fund projects	• This will be a key focus for the 2020-21 programme of work which the RPB are finalising. This will be undertaken within the context of national discussions on future funding.	Dec-20	Dec-20	Amber	On-going discussions taking place and the timescales may need to shift but will be reviewed again at the end of Quarter 1 2020/21
No ref	May-18	CHC	What's your NHS like for you? Hearing from people with a learning disability	Open	N/A	Unscheduled Care	Carol Cotterell	Director of Operations	NHSLikeForYou_001	N/A	R5. All Wales Working Group currently developing standards of practice for annual health checks including training programmes for GPs.	• Once finalised the standards of practice to be implemented across the GP practices • GPs to participate on All Wales Training Programme	Mar-19	~~Apr-20~~ Aug-20	Red	Educational Packs for GPs are ready to go and a launch at Welsh Government level is imminent – but no date has been received as yet. As soon as the pack is received the Community Learning Disabilities Team will participate in the delivery of the training to primary Care Teams.
No ref	Jul-19	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	A&EWGH_001	N/A	R1. Health Board (HB) needs to help people find ways of getting patients the information that they need so that they can go to the right place, when they need care.	To review the leaflets available to patients directing them to appropriate services; To request that the communications team use social media & display boards to send consistent messages to the public around accessing services; To implement a streaming service prior to registration in ED	Nov-19	N/K	Red	1/6/2020 emailed for a response - Clinical Nurse Lead response received to implement streaming service implementation date June - does not say completed.
No ref	Jul-19	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	A&EWGH_004	N/A	R3. HB needs to make sure that people do not feel overlooked when they are waiting	To progress the plan to install electronic screen in the Majors area; To establish robust 'rounds' within the Department to check on patients who are waiting; To agree daily schedule with Red Cross volunteer service to support patients within the Department.	Nov-19	Nov-20	Red	1/6/2020 emailed for a response - Response received Senior Sister ED to speak with Gareth Beynon as a paper has been written for Electronic Screens - delayed due to covid 19.
No ref	Jul-19	CHC	Accident and Emergency Department Withybush Hospital 22 July 2019	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	A&EWGH_015	N/A	R13. 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	1/6/2020 emailed for a response - Planned to implement in June not completed. Temporary change in service. Patients requiring access to mental health support/ requesting crisis in ED will be escorted to Bro Cerwyn MHU for assessment and will not have to wait in ED. the change will be monitored and reviewed.
CEO2526	Nov-19	CHC	Audiology (Hearing) Services November 2019	Open	N/A	Scheduled Care	Jane Deans	Director of Operations	CEO2526_009	N/A	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	05/05/2020- The webpage has been updated following email conversations with the Digital Communications Team (both pre and peri COVID-19).The cost of installing self-check-in screens at all 4 Audiology locations would be £3,408 per year. The IT department has been contacted to ascertain if we would have the IT hardware specifications if we were to consider purchasing this. Awaiting response from IT.
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_002	N/A	R2: The Health Board needs to consider some redecoration or improvements to patient areas could make the premises more presentable.	To work with Estates to agree a redecoration programme	Dec-19	Mar-20	Red	

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_003	N/A	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	
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_004	N/A	R4. The resource gap (lack of trolley service or visiting shop, etc.) might be something that the local community might be able to address in some way.	To request support from the League of Friends and HB Volunteer Manager with implementing a trolley service/shop services. And also to examine if we are able to operate a personal shopper programme for patients.	Mar-20	NK	Red	Unfortunately, the attempts made to recruit volunteers to the area to provide a personal shopping service has not been successful. We continue to work with the team to pursue this opportunity
CHC Llandovery	Nov-19	CHC	Llandovery Hospital August 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	Llandovery_006	N/A	R6.The physiotherapy room in particular was not welcoming and it would be beneficial if this could be reviewed by the Health Board to identify if any changes could be made to make it more welcoming.	To arrange a meeting between the Head of Community Nursing and the Head of Physiotherapy and Estates Dept. to identify if any changes could be made to make it more welcoming. To discuss how the environment can be further advanced	Feb-20	Jul-20	Red	Outside storage condemnded by Estates. An alternative is being considered.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	Mar-21	Amber	Due to COVID guidance from Royal College of Ophthalmologists only urgent and emergency appointments are being seen by target date, therefore not seeing risk factor 2 or 3 patients, which are validated by a clinician to establish that they can wait. In April there were 13,000 backlog of patients with risk 1 irreversible sight loss which has reduced to 11,000 as of May 2020. Currently seeing more of these higher risk patients as the referrals are not being made for lower risk patient (currently not working towards RTT Targets). By the middle of quarter 2 (August 2020) will have better idea of the waiting lists due to COVID and will review this recommendation at this time to establish if March 2021 deadline is still feasible.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	Mar-21	Amber	See update in recommendation 1- due to current COVID situation only those with greatest risk of sight loss now been given priority on the pathway. Recommendation to be reviewed in August 2020 to establish if March 2021 deadline is still feasible.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices004	N/A	R4. The Welsh Government and the NHS in Wales needs to make sure there are robust patient feedback arrangements in place to regularly monitor and review patient satisfaction	Development of a Patient Experience Group that reports to the Health Board Eye Care Collaborative Group	Apr-20	Jul-20	Red	Due to COVID the first meeting of Patient Experience Group that was scheduled for March 2020 did not take place. Director of Operations has also currently stepped down the Health Board Eye Care Collaborative Group. Currently exploring ways of how Microsoft Teams platform can support the sett up of virtual meetings/forums for this. To review recommendation in July 2020- hoping to get Eye Care Collaborative Group back in place at this time to discuss and plan priorities and discuss opportunities to redesign the system.
No Ref	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	Jul-20	Red	WG have awarded the contract and implementation of EPR will be progressed on an All wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. July 2020 new timescale-will then check on the roll-out of EPR system.
No ref	Not known	CHC	Women and children's services Visit report March 2018	Open	N/A	Women and Children's Services	Keith Jones/Julie Jenkins	Director of Operations	CHC_W&C_001	ng	R5. The health board needs to do all it can to resolve the current temporary reduced hours arrangements in PACU.	Discuss at Task and Finish Group with Medical Director for decision to be made	Sep-19	Dec-20	Red	Due to COVID 19 PACU patients now seen at GGH. To be reviewed possibly Dec 2020.
GP	Aug-18	CHC Contractors	Brynteg GP Practice, Ammanford Aug 2018	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	CHCGP_Brynteg	N/A	Practice need to make sure that the seating arrangements suit all needs, including people who may have limited mobility.	We will request grant support to change our seating arrangements when the next tranche of Health Board funding becomes available.	Mar-20	Dec-20	Red	The practice have applied for a grant to re-model the waiting room but is currently on hold pending a grant. They are hoping this can be processed later in the year after COVID.
GP	Aug-18	CHC Contractors	Brynteg GP Practice, Ammanford Aug 2018	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	CHCGP_Brynteg	N/A	Practice should consider introducing a Patient Participation Group	This is in the process of being set up in conjunction with new collaborative working with MG St practice.	Mar-20	Dec-20	Red	This is not practical at the moment but have recently completed a patient survey. There are too many unknowns at the moment (due to COVID) but hoping that these can be completed before the end of 2020.
GP	Oct-19	CHC Contractors	Llynyfran Surgery, Llandysul	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	N/A	N/A	Practice should consider introducing a Patient Participation Group	This is in the process of being set up in conjunction with new collaborative working with MG St practice.	Mar-20	Dec-20	Red	This is not practical at the moment but have recently completed a patient survey. There are too many unknowns at the moment (due to COVID) but hoping that these can be completed before the end of 2020.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_002	N/A	R2.The UHB should implement a mortality review process for patients who die after a wait greater than 36 weeks for planned treatment, to seek assurance that the delayed treatment was not a contributory factor to avoidable harm.	Retrospective review to identify number of patients in 2019/20 Month 1-6 who were removed from the waiting list due to RIP while waiting over 36 weeks in order to identify scope of any issues	Aug-19	~~Oct-19~~ ~~May-20~~ Aug-20	Red	Action has been delayed due to the COVID response, however this will now be reinstigated. Due to COVID we now have a waiting list position which is larger than anticipated at this time so the whole waiting list is being clinically validated to ensure we are able to categorise the patients urgency therefore we would expect the reviews of mortality while waiting within this list to take place at this time.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_004	N/A	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	No update received from service	Red	No update received from service.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_004	N/A	R4iii. The national work on patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) provides a framework for some planned care pathways.	Overseen by the Planned Care Programme assurance framework. PROMs and PREMs are in implementation (for example orthopaedics). Our follow up backlog bid to WG includes funding to further develop these systems.	Mar-20	No update received from service	Red	Assurance and risk officer has emailed Head of Value Based Healthcare requesting an update for this action, however it was reiterated to the GM Scheduled Care that the report as a whole sits under Schedule Care and herself as the reporting officer.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_004	N/A	R4iv. There is scope for the Health Board to expand its use of this framework.	Evaluation of service suitability for PROMs / PREMs to be evaluated for inclusion in 2020/21 transformational change programme.	May-20	No update received from service	Red	Assurance and risk officer has emailed Head of Value Based Healthcare requesting an update for this action, however it was reiterated to the GM Scheduled Care that the report as a whole sits under Schedule Care and herself as the reporting officer.
No ref	Nov-18	Delivery Unit	Review of the Impact of Long Waits for Planned Care on Patients	Open	N/A	Scheduled Care	Stephanie Hire	Director of Operations	DelUnit-PlannedCare_009	N/A	R9. Review of expectations for primary care consultations prior to referral for planned care is recommended to assist with improved management of patient expectations	Referral criteria forms part of the Transformation programme for all Scheduled Care services, with progress reported through establish groups. Electronic referral management continues to be rolled out across the Health Board. These processes are to be reviewed by the Assistant Director of Nursing (QI)	Mar-20	No update received from service	Red	No update received from service.
No ref	Mar-19	Delivery Unit	All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Open	N/A	Mental Health & Learning Disabilities	Angela Lodwick / Sarah Burgess	Director of Operations	AWAR_PCCAMHS_005	N/A	R5. The HB should undertake an engagement exercise with GPs to improve liaison and a shared understanding of CAMHS pathways.	GP'sand Primary care staff will be provided with a Service Specification for referral to CAMHS LPMHSS	Nov-19	Dec-20	Red	01/05/2020 Assurance and Risk Officer met with Director and Interim Deputy. Date extended due to Covid 19, further email to Angela Lodwick , this will not be achieved quickly due to COVID and also 50% absence in Primary care .
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio002		R2:Ensure that all administrative record keeping – both electronic and within the medical records – are maintained to the highest of standards.	Monthly audits of outcome form to establish % compliance - feedback any non-compliances with Clinical lead to address non-compliance.	Aug-19	No update received from service	Red	No update received from service.
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio003		R3b: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): b. clinical agreement that all referrals sent to tertiary service clearly include the clinically determined PSD and current adjusted PSD, including a standardised referral form which is consistent across HDUHB.	For 100% of referral letters to have a PSD identified by November 2019 - audit undertaken in February 2020 demonstrates a 31% compliance. SDM Cardiology and Cardiology Service Support Manager to reinforce need of PSDs to referring clinicians and re-audit in 3 months.	Ongoing	No update received from service	Red	No update received from service.
No ref	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Paul Smith	Director of Operations	DelUnitCardio003		R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.	HDUHB was in the process of working with IT to setup another Sharepoint system to move towards the electronic referral of patients between Cardiology and Cardiac Surgery. However, this hasn't been progressed due to the All Wales Accelerating Cardiac Informatics work being progressed on Hospital to Hospital Referrals. Cardiology Service Delivery Manager currently in discussion with HDUHB Informatics and AWACI.	Ongoing	No update received from service	Red	No update received from service.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_002	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	Jun-20	Red	IMTP has been submitted but due to COVID there are alternative plans for the service being developed. Royal College of Ophthalmologists and Welsh Government (WG) guidelines on delivery of eye services is being received on an all most weekly basis due to the COVID. WG has provided guidance on an increased community Ophthalmology pathway, however but our Consultants are not in agreement with the guidance. Service Delivery Manager meeting with Director of Operations for Exec Team steer on potential to not accept the WG guidance. New timescale of June 2020 to review position of developing plans during COVID.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_003	N/A	R3. Programme management resource be allocated to support the development and implementation of the long-term ophthalmic plan.	Business Justification Case for additional Service Manager support within Ophthalmology being considered by Panel.	Mar-20	Jul-20	Red	BJC was submitted but not successful in obtaining funding. In addition due to the current planning of the new 'norm' due to COVID it would not be suitable to bring a new person in at this time. New timescale July 2020 --to review the requirements of the recommendation in line with planning arrangements.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_004	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	Jul-20	Red	IMTP submitted but no feedback provided as yet. New timescale July 2020 to review the requirements of this action
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_006	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	Jun-20	Red	Same recruitment challenges exist. 2 recruitment campaigns has been unsuccessful and third recruitment round pulled due to COVID. Currently exploring options with Swansea Bay UHB to design a regional ophthalmology model for South West Wales. Clinicians have been requested to provide their option appraisals by the end of May 2020. New timescale of June 2020 to review what options have been put forward.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_007	N/A	R7. As part of the medium-long term plan development, the cataract service options require appraisal prior to the commencement of the next planning cycle, supported by a clear, time-bound delivery plan.	Options included as part of the IMTP.	Mar-20	Jul-20	Red	Due to COVID situation the cataract service has currently ceased. New timescale of July 2020 to review this recommendation in light of the developing COVID situation.
No ref	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_008	N/A	R8. A revised plan/ funding mechanism for extension of W-AMD services should be developed to ensure there is sufficient capacity to meet this urgent demand.	Options included as part of the IMTP.	Nov-19	Jun-20	Red	During COVID the W-AMD service has continued and increased number of sessions have taken place (due to more routine services currently ceasing), therefore allowing us to improve our waiting list and eliminate the backlog. Plans to continue this post-COVID (once services are relatively back to 'normal) are currently developed. New timescale of June 2020 to review this recommendation in light of the developing COVID situation.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_001	N/A	R1. The Health Board and its local authority partners should, as a matter of priority, improve integration across health and social care in learning disability services. This should include the alignment of policies & protocols to support joint working, the sharing of assessments, and the production of multi-agency CTPs.	As this is a high level action it sits within the HB Programme of work under transformation. A transformation fund has been made available across the Region and within this there is an allocation for developing integration. There are also clear links to transforming clinical services and transforming mental health services. A CTP Policy is being developed which will articulate the required joint working arrangements. Through the development of the WCCIS(integrated information database for Health and Social Care) there are minimum core data sets being developed as standardised across Wales and we are working with the All Wales Groups and DU to share these and understand how they can be implemented. As this is a high level action it sits within the HB Programme of work under transformation. A transformation fund has been made available across the Region and within this there is an allocation for developing integration. There are also clear links to transforming clinical services and transforming mental health services. A CTP Policy is being developed which will articulate the required joint working arrangements. Through the development of the WCCIS(integrated information database for Health and Social Care) there are minimum core data sets being developed as standardised across Wales and we are working with the All Wales Groups and DU to share these and understand how they can be implemented.	May-19	Mar-23	Red	No updates received.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_002	N/A	R2. A bespoke training programme to support the improvement of CTPs should be introduced to ensure that mental health and learning disability staff are, and remain, skilled in formulating CTPs and in enhancing the involvement and experience of service users in the process.	There is a Regional Workstream for Workforce Development and we are looking to ensure that this is aligned to work ongoing there. The TMH workstream is also taking this forward. Within LD a bid is currently being written for people who use services to help deliver and inform training and create be-spoke packages, this will include how we fund this work.	Mar-23	Mar-23	Amber	No updates received.
No ref	Not known	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_005	N/A	R5. Improvements are required in the recording of MDT involvement in care and treatment planning which includes, recovery and progression processes, discharge planning, risk management and crisis planning. IT systems used to record assessments and CTPs should be streamlined to improve their integration within a single multidisciplinary CTP.	A regional workshop was held in February to look at MDT decision making and how this informs commissioning. As referenced above there is work on a National level to produce templates to support WCCIS. The overall lead for WCCIS implementation sits with IT, but we will continue to contribute to the development of national tools. Considering a pilot with Ceredigion who already have WCCIS.	May-19	N/K	Red	No updates received.
No ref	Not known	Delivery Unit	National report- The Quality of Care and Treatment Planning - Assurance Review of Adult MH&LD Services	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	NR_QCTP_002	N/A	R2: A 'train the trainer' programme focussed on the formulation of CTPs which are	Bespoke training to be developed	Mar-23	Dec-21	red	MH&LD Management and WWAMH (a local and regional Mental Health development Charity) have been evaluating current and past Care Coordination training. Delays are due to the current Covid 19 situation. The proposed delivery method for the NHS staff will be Microsoft Teams and this is available for NHS staff. Likely to be 6 months before the pilot training is completed. Carers UK were asked to deliver a pilot training in the Ceredigion area in Feb but they have stopped delivering the Mental Health Care Coordination training and will not be delivering this in the future. A decision was then made to develop a bespoke training for the Hywel Dda area working with existing knowledge and experience within the NHS, LA, voluntary sector, carers, service users, and the peer led sector. WWAMH and the MHLD management will lead on this work. The pilot training will be reviewed and then rolled out over the following 12 months to a wider group. The training will involve people with lived experience and carers in the training and will be reflective learning and experience based. The training will be delivered to NHS staff, LA staff, voluntary sector organisations, private sector, and people with lived experience and carers. It will be delivered via MS Teams for NHS staff and Zoom for everyone else, although the WWAMH preferred format for group training is Zoom as it is more flexible and responsive for experience and reflective learning.
18262	Feb-19	HIW	Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams / Sally Farr	Director of Operations	WGHUnannounced001	N/A	R4. The health board is required to provide HIW with details of the action it will take to ensure that: Signage at the hospital is reviewed to ensure it is easy to navigate for all patients and visitors to the hospital	Signage to be reviewed, to include patient representation of those with visual impairment and alterations agreed as appropriate	Apr-19	Feb-21	Red	01/06/2020 emailed for a response - Response received: on hold due to Covid-19. More realistic date is Feb 21
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_014	N/A	R14:The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.	Clinical Directors to discuss the need for improved prescribing of oxygen with medical staffing. To provide training for ward staff on the use of oxygen therapy and prescribing.	Oct-19	N/K	Red	No update received from service.

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18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_016	N/A	R16: The health board must ensure that pain is assessed and managed by an appropriately trained member of staff, and that records are accurately completed.	To provide training on pain assessment, management and evaluation on Ceri ward.	Oct-19	N/K	Red	No update received from service.
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_017	N/A	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	N/K	Red	No update received from service.
19102	Aug-19	HIW	Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Open	N/A	Community & Primary Care (Pembrokeshire)	Sonia Hay / Ceri Griffith	Director of Operations	19102I1_001	N/A	R7. The health board policy for the management and prevention of VTE finalised and disseminated to all appropriate staff.	The Health Board VTE policy will be disseminated once approved by MMSC, to be completed and distributed to all appropriate staff.	Sep-19	N/K	Red	The HB is to adopt the All Wales policy once this has been approved at the All Wales level., delays due to Covid 19. An All Wales meeting is planned 16 June 2020.
19103	Aug-19	HIW	Amman Valley Hospital, Cysgod Y Cwm Ward, 20-21 May 2019 (Community)	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	19103_001	N/A	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	Completion of the work has been delayed due to Covid, Estates are resuming work but have given no completion date.
19105	Dec-19	HIW	Ystwyth Ward, BGH 03-04 Sep19	Open	N/A	Unscheduled Care (BGH)	Dawn Jones	Director of Operations	19105_013	N/A	R13: The location of the therapy suite is reviewed to make it more accessible to patients, and to minimise the risk of cross infection in an area that cared for immunocompromised patients	To relocated Leri day unit patients into the new Chemotherapy unit (that will be based in the Y Banwy footprint)	Mar-20	3 months after red COVID zone area removed	Red	The relocation of Leri day unit into a new Chemo Unit has been put on hold due to COVID-the new build is currently a red COVID zone area. This will be picked up once the red zone is no longer required, the timescale for which is currently unknown.
19105	Dec-19	HIW	Ystwyth Ward, BGH 03-04 Sep19	Open	N/A	Unscheduled Care (BGH)	Dawn Jones	Director of Operations	19105_015	N/A	R15: The health board must ensure that Deprivation of Liberty Safeguards, metal capacity and best interest assessments are routinely conducted.	To arrange further education and training by the mental health teams on timely assessments escalation and compliance. To support the implementation of the shared care project which will provide an outreach service form mental health to support ward staff	Mar-20	Aug-20	Red	The Safeguarding team provided outreach training and 1-2-1 training sessions prior to COVID. Majority of staff were trained but not all staff. This training will be picked up after COVID pressures have decreased.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_002	N/A	The health board must: Consider how the privacy of patients can be maintained if staff have discussions in the open plan bay area Consider gaining patients' views regarding visiting access of birthing partners.	Patient feedback questionnaire to be designed to collect patient views on birthing partners staying overnight.	Mar-20	Sep-20	Red	Unable to implement due to Covid 19 restrictions. Maternity services following RCOG and RCM guidance with only 1 birthing partner for delivery. Aim to review in Sept 2020 as awaiting further COVID 19 guidelines.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_003	N/A	The health board must ensure that: Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards Notice boards containing information about staff on duty are updated at every shift change Notice boards are reviewed to provide health promotion information Information throughout the unit is made available bilingually.	To discuss with Head of Estates department the maternity signage across Glangwili General Hospital	May-20	Sep-20	Red	New signage not implemented due to the Covid 19 pandemic. Current departments have been reconfigured to other clinical areas and signage adapted.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_003	N/A	The health board must ensure that: Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards Notice boards containing information about staff on duty are updated at every shift change Notice boards are reviewed to provide health promotion information Information throughout the unit is made available bilingually.	Clinical lead to meet with Head of Welsh Language services to discuss appropriate information being available in Welsh	Mar-20	Dec-20	Red	Letters available bilingually. Notice boards have been updated however further update will be following COVID 19 pandemic. To be reviewed Dec 2020.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_004	N/A	The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation.	Audit to be undertaken on compliance of completed 'Birth Choices' documentation in the All Wales Handheld record	Mar-20	Aug-20	Red	500 Clinical notes audit has been undertaken and will be collated into a report new date given 31st August 2020
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_007	N/A	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~~ Dec 20	Red	Covid 19 has delayed the full implementation of disposable curtains. Infection Control have advised that linnen curtains meet infection control standards. Labour ward is compliant.
19257	Jan-20	HIW	Withybush Hospital (Maternity), 3-4 December 2019	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19257_007	N/A	The health board must consider the effectiveness of communication with staff including around the service change and how to address staff morale. The health board must ensure the content of the PROMPT guidance folders are tailored specifically for care within the unit and that future PROMPT training is aligned to the new service.	NHS staff survey to be distributed to all staff 01/03/20 to ascertain staff morale following organisational change.	Mar-20	Sep-20	Red	1/6/20 Delayed due to covid 109. Full staff survey is to be completed by Sept 2020
19097	Feb-20	HIW	Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Open (COVID-19)	N/A	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	19097IA_004	N/A	R4. The Health Board is required to provide HIW with details of the action it will take to ensure that: Fire doors are fitted to the entrance of ward 7 in line with the requirements of the Enforcement notice issued by the Mid and West Wales Fire and Rescue Service to ensure the Health Board adequately protects patients, staff and the general public in the event of fire. We were informed that the doors to the entrance of ward 7 were not fire doors. An Enforcement Notice was issued by the Mid and West Wales Fire and Rescue Service requiring action to fit fire doors by the 30th November 2019. We were informed the doors were due to be replaced in September 2020 at the earliest as part of phase 2 of improvement work.	The Health Board has a fully structured plan for fire safety at WGH developed in response to the Mid and West Wales Fire and Rescue Service Enforcement Notice (MWWFRS). The plan presented to MWWFRS is a staged approach allowing us to undertake advance works very promptly with the substantive element of work progressed via a Business Case process. Within this plan all fire requirements to escape routes identified within the above Enforcement Notice will be undertaken at WGH between May 2020 and August of 2021. This programme is currently being considered by the MWWFRS and we are awaiting further clarity from them on the agreed timelines on this work. The Welsh Government are also fully engaged in this process and are supportive of the approach being taken by the Health Board. This work will include doors at the entrance to Ward 7 and any other Fire Doors necessary within the escape routes in this Hospital. The MWWFRS have recommended that the remaining works within Wards and Departments will be undertaken as a second stage to the above.	Aug-21	Aug-21	Amber	Relating to work for fire which has a date of 2021.
19101	Feb-20	HIW	Llandovery, 26-27 November 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	19101_001	N/A	The health board is required to provide HIW with details of the action it will take to ensure that: * Palliative care rooms are provided with full privacy and gaps around windows are obscured * Visitor toilets provide access for wheelchair users * All patient areas are free from draughts.	Work is underway to conceal the gaps inthe wndow coverings. Spray purchased for the window, estates to apply – no date for this as yet.	Feb-20	NK	Red	Spray purchased for the window estates to apply – no date for this
19101	Feb-20	HIW	Llandovery, 26-27 November 2019	Open	N/A	Community & Primary Care (Carmarthenshire)	Lois Rees	Director of Operations	19101_014	N/A	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	Alternative models of care are being explored to ensure compliance with break periods for staff Delayed due to covid 19 no end date given

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GP	Jan-19	HIW Contractors	Narberth Surgery, 21/10/19	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	Director of Primary, Community and Long Term Care	N/A	N/A	Not UHB Managed - contracted out therefore individual recommendations not included in relation to this report.	Not UHB Managed - contracted out therefore individual recommendations not included in relation to this report.	Jul-20	Jul-20	Amber	Not UHB Managed - contracted out therefore individual recommendations not included in relation to this report.
18173	Feb-19	HIW MHLD	North Ceredigion Community Mental Health Team (Gorwellion) 20-21 Nov 2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	18173_015	N/A	The process for staff supervision must be robust to ensure all staff receive meaningful supervision in a timely and consistent way	Develop and implement supervision guidelines for directorate to include standardised supervision template, frequency and type of supervision	Aug-19	Jun-20	Red	Sara Rees was to chase this up but no response and no update.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	HDUHB will ensure there is an up to date Transition Policy in place for transition from S-CAMHS to AMHS	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	This Policy will be formally ratified by the Written Policy Control Group and reviewed by the multi disciplinary group every 3 years or when national policy indicates.	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_021	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Transition workshop/s will be held across both services to provide training & awareness on transition and disseminate good practice including the Welsh Governments documents : - HDUHB Transition Policy /Pathway - T4CYP Good Transition Guidance for CAMHS - Young Persons Passport - NICE Guidelines Transition - Emotional needs of young people and families –systemic approach	Dec-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_022	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	HDUHB will develop a multiagency Transition Steering Group which will provide oversight and effective governance on transition	Aug-19	Dec-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_022	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	The Steering Group will have clear Terms of Reference which include the following: - Monitor implementation of the Transition Policy - Review of the data on all transitions 6 monthly - Coordinate training on Transition & pathways - Quality assurance on adherence to policy/ processes HDUHB will undertake an audit of transition on an annual basis to review its compliance with Transition Policy via the Quality Assurance Team (Appendix 5)	Aug-19	Dec-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_026	N/A	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	HDUHB will implement the Young Persons Passport to increase awareness of transition, increase their participation in the transition process and provide support.	Sep-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_027	N/A	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	A transition referral will be completed to formalise the handover of care as per Transition Policy.	Sep-19	Dec-20	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
No ref	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_032	N/A	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.	Colleagues in adult mental health services will be provided with training to understand the developmental needs of young people and their families in accessing mental health services and the need for a individual systemic approach for some young people in accessing services.	Sep-19	Mar-21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post.
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_003	N/A	The health board must ensure that the new observation panels on each room can be used by staff	Latent defect following new installation – estates department to contact contractor/manufacturer to resolve defect.	Jun-19	N/K	Red	Latent defect has been disputed with the manufacturers, issue escalated to Senior Manager Rob Elliot.
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_010	N/A	The health board must repair or replace the damaged flooring within the whole unit as this causes a risk to patient safety	Submit Capital Bid of £10,000 to replace flooring. (Subject to approval and availability of Capital)	Dec-20	Dec-20	Amber	no progress
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_011	N/A	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	no progress
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_017	N/A	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	Long term action.
190417	Apr-19	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_018	N/A	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	Long term action.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_001	N/A	Health boards should ensure there is clarity over the criteria for accessing CMHTs and the various community support teams that exist. In particular GPs and primary care practitioners need to have the information and support to enable them to provide the best possible advice for service users.	Refine the current GP/Primary Care link working system which will be implemented as part of the delivery of Transforming Mental Health.	Dec-22	Dec-22	Red	01/05/2020 Date linked to transforming program. Query strategic log?
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_002	N/A	CMHTs need to ensure that service users are clear on how to access or contact services out of hours, or in the event of crisis or serious concern	Develop bespoke training to be delivered in conjunction with service users/carers/third sector. This will include effective crisis and contingency planning and will be audited through the established CTP Audit. Monitored via Mental Health Legislation Scrutiny Group (MHLSG).	Sep-20	Sep-20	Amber	01/05/2020 Working with exernal provider CTP training to deliver training date extended due to Covid 19.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_007	N/A	CMHTs need to improve the recording of risk assessments within CTPs to ensure risks and management plans are more comprehensively recorded, more detailed and relevant to individual circumstances and particular situations	Develop bespoke training to be delivered in conjunction with service users/carers/third sector. Compliance will be audited through the established CTP Audit to be monitored via the MHLSG.	Mar-20	Dec-21	Red	01/05/2020 Working with exernal provider CTP training to deliver training date extended due to Covid 19.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_008	N/A	CMHTs need to ensure that CTPs are of sufficient quality, with evidence that service users have been involved in their development, and that the resulting CTPs are relevant to the outcomes the service user wishes to achieve.	Develop bespoke training to be delivered in conjunction with service users/carers/third sector with compliance monitored via MHLSG through CTP audits.	Mar-20	Dec-21	Red	01/05/2020 Working with exernal provider CTP training to deliver training date extended due to Covid 19.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_018	N/A	CMHTs need to develop processes to evaluate the effectiveness of information, advice and assistance that is provided for service users	Discussions to take place at the transformation board for partnership consideration to develop a joint plan.	Nov-19	N/K	Red	No update received in May 2020.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_021	N/A	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection	The MH/LD Directorate continues its commitment to co-producing the implementation of its Transforming Mental Health Programme. A data and evaluation work stream has recently been established to review data gathering processes and develop means of continuous quality improvement. The UHB are being assisted by Swansea University. Ensure information systems are updated with a move to Welsh Patient Administration System (WPAS) anticipated this year, followed by migration to Welsh Community Care Information System (WCCIS) across health and social care services.	Dec-22	Dec-22	Amber	01/05/2020 Long term action linked to the Transforming Mental Health program.

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No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_023	N/A	All CMHT staff should receive training in the following; RED • Mental Health Act • Social Services and Well Being Act • First Aid and the use of defibrillators	Produce training plan to ensure all CMHT staff are trained in the Social Services and Well Being Act.	Nov-19	N/K	Red	No update received in May 2020.
No ref	Jul-19	HIW MHLD	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	JTR_023	N/A	All CMHT staff should receive training in the following; RED • Mental Health Act • Social Services and Well Being Act • First Aid and the use of defibrillators	Identify CMHT staff trained in First Aid and produce a training plan to ensure all CMHT staff are trained.	Nov-19	N/K	Red	No update received in May 2020.
19009	Sep-19	HIW MHLD	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Open	N/A	Mental Health & Learning Disabilities	Melanie Evans / Kay Isaacs	Director of Operations	19009_007	N/A	The Health Board must ensure that their policy/s on the interface between DoLS and MHA is compliant in law to ensure it does not diverge from the principle in law	Following reviews of current legislation, interface guidance between DOL's and MHA will be developed and draft will be sent to HB legal department for review prior to ratification.	Jul-20	Jul-20	Amber	1/05/2020 Awaiting National advice, outside th econtrol of the HB.
19009	Sep-19	HIW MHLD	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Open	N/A	Mental Health & Learning Disabilities	Melanie Evans / Kay Isaacs	Director of Operations	19009_008	N/A	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	01/05/2020 Possible closure at next meeting if evidence is sufficient, however no formal update.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Director MH&LD	Director of Operations	19106IA001	N/A	During the inspection, we found that three members of staff employed by the health board, and working at the Brynmair Clinic, did not have a current Disclosure and Barring Service (DBS) certificates in place. This meant that we could not be assured that the staff members were suitable to work with vulnerable adults .We consider the above practice to be unsafe and increases the risk of harm to patients. Improvement needed The Health board must ensure all staff (where applicable), have DBS checks completed with a record of completion kept on file.	With advice and input from the central Resourcing Team, to undertake an audit of the DBS status of all staff within the MH&LD Directorate	Jan-20	Jul-20	Red	Delayed to Covid-19. Work is being undertaken by New Manager and awaiting a response
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	Head of Service to send a communication brief to all CMHT staff to remind them they must record the offer of advocacy services in service users electronic record.	Mar-20	Jul-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to July 2020
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	To use staff meetings and supervision to ensure staff are reminded of this.	Mar-20	Sep-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to Sept 2020
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_001		The health board and local authority must ensure that the offer of advocacy services is recorded in service users' care notes.	To send a communication briefing to staff reminding them that they must record the offer of advocacy services in care notes To use staff meetings and supervision to ensure staff are reminded of this.	Mar-20	Sep-20	Red	Not completed at present in the process of meeting the 3rd Sector Advocacy Manager and planning a Team meeting/training at Brynmair. Date extended to Sept 2020
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities			19106_007		The health board and local authority must ensure that all service users are made aware of how to contact the CMHT out of hours.	Service Users to contact Delta Wellbeing for access to Local Authority out of hours.	Sep-20	Sep-20	Amber	Query on this management response Sara to check no update received. not reached date yet.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_010		The health board and local authority must ensure that service users are given enough time to discuss their needs and treatment.	To ensure that all Service users are offered a CTP pre review meeting, this will ensure that CTPs are allocated adequate time for the review on an individual basis.	Sep-20	Sep-20	Amber	Not reached date yet
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_012		The health board and local authority must ensure that care and treatment plans are person centred and strength based with documented evidence of service user engagement in the process.	CTP training session to be competed with the team.	Sep-20	Sep-20	Amber	Delayed due to covid 19, working with external supplier to deliver CTP training.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_013		The health board and local authority must consider installing an emergency call system within the consulting rooms and other clinical areas.	To complete a risk assessment of the consulting rooms and clinical areas to determine any requirement for an emergency call system.	Jun-20	Sep-20	Red	Delayed due to Covid19, Senior MH Nurse allocating work to Manager.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_013		The health board and local authority must consider installing an emergency call system within the consulting rooms and other clinical areas.	To act on the results and recommendations.	Jun-20	Sep-20	Red	Delayed due to Covid19, Senior MH Nurse allocating work to Manager.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_014		The health board and local authority must provide HIW with a copy of the most recent ligature risk assessment.	To send ligature risk assessment to HIW	Mar-20	Jun-20	Amber	1/06/2020 risk assessment completed establishing the mechanism to send to HIW via secure portal.
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_017		The health board must ensure that staff employed by the health board receive further training to enhance their understanding of their roles and responsibilities under the SSWBA.	Refresher training session to be arranged	Sep-20	Sep-20	Amber	Not reached date yet
19106	Feb-20	HIW MHLD	HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team,	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	19106_020		The health board must ensure that the staff induction process is formalised.	To produce a staff induction check list in line with LA.	Jun-20	Sep-20	Red	Delayed due to Covid 19, work is being progressed.
HDUHB1718-35	Apr-18	Internal Audit - HDUHB	Theatres Directorate	Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_002	Medium	R10. The practice of providing unnecessary 'rest days' to staff at BGH should be promptly reviewed. Any future agreement on rest time, following a period of on-call, should be in line with the A4C NHS terms and conditions of service.	Work already underway to remove compensatory rest day from roster and align on-call practice with A4C and the NHS Wales Harmonising On Call Arrangements (May 2012). This finding is directly linked with Grievance in progress. Working group established to address issues and concerns. As of 13 Feb 2018, HoN Scheduled Care assumes responsibility with SNMs for all elements of workforce management.	Nov-17	N/K	Red	The recommendations cannot be addressed until grievance process is complete
HDUHB1819-17	Feb-19	Internal Audit - HDUHB	Charitable Funds	Open	Substantial	Finance	Jennifer Thomas	Director of Finance	HDUHB1819-17_001	Low	R3. The Charitable Funds Financial Administration and Governance Policy should be reviewed and updated appropriately	The Charitable funds Policy is currently under review.	Feb-19	~~Apr-20~~ Jul-20	Red	The Charitable funds procedure is being updated further due to the Charitable funds strategy meeting. This has been delayed further due to COVID-19.
HDUHB1819-33	Feb-19	Internal Audit - HDUHB	Records Management	Open	Limited	Health Records	Sian-Marie James	Director of Planning, Performance & Commissioning	HDUHB1819-33_001	Medium	R1. Management should ensure the Corporate Records Management Strategy and Policy are submitted to the Business Planning & Performance Assurance Committee for approval.	Following internal discussions, the Corporate Office is leading the review and updating of the Corporate Records Management Strategy and Policy. This will require contributions and input from a number of teams across the UHB. Once reviewed, these will be submitted to the Business Planning & Performance Assurance Committee at the earliest opportunity.	Sep-19	Sep-20	Red	Apr 20 ARAC update: Due to COVID outbreak, the work associated with many of the recommendations has been delayed by at least 3-4 months. A revised policy was due to be considered at the March 2020 IGSC, however this was postponed due to current outbreak. A meeting had been scheduled with the Information Governance Team to progress this work, but due to the pandemic, two meetings have been cancelled. An extension until September 2020 would be appreciated to allow time agree an approach and action the work required.
HDUHB-1819-25	May-19	Internal Audit - HDUHB	Review of Discharge Processes (Follow-up)	Open	Reasonable	Unscheduled Care	Carol Cotterell/ Rhian Dawson	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~~ Sep-20	Red	Discharge Standards had been completed however now having to be reviewed against new WG Discharge Requirements.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
HDUHB 1819-12	Jun-19	Internal Audit - HDUHB	Savings Planning & CIP	Open	Reasonable	Finance	Andrew Spratt	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~~ No update received	Red	Actions 1 and 2 are completed. Action 3 - the checklists have now been pulled together and just need to be circulated to budget holders and confirmation returned that they have received and reviewed them. This should now be complete by December 2019. Action 4 - In progress and on track. Embedding the turnaround process and the approach will form part of the Health Boards 3 year plan. May 2020- action reassigned from Andrew Carruthers to Andrew Spratt. No update provided in May 2020 from Andrew Spratt.
HDUHB-1920-34	Aug-19	Internal Audit - HDUHB	Environmental Sustainability Report	Open	Reasonable	Estates	Terri Shaw	Director of Operations	HDUHB-1920-34_001	Medium	R1: Management should ensure narrative within the Sustainability Report includes explicit discussions of organisational targets and direction in terms of performance as outlined in the Manual for Accounts.	An Energy Strategy is currently being developed, which will identify carbon reduction targets for any projects delivered. This wasn't available in 18/19 but will be available for reporting in the 19/20 Sustainability Report.	May-20	Mar-21	Red	The Decarbonisation strategy is on hold for the Health Board as Shared Services are aiming to review the Carbon footprint of all HB's and then produce an 'All Wales Decarbonisation Strategy' with targets to align with the Welsh Government targets by September 2020 (this has been delayed several months due to COVID 19). Hywel Dda University Health Board will then complete its Decarbonisation strategy to align with the all Wales Strategy which will have targets going forward by March 2021. Progress against these carbon reduction targets will be reported in future Sustainability Reports from 20/21 onwards.
HDUHB-1920-34	Aug-19	Internal Audit - HDUHB	Environmental Sustainability Report	Open	Reasonable	Estates	Terri Shaw	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	Jun-20	Red	The Sustainability Report was submitted on 11/05/2020 with a caveat that due to all invoices not being received and verified by the deadline for submission of the report that some figures have been estimated. There were also issues with availability of transport emissions but a note has been made in the Report to reflect this. The report now reflects progress of previous year's initiatives relating to finite resources. Once all invoices have been received and verified the data in the report will be updated and resubmitted, which will provide accurate progress against previous year's initiatives.
HDUHB-1920-34	Aug-19	Internal Audit - HDUHB	Environmental Sustainability Report	Open	Reasonable	Estates	Terri Shaw	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	Aug-20	Red	Some procedures have been updated, however others still require updating. The ISO14001 gap analysis (phase 1) in April 2020 resulted in 4 minor non-conformances and 2 recommendations for the UHB. Phase 2 of the audit is scheduled to take place in August 2020 (providing access is not restricted due to COVID-19) after which time the remaining documented procedures can be completed as part of the finalisation of the ISO 14001 accreditation.
HDUHB-1920-34	Aug-19	Internal Audit - HDUHB	Environmental Sustainability Report	Open	Reasonable	Estates	Terri Shaw	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	Jun-20	Red	All staff have been reminded of the importance to accurately input data onto spreadsheets, and this is also emphasised as part of any new staff induction into the team. Once all invoices for 19-20 have been processed and verified a review will be carried out to check a sample of data entries against invoices (to conclude in June 2020). Any errors picked up by this review will be highlighted to the appropriate staff member. This review will take place annually as part of the sustainability report process. For Utility invoices, a sample from each dataload is reviewed and countersigned to reduce human error.
HDUHB-1920-05	Oct-19	Internal Audit - HDUHB	Welsh Language Standards Implementation	Open	Reasonable	Partnerships and Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_001	Low	R1. Management should consider introducing a Welsh Language Standards e-learning module as part of the ESR training programme to ensure staff and managers understand their roles and responsibilities in line with the Standards.	The Welsh Language Services Team has contributed to a national piece of work being co-ordinated by Betsi Cadwaladr UHB and Shared Services, in the Once for Wales spirit of partnership, and the outcome is an e-learning resource. Timescale for this is currently unknown, but we plan to roll out once launched. In the meantime, we are targeting focused training and awareness and cascading through key teams.	Oct-19	Oct-20	Red	The All Wales work is continuing but there is a possibility this will be delayed due to Covid-19. In addition, face to face induction and training programmes have been stood down. Timescale of October 2020 still noted on TeamCentral.
HDUHB-1920-05	Oct-19	Internal Audit - HDUHB	Welsh Language Standards Implementation	Open	Reasonable	Partnerships and Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_002	Medium	R2. Management should ensure progress updates of the completion of the Readiness Assessments and any subsequent actions are reported to the Workforce & OD Sub-Committee.	This will be implemented with immediate effect.	Dec-19	Oct-20	Red	As the Workforce & OD Sub-Committee meetings have been stood down (due to Covid-19), it is suggested that this recommendation is reviewed in October 2020.
HDUHB-1920-05	Oct-19	Internal Audit - HDUHB	Welsh Language Standards Implementation	Open	Reasonable	Partnerships and Corporate Services	Sian-Marie James	Director of Partnerships and Corporate Services	HDUHB-1920-05_003	Medium	R3. Management should establish interim arrangements to enable the reporting of Health Board compliance against the Welsh Language Standards whilst key performance indicators and monitoring processes are being developed.	A Welsh Language update is reported to the Improving Experience Sub-committee, which includes reports demonstrating compliance against the Welsh Language Standards.	Oct-19	Oct-20	Red	Prior to the Covid-19 pandemic, it was agreed that consideration would be given to establishing a Group sitting under the auspices of the Well-being of Future Generations (Wales) Act 2015 that woudl specifically focus on the Welsh Language and cultural issues. As the Improving Experience Sub-Committee had not met for some time, this would provide a vehicle for ensuring the Welsh Language Standards were effectively performance managed and scrutinised. This action has been delayed. Revised date of October 2020 provided.
HDUHB 1920-16	Jan-20	Internal Audit - HDUHB	Medical Devices	Open	Reasonable	Clinical Engineering	Chris Hopkins	Director of Operations	HDUHB 1920-16_003	Medium	R3: Management should ensure the identified medical devices policies and procedures are promptly reviewed and submitted for approval.	To review current procedure for the management of safety notices and alerts and issue for consultation. (Complete) To present the revised procedure to the appropriate committee for ratification (June 2020)	Jun-20	Jun-20	Amber	Revised management response to be reported to ARAC June 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_004	Medium	R4. The Bronglais General Hospital Management Committee should establish an annual work plan to ensure organisational business objectives and goals provided by supporting groups, committees and external sources are captured and reported.	A work plan will be developed by the BGH Management Committee to ensure key items are listed and reviewed throughout the year. In addition, the newly re-established Quality Forum, Chaired by the Head of Nursing, will operate as a formal sub-group of the BGH Hospital Management Committee. The QF will receive reports outcomes and review actions from QSEAC, external reviews – HIW etc., development of the BGH Clinical Strategy, capital projects and site improvements plan. The minutes and actions from the QF will be submitted to the HMC in order to provide assurance on delivery.	Mar-20	Mar-20	Red	No update received in May 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_005	Medium	R5. 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	No update received in May 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_007	Medium	R7. Bronglais Hospital Management should ensure the Health Board registers of gifts, sponsorship and hospitality are accurate and up-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	No update received in May 2020.
HDUHB 1920-26	Feb-20	Internal Audit - HDUHB	Bronglais General Hospital Directorate Governance Review	Open	Limited	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	HDUHB 1920-26_008	Medium	R8. Directorate Management should liaise with Finance colleagues to identify further actions to address the financial challenges impacting on the forecasted year-end overspend.	The ability to manage and deliver within budget is impacted due to key drivers affecting Bronglais General Hospital – in the main agency premium costs (40% nurse vacancy rate) and variable pay for doctors to cover vacancies. BGH Management will continue to liaise regularly with Finance colleagues through regular on site meetings and monthly workshops to address overspends. Progress is being made where possible, e.g. the avoidance of using agency doctors, which has been in place for the past two years. Medium to long term plans have also been identified that will aid in the improved recruitment of staff (and therefore reduction in agency costs). This includes the 5-year nurse recruitment strategy that will see the establishment of a local School of Nursing & Faculty of Health Sciences at Aberystwyth University.	Apr-20	Apr-20	Red	No update received in May 2020.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
HDUHB 1920-20	Feb-20	Internal Audit - HDUHB	Cyber Security (Stratia Report)	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Paul Solloway/ Anthony Tracey	Director of Planning, Performance & Commissioning	HDUHB 1920-20_001	Medium	A cyber security role for the Health Board should be properly defined and operating appropriately so to enable the Health Board ICT department to fully use the security products available to them.	Management response to be agreed at ARAC June 2020: Agreed. Following the announcement of the Digital Priorities Invest Fund (DPIF) from Welsh Government, the Health Board secured resources to appoint a Band 6 Cyber Security post. However, due to the funding letter only arriving in December 2019, and the requirement to spend the investment by March 2020, the funding for 2019/20 was utilised to strengthen the cyber tools within the Health Board. The recurring funding will be directed towards funding a full time post for cyber security, to provide the monitoring of the tool sets purchased, both at a national and local level. The post has been through the appropriate governance mechanisms within the Health Board and is ready to be advertised as soon as funding from Welsh Government is received, which is imminent. It is anticipated the post holder will have a start date of September 2020.	Sep-20	Sep-20	Amber	ARAC has requested that the management response be revisited/updated to provide further detail on whether plans are in place to address the audit findings. Revised management response to be reported to ARAC in June 2020.
HDUHB-1920-32	Mar-20	Internal Audit - HDUHB	Rostering	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_002	Medium	Management should ensure that the rosters for the CHRT (Carmarthen) are being produced and made available with a minimum of 4 weeks of notice in order to comply with Health Board policy.	Roster team are tracking issues around roster publication and supporting the operational nurse. Advice and guidance has been provided to MHLD. Director of Mental Health aware and ensure delivery of recommendations.	Oct-20	Oct-20	Amber	MH&LD issued report to Senior Managers, no update as yet.
HDUHB-1920-32	Mar-20	Internal Audit - HDUHB	Rostering	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_005	Low	The Rostering policy should be updated to reflect the good practice observed of rosters being produced 6-8 weeks in advance. (This would also align the policy with what is detailed in the 'Audit Tool' of the 'Interim Guidelines to Support Effective Rostering for Nurses and Midwives Appendix of Rostering Policy').	Policy to be updated in line with Allocate rollout June 2020	Jun-20	Mar-21	Red	Allocate delay, new guidance document live from 08/01/2020 new policy to be written in line with Allocate system Q4 2020-2021
HDUHB-1920-32	Mar-20	Internal Audit - HDUHB	Rostering	Open	Reasonable	Workforce & OD	Michelle James / Daniel Owen	Director of Workforce & OD	HDUHB-1920-32_006	Low	The Health Board should consider that ward/departments are asked to formalise their annual leave arrangements to ensure transparency of working practice across the organisation.	Workforce and Nursing are creating an abstraction overview to track all unavailability including annual leave, this will allow senior managers to pick up incorrect variance across wards and departments and will allow workforce to report. Introduction of Allocate will also allow dashboards for all managers to easily identify issues. (Leave rules will be created in Allocate to warn managers when going over leave allowance) Date completion end of 2020.	Dec-20	Dec-20	Amber	Allocate delay due to COVID will be part of roll out plan
HDUHB-1920-01	May-20	Internal Audit - HDUHB	Health and Care Standards	Open	Reasonable	Nursing	Sian Passey / Cathie Steele	Director of Nursing, Quality & Patient Experience	HDUHB-1920-01_001	Medium	R1: Management should ensure that all Health & Care Standards criteria listed in the assurance matrix is accurately mapped to an appropriate group or committee with reporting arrangements to the Board.	Accepted. The Assurance, Safety and Improvement Team will work with the Board Secretary and Corporate Governance Team to ensure that the mapping is revised to reflect the committee and sub-committee arrangements that have recently been reviewed.	Jun-20	Jun-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: • Ward sisters to ensure that requisition forms are correctly completed and receipted.	Jun-20	Jun-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: • Quarterly schedule of spot check audits held in pharmacy department and undertaken by Pharmacy – spot checks on CD order books will be done as part of 3 monthly CD stock check.	Jun-20	Jun-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_002a	Medium	R2a: Ward managers should ensure all controlled drug requisition forms are accurately and fully completed in line with the requirements of the Medicines Policy.	Controlled drug requisition forms are to be completed in line with requirements of the Medicines Policy through: • Pharmacy to feedback any anomalies from spot check audits to nursing staff – feedback to ward/department manager via e-mail.	Jun-20	Jun-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_003	Medium	R3: The Pharmacy Department should ensure that full stock controlled drug reconciliations are undertaken on all applicable wards a minimum of every three to six months, with a record of the wards visits accurately recorded and maintained on the monitoring spreadsheets.	It is noted that this element of policy implementation has not been routinely implemented. Some of the challenge is availability of a pharmacist and senior nurse to undertake the reconciliation. However, it is accepted that this area needs further work. • Effective Control Systems for controlled drug reconciliations to be implemented across the hospital sites/including Maternity units and Paediatric areas.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_003	Medium	R3: The Pharmacy Department should ensure that full stock controlled drug reconciliations are undertaken on all applicable wards a minimum of every three to six months, with a record of the wards visits accurately recorded and maintained on the monitoring spreadsheets.	It is noted that this element of policy implementation has not been routinely implemented. Some of the challenge is availability of a pharmacist and senior nurse to undertake the reconciliation. However, it is accepted that this area needs further work. • Rolling programme of CD reconciliation to be developed by each site for wards, clinical areas and community hospitals with confirmation feedback of completed audits in senior pharmacy team meeting.**Each site has a rolling programme, however, undertaking of audit has been delayed due to COVID-19 outbreak	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_004	Medium	R4: Management should ensure that medication error incidents recorded on Datix are approved in a timely manner in line with Health Board policy and procedure.	All DATIX Incidents Reports to be investigated and remedial action implemented to mitigate risk.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-18	May-20	Internal Audit - HDUHB	Nursing Medication Administration & Errors	Open	Reasonable	Medicines Management	Jenny Pugh-Jones	Director of Nursing, Quality & Patient Experience	HDUHB-1920-18_004	Medium	R4: Management should ensure that medication error incidents recorded on Datix are approved in a timely manner in line with Health Board policy and procedure.	All DATIX Incident reports relating to Nursing Medication Error and breaches of 30 day non-compliance to be reviewed in local site/Directorate scrutiny meetings.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-38	May-20	Internal Audit - HDUHB	Review of PADR Process (Follow Up)	Open	Reasonable	Workforce & OD	TBC	Director of Workforce & OD	HDUHB-1020-38_002	Medium	Management should ensure managers and leads across the organisation receive PADR training in order to aid them in undertake appraisals in line with Health Board expectations, thus increasing the quality of the reviews. PADR Training Follow Up Comments In the original report, a review of the bespoke and NHS bespoke passport training register maintained by Workforce & OD identified seven (of 11) sampled wards and departments where at least one employee had not received PADR training. A review of the Workforce & OD register, as at April 2020, continued to identify three of the seven wards where no employee had received PADR training – Catering BGH, Endoscopy BGH and Ceredig Ward BGH.		Mar-20	No timescales included in follow up report.	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales.
HDUHB-1920-38	May-20	Internal Audit - HDUHB	Review of PADR Process (Follow Up)	Open	Reasonable	Workforce & OD	TBC	Director of Workforce & OD	HDUHB-1020-38_003	Medium	Management should undertake a periodic sample verification of PADR compliance figures to ensure accuracy of reported information. PADR Compliance Figures Follow Up Comments The original report noted instances where the PADR compliance figures recorded within the ESR system were inaccurate for a sample of wards and departments. Concluding a review of PADR compliance levels, as at 31st March 2020, we can confirm that ward and department compliance figures are only recorded and maintained on ESR. Due to the outbreak of coronavirus (COVID-19), we were unable to verify PADR numbers against the figures recorded in ESR.		Jul-19	No timescales included in follow up report.	Red	27/05/2020- This follow up report came to the conclusion that the all 3 recs from previous report HDUHB 1819-35 (which had been closed as implemented on the audit tracker) are still outstanding. Follow up report did not include any revised timescales therefore Assurance and Risk Officer will be making contact with the reporting officers to request the timescales.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
HDUHB-1920-43	May-20	Internal Audit - HDUHB	Annual Quality Statement 2019/20	Open	Substantial	Quality	Sian Passey / Cathie Steele	Director of Nursing, Quality and Patient Experience	HDUHB-1920-43_001	Medium	Management should ensure mechanisms are in place to enable the delivery and publication of the Welsh version of 2019/2020 AQS document onto the Health Board website in line with Welsh Government requirements.	Action: to liaise with the translation team to ensure that the Board approved versions of the AQS are published on the Health Board internet simultaneously. The Board will receive the final version of the AQS for approval at the meeting scheduled for 28th May 2020. This final version has been sent for Welsh translation. It is recognised that a few amendments may be required at the request of the Board. A plan is in place to ensure that the required changes are made to both the English and Welsh versions of the AQS.	Jun-20	Jun-20	Amber	
SSU_HDU_18 19_01	Apr-19	Internal Audit - SSU	Capital Follow Up (W&C Phase 2, and Bronglais Front of House)	Open	Reasonable	Planning, Performance & Commissioning	Peter Skitt	Director of Planning, Performance & Commissioning	SSU_HDA_181 9_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	~~June -20~~ Mar-21	Red	Superseded by SSU_HDA_1920_01.2 Capital - Follow Up report, which is currently still in draft. Follow up report shows this recommendation outstanding with a revised date of March 2021 and the following current status (At the time of issuing this draft report, the completion of the Front of House scheme was scheduled for June 2020. This is the end of the defects period for the final phase [Theatre Evacuation lift]. Completion of the PPE was anticipated during the end of the financial year 2020/21. Once follow up report is approved by ARAC in June 2020 this recommendation will be closed and re-opened against the new follow up report.
SSU_HDU_18 19_11	Apr-19	Internal Audit - SSU	Cardigan Integrated Care Centre	Open	Reasonable	Planning, Performance & Commissioning	Peter Skitt	Director of Planning, Performance & Commissioning	SSU_HDU_181 9_11_009	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	Legal advise to be sought to determine if recommendation will be implemented or not.	Red	Surface Water Drainage connected to surface water drainage point but future adoption and maintenance beyond HB site boundary is unresolved. Capital Development Manager's recommendation is leave unresolved due to multiple ownership issues which represent a limited risk to the Health Board. No issues to date been noted with the surface water discharge and which have had a good test with all the recent storms. Review from legal adviser to be undetaken before position is determined that this recommendation will not be implemented.
SSU_HDU_18 19_11	Apr-19	Internal Audit - SSU	Cardigan Integrated Care Centre	Open	Reasonable	Planning, Performance & Commissioning	Peter Skitt	Director of Planning, Performance & Commissioning	SSU_HDU_181 9_11_010	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	Legal advise to be sought to determine if recommendation will be implemented or not.	Red	Outstanding Action - although this would require an independent solicitor to review previous legal advice to establish the information that existed and advice provided at the time of the purchase of the CICC site. The independent solicitor would be required to prove that the existing practice had been negligent in their advice to the Health Board and not just made a genuine error in their advice. The costs of pursing this recommendation could be substantial are likely to outweigh the benefits. The issue of the foul drainage adoption has been resolved as part of the scheme works so had no impact on the HB ability to open its site as planned. Pursing this recommendation could also damage relationships with the Health Boards Framework solicitors who act on behalf of the HB on many other proceedings. It should also be noted they are currently acting on the HB behalf in relation to the Cardigan boundary dispute with the adjoining property owners. Review from legal adviser to be undetaken before position is determined that this recommendation will not be implemented.
SSU_HDU_18 19_04	Apr-19	Internal Audit - SSU	Data Centre Project	Open	Reasonable	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Director of Planning, Performance & Commissioning	SSU_HDU_181 9_04_008	Medium	R8. The remaining two outstanding actions identified at the action log will be prioritised for completion	Agreed. The user manual for CCTV has been completed; and work remains ongoing regarding the Biometrics entry system and cabling for additional security.	May-19	Jul-20	Red	Work is underway to complete these tasks. There is an issue with completing one of the actions by the end of March due to Asbestos issues which are waiting to be resolved. All other tasks will be completed. Revised timescale of July 2020 provided in draft follow up report SSU_HDA_1920_01.2.
SSU_HDU_18 19_01	Apr-19	Internal Audit - SSU	Estates Follow Up (Residential Accommodation/ Backlog Maintenance/ Fire Precautions Follow Up).	Open	Reasonable	Finance	Jayne Noble	Director of Finance	SSU_HDU_181 9_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	Jul-20	Red	Recommendation showing as partially implemented in draft Internal Audit SSU_HDU_1920_01.1 Estates Assurance - Follow Up. Finalised follow up report due to be reported to ARAC in June 2020, at which time this report (SSU_HDU_1819_01 Estates Follow Up) will be closed. Update provided on recommendation 10 (Sift monies). Assurance and risk officer emailed Auditor from SSU for confirmation if this recommendation can now be closed.
HDUHB-1920-29	Dec-19	Internal Audit - SSU	Consultant and SAS Doctors Job Planning	Open	Limited	Medical	Helen Williams	Medical Director & Director of Clinical Strategy	SSU_HDU_192 0_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	Dec-20	Red	The Covid19 pandemic meant that all job plan training sessions were cancelled. The majority of the service delivery managers have received the training and there are user guides and webinars available until face to face training can recommence. No updated date to be completed.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_003	Medium	R3: Management should ensure evidence of appropriate insurance coverage is provided prior to the commencement of work.	Accepted. Refer to the recommendation 2. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_004	Medium	R4: RAMS (where applicable) should be requested, checked and retained prior to the contractor commencing the relevant activity on site.	Agreed. The Job Requisition and Authorisation form [as per the new policy] stipulates the return of a RAMS by the appointed contractor. Estates Officers will be expected to sign acceptance of the receipt and content of the RAMS for retention at the specific site. Noting the unprecedented times we are facing an initial imeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_006	Medium	R6: A robust, and consistent, site access control system should be implemented across all sites that ensures: ▪ Daily sign in / out of ALL contractors ▪ Uniquely identifiable badges issued and recorded on the sign in/out register ▪ Robust process for management of contractors out of hours ▪ A sign in/out system should be in place at each community site, using measures appropriate to the site, with ALL contractors required to action daily	Agreed. The sign in / out process currently followed at GGH will be rolled out to all sites. For community sites, an additional section within the Asbestos Registers will be used for contractors to sign in / out and they will informed of this expectation prior to going to site. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_008	Medium	R8: Management should formalise the output of contractor monitoring and report to an appropriate forum.	Agreed. This will be a standing agenda item for the Operational Delivery Group meetings for Operational Officers to provide updates / escalate concerns. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-07	May-20	Internal Audit - SSU	Control of Contractors	Open	Limited	Estates	Rob Elliott	Director of Operations	SSU-HDU-1920-07_009	Medium	R9: Management should embed a standard formal sign off process across all sites that: 1. Confirms completion of the work; and 2. Facilitates the sharing of any lessons learnt.	Agreed. All Site Operations Managers will be reminded of the requirement for formal sign off on completed works. Noting the unprecedented times we are facing an initial timeframe of six months has been set. All recommendations will be re-reviewed at this date. Furthermore, we are requesting a follow-up audit of this area in Q1 of the 2021/22 Internal Audit Plan to provide assurances on appropriate application of the policy across the UHB.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_005	Medium	R5. Management should ensure where SLA contract issues arise they are reviewed and reported to directorate and/or service management.	This recommendation is accepted, and a process will be put in place to ensure that review requirements are highlighted to directorates.	Oct-20	Oct-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_006	Medium	R6. To ensure a consistent approach is being undertaken in the establishment of contracts, management should ensure standard operating procedures are developed and implemented immediately.	This work is being undertaken at present, we are expecting to have all Standard Operating Procedures in place by September.	Nov-20	Nov-20	Amber	New report received at ARAC May 2020.

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HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_007	Medium	R7. Contract leads should ensure a copy of all contracts are submitted to the Contracts Team and uploaded onto the contracts register.	This recommendation is accepted. The contracts team will work with contract leads and the Operational Directorates to get copies of the contracts.	Dec-20	Dec-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_008	Medium	R8. Management should ensure that reviews in relation to the extension of SLA contracts should be fully documented and authorised by appropriate individuals.	This will form part of the work being undertaken by the contracts team working with the Operational Directorates and Business Partners. There will be a value based framework drafted to support either: 1. The on-going commissioning of said services 2. The service continues but support to change (this is to support the directorates and their needs) 3. The service no longer offers value for money and will be decommissioned	Oct-20	Oct-20	Amber	New report received at ARAC May 2020.
HDUHB-1920-14	May-20	Internal Audit - SSU	Contracting	Open	Limited	Finance	Shaun Ayres	Director of Finance	HDUHB-1920-14_009	Medium	R9. Management need to ensure that all agreements between the Health Board and other parties are fully signed and dated by authorised signatories prior to the commencement of the contractual period.	This has been remedied as part of the 20/21 contracting round between Health Boards.	Jul-20	Jul-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_001BGH	Low	R1. The Bronglais Draft Water Safety Plan should be appropriately ratified and published (and stating the need to label accessible pipework)	Agreed. The Bronglais General Hospital Water Safety Plan (WSP) has been changed to incorporate the need to label accessible pipework. This revised WSP will be ratified at the next Water Safety Group Meeting. A complete site review will now commence to establish what areas of the site are accessible, in order to complete the labelling of pipework within 2020/21 financial year.	Jul-20	Jul-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_002BGH	Medium	R2. Local commissioning records should include design risk assessment (including Theatres 1 & 2).	Agreed. All future works will now incorporate a design risk assessment to identify any inherent risks as part of the scheme. This process will commence immediately.	At future schemes	At future schemes	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_003BGH	Medium	R3. In accordance with the Bronglais Water Safety Policy, reporting to the Water Safety Group should include outcomes from periodic management audits, categorised levels of legionella findings, temperature test results, progress against external review recommendations, and delivery against targets.	Agreed. The revised key actions report now incorporates all of the additional reporting elements identified above and will be tabled at the next WSG meeting for approval.	Jul-20	Jul-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_004BGH	Medium	R4. Management/ WSG should formally consider the cost / benefit of BMS upgrade options to ensure compliance with the WHTM.	Agreed. Management have since reviewed the cost benefits of this enhancement, specifically in relation to the reduction of staff time to perform manual temperature testing. It also provides additional levels of assurance that enhanced monitoring is in place at the site. Additional wireless monitoring will now be installed at the site to cover intermediate points of pipework. Specialist companies have already been engaged. Tenders for this will be issued by July 2020, commencement of work in August 2020 with a full completion by September 2020.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_005BGH	Medium	R5. Management should ensure that "as fitted" drawings are sufficiently detailed (inclusive of risk factors) to inform risk assessment and remedial works in accordance with HTM 04.	Agreed. Management have already engaged with external consultants to address the outstanding as fitted drawings at the site. This will be issued for tender in July with a commencement on site in August and completion by the end of September. This information will be used to support the new 2020 legionella risk assessment in identifying any areas of non-compliance with pipework dead-legs of other inherent risks that can be addressed.	Sep-20	Sep-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_006BGH	Medium	R6. A site risk assessment should be commissioned and appropriately informed in relation to the "as fitted" infrastructure / configuration in accordance with the WHTM / HSE requirements (i.e. sufficiently detailed to show risk factors within the configuration).	Agreed. Management have now programmed a commencement date for the 2020 legionella risk assessment at the site with consultants. This will be programmed in two phases. ▪ Phase 1 commencing in July 2020, focusing on areas of the site where there are detailed as fitted drawings to support the risk assessor. ▪ Phase 2 of the works will commence following receipt of the outstanding drawings in September 2020. ▪ On receipt of the reports, the findings will be reviewed carefully to prioritise any actions that require addressing. Actions will also be tracked and presented at the WSG for reporting.	Oct-20	Oct-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety - Bronglais General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_007BGH	Medium	R7. Management should routinely report to the Water Safety Group the implementation status of recommendations arising from external reviews, including those of; ▪ the Authorised Engineer; ▪ Welsh Water (infringement notices); and ▪ site survey risk assessment.	Agreed. Management can confirm that: ▪ Infringement notices - There are currently 2 high risk actions outstanding at the site. This work is now being programmed for completion in September, via the 2020/21 capital allocation. ▪ Authorising Engineer Audit Actions – All outstanding actions will be addressed by October 2020. Actions were subject to addressing staff shortages (HTM Gap Analysis), which has now been concluded. ▪ All of the actions contained in the (new) 2020 external water risk assessment will be tracked accordingly and communicated to the WSG by the designated RP.	Oct-20	Oct-20	Amber	New report received at ARAC May 2020.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_005WGH	Medium	R5. Management should address recommendation 2 of the 2015 Withybush Hospital site survey (in accordance with WHTM 04) i.e. that "controls are implemented to ensure that the file of drawings is kept specific risks can be added, up to date." Partially addressed Example water services diagrams have been provided from the updated set (now advised as complete). These drawings are to act as a basis for appending risk factors to inform the risk assessment and remedial works e.g. TMV's, proximity of hot and cold pipes, flow straighteners (as required by WHTM 04). WHTM 04-01 states the requirement for: "accurate as-fitted drawings.. that "will assist in identifying any potential problems with poor hot water circulation and cold water dead-legs where flow to infrequently used outlets can be low" and that "identify all key components in the installations, for example water meters, cisterns, filtration equipment (where fitted), calorifiers, and the location of isolating valves in the systems." (Part B 6.80/81) and that: "The risk assessor(s) should be given access to competent assistance from the client. This may be in the form of as-fitted drawings and schematic diagrams" to enable "engineering assessment of water systems". It is appreciated that as full identification may involve invasive works, this would be updated over time, and as issues become apparent. It is also appreciated that this is also in context of considerable work addressing identified issues with the result that the hospital currently has clear legionella readings. The updated set of drawings do not currently show risk factors (i.e. as fitted). The risk rating of this recommendation has been amended accordingly to reflect the above actions.	Agreed Detailed schematic drawings have now been produced and received by the HB. They will be used to support the ongoing management of water safety for the site. They will be continually reviewed and kept up to date by the RP for water. Management will now use these drawings to address risks on site. They will be used to support the 2020 site legionella risk assessment, scheduled for August 2020.	Mar-20	Aug-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_009WGH	Medium	R9. Location specific risk assessments should be accurately informed in relation to the infrastructure / configuration in accordance with the WHTM / HSE requirements. Outstanding The application for funding to commission this assessment is acknowledged. The priority rating has been re-assessed in the context of the additional mitigations of updated drawings, and risk reduction referenced above.	The 2020 legionella site risk assessment is now being programmed for commencement in August 2020. The new as fitted drawings will now support this assessment in greater detail.	Dec-19	Sep-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.

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SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_02WGH	Low	r2. Reports should be presented to the Water Safety Group to provide it with appropriate assurances, and to facilitate scrutiny in accordance with its role (including flushing, maintenance,management audit, summary test findings, and purification / remedial works). Partially addressed A comprehensive overview report to the Water Safety Group was evidenced (including assurances that certain elements were being enhanced) e.g. ▪ the Planned Preventative Maintenance report, will summarise response times (demonstrating compliance with targets - as per Section 6 of the Water Safety Plan); and ▪ the showerhead replacement programme is to report against target coverage. While, quarterly / six monthly management audits were not reported in accordance with procedures, the risk rating has been re-assessed based on the recommendation being substantially addressed by enhanced reporting.	Agreed Comprehensive reporting is now being provided and will be enhanced in accordance with the audit recommendation. This will incorporate a significant amount of additional information and content, thus offering improved levels of assurance to the Water Safetyassurance to the Water Safety Group (WSG) and to the HB.	Dec-19	Jul-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_003WGH		R3. Commissioning records should be available locally including design risk assessment and performance testing. Partially addressed The following were evidenced: ▪ contractor assessment;▪ agreement of the design; ▪ agreed drawings; and ▪ biological test results, including legionella testing and chlorination. The Water Safety Plan requires assessment of the design by the "appointed Capital and Operational RP (Water) and/or the Authorising Engineer (Water), and a representative of Infection Prevention Control". While drawings were provided by the scheme engineer, no written risk assessment commentary was provided by the relevant parties, in accordance with the Pro forma Appendices C & D of the Water Safety Plan.	Agreed All future works will now incorporate a formal design risk assessment to identify any inherent risks as part of the scheme. This process will commence immediately. All commissioning records will be available locally by the RP water.	Dec-19	At future schemes	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_006WGH	Low	R6. The Water Safety Plan should be updated to accurately reflect requirements and the UHB's approach to pipework labelling. Additional observation Finding 6 of the October 2019 audit noted that labelling of pipework: "should be maintained on an ongoing basis in refurbished / new build areas and in accessible areas such as plant rooms (as separately required by WHTM04)". The revised Water Safety Plan (as of November 2019) states that there should be: "Clear labelling of pipework in new installations and major refurbishment." i.e. does not make explicit reference to existing accessible pipework. For completeness we have therefore raised an additional recommendation: Additional recommendation For clarity, the Water Safety Plan should additionally specify policy relating to pipework labelling in accessible areas such as plant rooms (in accordance with HTM 04, and findings of the October 2019 audit).	Agreed. The Withybush General Hospital Water Safety Plan (WSP) has been changed to incorporate the need to label accessible pipework.	Mar-21	Mar-21	Amber	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of a) Welsh Water (infringement notices); Partially addressed a) Partially addressed These are now substantially actioned. Completion is now reported as: ▪ Showerheads is 98% ▪ Dead-end removal is 90% ▪ Tap Alterations is 94% ▪ Pipework Alterations is 100%	Agreed a) Management can confirm that the recommendations it has received from the Welsh Water Infringement Notices have been tracked and actioned accordingly.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of b) the Authorised Engineer b) Partially addressed NWSSP: Specialist Estates Services tracker states 73% of actions from April 2019 have been actioned, these largely relate to the "low" risk / priority items. Only 14 of the 37 "high" recommendations have been actioned (38%). (Only 3 of these "high" priority recommendations are stated to await resource / capital).	Authorising Engineer Audit Actions – All outstanding actions will be addressed by October 2020. Actions were subject to addressing staff shortages (HTM Gap Analysis), which has now been concluded.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
SSU-HDU-1920-13	May-20	Internal Audit - SSU	Water Safety Follow-Up - Withybush General Hospital	Open	Reasonable	Estates	Rob Elliot	Director of Operations	SSU-HDU-1920-13_011WGH	Low	R11. Management should confirm that agreed recommendations of external reviews have been actioned, including those of c) site survey risk assessment. Partially addressed We were advised that the majority of recommendations from 2016 have been actioned, subject to confirmation at the 2020 risk assessment (see item 9 above). We recognise that the above action status will have been superseded (e.g. in the case of NWSSP:SES recommendations being the position as of April 2019). Accordingly the changed position as advised by management is noted. It is also noted that that such are the extent of recommendations at such technical reviews that a number of issues will typically be outstanding at any point in time. Additionally noting active reporting, there is evidence that management are actively addressing the same, and the risk rating has been amended accordingly.	c) Management have now programmed a commencementdate for the 2020 legionella risk assessment at the site with consultants. This will be programmed for August 2020. On receipt of the report, the findings will be reviewed carefully to prioritise any actions that require addressing. Actions will also be tracked and presented at the WSG for reporting.	Mar-20	Oct-20	Red	This is the follow up report to the SSU HDU 1920 07 Water Safety – Additional Sampling report. This recommendation is noted as red (behind schedule) as the original completion date from the original report has now passed.
No ref	Not known	Peer Review	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Open	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-CYPDiabetes001	N/A	R1. Absence of a 24 hour on-call advice system	Discuss development of a regional / All Wales 24/7 helpline with other UHBs as a more cost effective alternative to UHB specific arrangements.	2015/16	TBC	Red	14/05/2020 MDM confirmed this has been completed, 1/6/2020 Remains open until confirmation of outcome requested from SDM.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open (external rec)	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-GGH001	N/A	R1. Lack of 24 hour neonatal transfer service Currently CHANTS, the neonatal transfer service in South Wales is only operational between the hours of 0800-2000 .Outside of these hours babies remain on the unit or transfers are undertaken on the goodwill of transport/NICU consultants	Neonatal network to review plans for 24 hours transport service Mitigation • Follow Local protocol(s) for emergency out of hours stabilisation to support management of babies pending arrival of CHANTS retrieval service. • DATIX report all delays of transfer • Close working with local tertiary NICU • Carry out non- CHANTS transfer as appropriate	To be confirmed by Neonatal Network	N/K- outside gift of UHB.	Red	22/05/2020 Senior Nurse confirmed all actions within the HB remit have been completed further work is to be set by Wales Neonatal Network & WHSSC.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-GGH003	N/A	R6. Training and education Only 55% of nurses are Qualified in Specialty (QIS). 6 out of the 7 consultants and 87% of nursing staff are NLS compliant.	Completed training programme in place to support staff to achieve QIS. Due to the nature and length of available neonatal training programmes, the training of a further 6 WTE staff will not be completed until December 2023. Continue efforts to recruit QIS neonatal nurses	Dec-23	Dec-23	Amber	Long term action.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-GGH004	N/A	R7. Guidelines There is a potential for confusion over which guideline to use due to the number available	Schedule of available guidelines to be revised	Dec-19	Jul-20	Red	22/05/2020 Schedule of available guidelines to be revised. A new consultant is working on this and guidelines should be in place by the end of July/Aug for new tranch of staff. Date given as 30/07/2020
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-GGH005	N/A	R9. Transitional Care There is no transitional care facility	Dedicated transitional care facility will not be available until completion of Phase 2 scheme. However transitional care is currently provided in the post-natal ward. No further interim action is proposed pending availability of a dedicated transitional care facility.	Dec-19	Nov-20	Red	22/05/2020 There have been delays in the phase 2 scheme which will impact on the ability to have a designated transitional care area.
No ref	Not known	Peer Review	Glangwili Neonatal Unit Peer Review Report	Open	N/A	Women and Children's Services	Keith Jones	Director of Operations	PeerReview-GGH006	N/A	R10. Infection Prevention and Control The panel felt that some neonatal elements were not reflected in the Health Board IPC Policy	Liaise with infection prevention and control department to develop a neonatal appendix to the Standard Infection Prevention and Control Precautions Policy at next policy review	Aug-20	Aug-20	Amber	Not reached date yet.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service Yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director.	Dec-19	Dec-21	Red	This has yet to be formally resolved but improvements in shift fill have alleviated some of these issues. This will be tackled as a part of the TCS work when the team is able to reconvene.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Review 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	Mar-20	Sep-20	Red	This action is dependent on education of staff. Revised timescale of September 2020 to allow for resits of 1 year APP course if required. This recommendation is led by WAST with financial negotiation from the UHB.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Review the use of Urgent Care Practitioners utilising the lessons learnt from Shropdoc and Cardiff & Vale.	Link with the HEIW /111 team to develop this function as part of winter planning. To confirm with Steve James	Mar-20	Not provided	Red	Responsible officer to check with 111 colleagues and will report back to Assurance and Risk Officer.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH006	N/A	R6. Wider Workforce Planning The 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 provided	Red	Responsible officer to check with 111 colleagues and will report back to Assurance and Risk Officer.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH013	N/A	R13. Communication and Feedback A feedback form needs to be developed for staff to support learning outcomes and issues from bases /shifts	Note: Use the NHSD form as a basis for refinement for local team Currently in development with OOH IT support	Jan-20	Oct-20	Red	Currently in development with OOH IT support, however this has been delayed by several months as I.T support has been redirected to assist with COVID-19 pressures. In the interim there are mechanisms in place to allow staff to feedback. Currently in development with OOH IT support, however this has been delayed by several months as I.T support has been redirected to assist with Covid pressures. In the interim there are mechanisms in place to allow staff to feedback.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical /operational staff In hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	Mar-20	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19.
No ref	Not known	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Out of Hours	Nick Davies	Director of Operations	PeerReview-OOH010	N/A	R10. 111 Service It was noted a large number of compliments were received in HD. It was agreed this information would be shared on an All Wales basis and lessons learnt would be shared. It was agreed patient surveys would be looked at in the future	In hand including CHC and APP OOH surveys.	Dec-20	Dec-20	Red	Patient survey is outstanding and will be picked up again (delayed by several months due to Covid-19).
201900771	08/11/2019	Public Service Ombudsman (Wales)	10373	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations		N/A	R4. Take action to ensure that each district general hospital in its area has a minimum of one Paediatrician who has completed all 3 levels of the BPNA training and can review new patients who have, or are suspected to have, epilepsy.	Action plans held with Ombudsman Liaison Manager.	Feb-20	N/K	Red	22/05/2020- Further evidence has been requested by PSOW. This evidence is still awaited from Paeds consultant. PSOW did not give a time deadline for the clarifying information requested.
201901989	11/12/2019	Public Service Ombudsman (Wales)	201901989 (13248)	Open	N/A	Scheduled Care	Karen Barker	Director of Operations	201901989_003	N/A	R3. Review the pathway for the management of such cases to ensure that it is robust, clinically sound yet patient centred.	Action plans held with Ombudsman Liaison Manager.	Mar-20	N/K	Red	Lack of evidence for the final two actions has been informed to the Board. However, we await presentation to the Endoscopuy users group to complete and we do not know when this will happen.
201901989	11/12/2019	Public Service Ombudsman (Wales)	201901989 (13248)	Open	N/A	Scheduled Care	Karen Barker	Director of Operations	201901989_004	N/A	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.	Action plans held with Ombudsman Liaison Manager.	Mar-20	N/K	Red	Lack of evidence for the final two actions has been informed to the Board. However, we await presentation to the Endoscopuy users group to complete and we do not know when this will happen.
201905316	05/03/2020	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_004	N/A	R4. If any failings in the care and treatment provided to Mrs B are identified by the expert, the Health Board will provide within 1 month of the receipt of the expert clinical report: • A written apology for any failings identified by the expert. • Any reimbursement of private consultation fees recommended by the expert.	Action plans held with Ombudsman Liaison Manager.	Aug-20	Aug-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201905316	05/03/2020	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_005	N/A	R5. The Health Board will implement any future care and treatment recommendations made by the expert in line with the timescales recommended by them.	Action plans held with Ombudsman Liaison Manager.	Date not yet known	Date not yet known	Amber	Ombudsman Liaison Manager confirmed timescale is not yet known.
201905316	05/03/2020	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_006	N/A	R6. Within 1 month of the receipt of the expert report, the Health Board will implement any improvements in practice recommended by the expert.	Action plans held with Ombudsman Liaison Manager.	Aug-20	Aug-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201905316	05/03/2020	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_007	N/A	R7. Within 3 months, the Health Board will review their Putting Things Right policy and process for investigating concerns and produce a revised handbook for relevant staff. This will be supported by a skills-based training programme to ensure improved quality of investigation outcomes and responses as well as timeliness for replies.	Action plans held with Ombudsman Liaison Manager.	Jun-20	Jun-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201905316	05/03/2020	Public Service Ombudsman (Wales)	10076	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_008	N/A	R8. The Health Board will submit evidence of completion of all these measures to the Ombudsman.	Action plans held with Ombudsman Liaison Manager.	Date not yet known	Date not yet known	Amber	Ombudsman Liaison Manager confirmed timescale is not yet known.
201904831	19/03/2020	Public Service Ombudsman (Wales)	14088	Open	N/A	Unscheduled Care (BGH)	Dawn Jones	Director of Operations	201904831_003	N/A	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.	Action plans held with Ombudsman Liaison Manager.	Jun-20	Jun-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201803909	08/04/2020	Public Service Ombudsman (Wales)	8631	Open	N/A	Unscheduled Care (WGH) / MH&LD	TBC	Director of Operations	201803909_002		R2. Address with the staff responsible for Mr C's care on the mental health ward at the First Hospital, the shortcomings referred to at a) above, using the relevant parts of this report as a learning tool and in a manner which generates clear documentary evidence of that learning by way of, for example, meeting minutes, training materials, staff attendance logs etc.	Action plans held with Ombudsman Liaison Manager.	May-20	N/K	Red	The remaining action is being undertaken but COVID-19 has put limits on how this may be acheved. More time has been requested from PSOW to complete outstanding action. Ombudsman Liaison Manager confirmed he does not know when this will be completed as this action is currently with the Consultant.
201902393	08/04/2020	Public Service Ombudsm	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_005		Implement any recommendations arising from this expert report and engage the NHS redress procedure, if appropriate and with your agreement.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201902393	08/04/2020	Public Service Ombudsm	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_006		Undertake enquiries to determine how the original complaint responses provided conflicting information and implement measures to ensure improved accuracy in the future.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
201902393	08/04/2020	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_007		Remind all clinicians of the necessity to notate in the clinical record when a patient does not consent to interventions and the conversation associated with this. In addition, clinicians will be reminded to ensure that patients with Barrett's Oesophagus are 'counselled' about the possible future course of their condition and the risks associated with it.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
201902393	08/04/2020	Public Service Ombudsman (Wales)	9905	Open	N/A	Scheduled Care	Caroline Lewis	Director of Operations	201902393_008		Remind all gastroenterologists and other appropriate clinicians of the need to ensure that repeat endoscopies are planned at the relevant intervals for patients diagnosed with Barrett's Oesophagus.	Action plans held with Ombudsman Liaison Manager.	Oct-20	Oct-20	Amber	Ombudsman Liaison Manager confirmed action is still amber.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_002	Not stated	CE+ 2: Removing old/unnecessary/unsupported software from the estate will reduce the potential attack surface as well as removing inherent vulnerabilities. Vendor software i.e. Adobe Reader and Adobe Flash Player on a large number of hosts requires patching to a supported level. Adobe Reader and Adobe Flash are standalone software applications that can normally be updated or patched with low impact on other applications or services.	No progress. Detailed audit of installed software to be undertaken. Initial snapshot showed 32,000 software applications and updates installed. No further progress as no Cyber security resources have been allocated to the department.	N/K	Mar-21	Red	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_003	Not stated	CE+ 3: On the HDUHB supported infrastructure, up to date Microsoft Windows security updates, patches for vendor software 7-Zip and VPN client Cisco AnyConnect should be implemented, and a more comprehensive patch management plan agreed for future updates.	Microsoft security patches are now deployed as per CE+1. Other vendor patches cannot be addressed until Cyber security resources are available to ICT.	Mar-21	Mar-21	Amber	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_005	Medium	CE+ 5: Six monthly network scans will allow progress on the points mentioned above to be measured over time, and give a clearer, ongoing picture of the Health Boards exposures. It will also allow efficient and effective deployment of IT resources.	Reliant on NWIS National procurement of vulnerability scanning solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood.	N/K - reliant on NWIS (outside the gift of the UHB)	N/K - reliant on NWIS (outside the gift of the UHB)	Red	Reliant on NWIS National procurement of vulnerability scanning solution- timescale unknown.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_008	Medium	A.7.3 & A.9.2: A robust movers and leavers process to be introduced and continually monitored.	Hywel Dda Policy (301) is in place for user account management. A 'task and finish' group has been setup to improve the current operational processes. A review of user accounts has resulted in removal of more than 4000 unused accounts. Updated policy to be presented to IGSC for approval. New user forms are live on the ICT Portal and Trustmarque has been commissioned to automate and improve the current process based on technologies now available in O365.	Dec-20	Dec-20	Amber	Action plan provided to assurance and risk officer in May 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_009	Medium	A.8.1: The asset register for technical items to be fully completed. Work to complete the IAR to be maintained so that it is complete by the time that GDPR comes into force.	Work is progressing well through the Information Asset Owners group. Technical asset register has been completed for servers and network switches. These are currently being mapped to Information Asset Owners.	Dec-20	Dec-20	Amber	Action plan provided to assurance and risk officer in May 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_011	Medium	A.11.1: Staff resources to be provided to allow the communications room security audits to be completed across the Health Board in a timely fashion.	Communication room security audits are complete. A formal risk assessment will be submitted to IGSC outlining resources required to address.	Dec-20	Dec-20	Amber	Action plan provided to assurance and risk officer in May 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_012	Medium	A.12.1: The remaining XP machines should be segmented off the main network and access to them strictly controlled, all unnecessary services removed from user access.	Windows XP devices has reduced from 33 to 23. Awaiting update to Audiology and Chubb security system to enable upgrade to Windows 10. Review of remaining systems is underway and report will be made available for IGSC.	Aug-20	Aug-20	Amber	Action plan provided to assurance and risk officer in May 2020.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_013	Medium	A.12.2: Further staff resources to be allocated to enable a more robust server patching regime to be achieved.	Paper has been provided to the executive team to identify the resources required to improve the rates of server patching. This equated to 3 x Band 5's. No funding has been identified so patching still at best endeavours using existing resources.	N/K	TBC	Red	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020. Status is red as no progress made to date.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_015	Medium	A.12.4:NWIS are purchasing the LogRhythm SIEM solution. Once the purchase and staff training has been completed its deployment to the various Health Boards should be expedited.	Reliant on NWIS national procurement of LogRhythm solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood (2 HDD staff members attending LogRhythm training 25-26th March, 2020).	N/K - reliant on NWIS (outside gift of UHB)	N/K - reliant on NWIS (outside gift of UHB)	Red	Reliant on NWIS national procurement of LogRhythm solution.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open (external rec)	N/A	Planning, Performance & Commissioning (Informatics)	Anthony Tracey/ Sarah Brain	Director of Planning, Performance & Commissioning	Stratia_016	Medium	A.12.6: A CE+, or similar scan, to be carried out periodically (suggest 6 monthly) to provide an independent view of the patching status of the infrastructure.	Reliant on NWIS national procurement of vulnerability scanning solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood.	N/K - reliant on NWIS (outside gift of UHB)	N/K - reliant on NWIS (outside gift of UHB)	Red	Reliant on NWIS national procurement of vulnerability scanning solution.
No ref	01/03/2019	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Director of Workforce & OD	Ann Marie Thomas	Director of Workforce & OD	PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Mar-20	Red	
No ref	01/03/2019	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Director of Workforce & OD	Ann Marie Thomas	Director of Workforce & OD	PCTWL_008	N/A	R8. Health Education and Improvement Wales, health boards and higher education establishments need to work together to develop a clear connection between the recruitment process on the basis of linguistic ability and the contents and medium of the training provision within higher education establishments.	The Health Board will publish the new Bi-Lingual Strategy, which sets out the skills assessment by department to inform workforce planning and the recruitment process. (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Aug-20	Red	AT -HB strategy delayed due to Covid 19 workload.
No ref	01/03/2019	Welsh Language Commissioner	Primary care training and the Welsh language	Open	N/A	Director of Workforce & OD	Ann Marie Thomas	Director of Workforce & OD	PCTWL_013	N/A	R13. Health boards and primary care clusters should develop a framework for ensuring effective progression between identifying the linguistic needs of the local population, providing education and training based on these needs, and recruiting and appointing primary care workers with bilingual professional skills	The Health Board will publish the new Bi-Lingual Strategy, which sets out the skills assessment by department to inform workforce planning and the recruitment process (RESPONSE STILL TO BE AGREED BY DIRECTOR OF WORFORCE & OD)	Mar-20	Aug-20	Red	AT -HB strategy delayed due to Covid 19 workload.
CSG584	13/08/2019	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_001	N/A	R1. The Health Board must conduct a review to check that appointment letters sent from other departments comply with standard 5 and act upon the results of the review.		Apr-20	Oct-20	Red	This recommendation has been put on hold for the last several months as engagement of clinicians has not been achievable due to COVID-19. Service will start to pick this back up now but will be dependent on the capacity of the operational teams. Welsh Commissioner confirmed on 31/03/2020 that due to COVID-19 they will not be asking for evidence of the implementation of enforcement action. Recommendation to be reviewed October 2020.

Reference Number	Date of report	Report issued by	Report Title	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (RAG)	Progress reported to ARAC February 2020: Work still underway.
CSG584	13/08/2019	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_001	N/A	R3. Hywel Dda University Health Board must provide sufficient written evidence to satisfy the Welsh Language Commissioner that it has carried out enforcement actions 1-2.		Apr-20	Oct-20	Red	This recommendation has been put on hold for the last several months as engagement of clinicians has not been achievable due to COVID-19. Service will start to pick this back up now but will be dependent on the capacity of the operational teams. Welsh Commissioner confirmed on 31/03/2020 that due to COVID-19 they will not be asking for evidence of the implementation of enforcement action. Recommendation to be reviewed October 2020.
CSG584	13/08/2019	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	Welsh Language	Sian-Marie James	Director of Partnerships and Corporate Services	CSG584_002	N/A	R2. The Health Board must conduct a review to check that forms provided to the public by other departments comply with standard 36 and act upon the results of the review.		Apr-20	Oct-20	Red	This recommendation has been put on hold for the last several months as engagement of clinicians has not been achievable due to COVID-19. Service will start to pick this back up now but will be dependent on the capacity of the operational teams. Welsh Commissioner confirmed on 31/03/2020 that due to COVID-19 they will not be asking for evidence of the implementation of enforcement action. Recommendation to be reviewed October 2020.

Reports Closed on the Audit Tracker since ARAC February 2020

Report name	Lead Executive/Director
CHC The Fragility of GP Out of Hours Services in Wales	Director of Operations
CHC Phlebotomy Clinic, Prince Philip Hospital and the Antioch Centre, Llanelli, November 2018	Director of Operations
CHC Bronglais Hospital, Dyfi Ward and Clinical Decisions Unit, 21 November 2018 and 24 January 2019	Director of Operations
CHC Maternity Services Report, May 2019	Director of Operations
HIW Bronglais Hospital (Maternity), 21-23 October 2019	Director of Operations
HIW MHLD NHS Learning Disability Service Inspection: Bro Myrddin, 2 April 2019	Director of Operations
HIW/CHC Contractors Meddygfa Minafon, Kidwelly	Director of Primary, Community and Long Term Care
HIW/CHC Bridge Street Dental Practice, Haverfordwest	Director of Primary, Community and Long Term Care
Internal Audit Low Vision Service Wales – Review of New Arrangements	Director of Primary, Community and Long Term Care
Internal Audit Single Tender Actions	Director of Finance
Internal Audit Preparedness & Compliance with the Nurse Staffing Act	Director of Nursing, Quality and Patient Experience
Internal Audit Budgetary Planning	Director of Finance
Internal Audit Annual Quality Statement	Director of Nursing, Quality and Patient Experience
Internal Audit Electronic Staff Record (ESR) System	Director of Workforce & OD
Internal Audit Departmental IT System: Lile – Sexual Health Management Internal Audit Water Safety – Additional Sampling	Director of Operations
MWWFRS The Regulatory Reform (Fire Safety) Order 2005, Llys Steffan, Lampeter, Ceredigion SA48 7BJ	Director of Operations
MWWFRS Enforcement Notice: The Regulatory Reform (Fire Safety) Order 2005: Article 30. Withybush General Hospital	Director of Operations
MWWFRS Enforcement Notice: The Regulatory Reform (Fire Safety) Order 2005: Article 30 St Caradogs, WGH	Director of Operations
PSOW 13632	Director of Primary, Community and Long Term Care

Reports Open on the Audit Tracker since ARAC February 2020

Report name	Lead Executive/Director	Final report received at
Audit Wales: Implementing the Well-being of Future Generations Act- Hywel Dda Health Board. Oct 2019	Director of Partnerships and Corporate Services	Audit and Risk Assurance Committee October 2019 (previously omitted from the audit tracker error)
Audit Wales: Integrated Care Fund (ICF) Review Update (West Wales RPB). Oct 2019	Director of Partnerships and Corporate Services	Audit and Risk Assurance Committee August 2019 (previously omitted from the audit tracker error)
Audit Wales: Structured Assessment 2019. Dec 2019	Board Secretary	Audit and Risk Assurance Committee February 2020
CHC: Audiology (Hearing) Services November 2019. Feb 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
CHC: Eye Care Services in Wales Follow Up. Feb 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
HIW: Llandovery, 26-27 November 2019. Feb 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
HIW: Withybush Hospital (Maternity), 3-4 December 2019. Mar 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
HIW: Withybush General Hospital, Hywel Dda University Health Board – Wards 7 & 11 (Immediate Improvement plan), Feb 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team Mar 2020	Director of Operations	Quality Safety & Experience Assurance Committee March 2020
HIW/CHC Contractors: Neyland Surgery. Sep 2019	Director of Primary, Community and Long Term Care	To be received at Quality Safety & Experience Assurance Committee August 2020
HIW/CHC Contractors: My Dentist / The Friars. Mar 2020.	Director of Primary, Community and Long Term Care	Quality Safety & Experience Assurance Committee May 2020
Internal Audit: Annual Quality Statement 2019/20. May 2020	Director of Nursing, Quality and Patient Experience	Audit and Risk Assurance Committee May 2020
Internal Audit: Bronglais General Hospital Directorate Governance Review. Feb 2020	Director of Operations	Audit and Risk Assurance Committee Feb 2020
Internal Audit: Contracting. May 2020	Director of Finance	Audit and Risk Assurance Committee May 2020

Internal Audit: Control of Contractors. May 2020	Director of Operations	Audit and Risk Assurance Committee May 2020
Internal Audit: Cyber Security (Stratia Report). Feb 2020	Director of Planning, Performance & Commissioning	Audit and Risk Assurance Committee Feb 2020
Internal Audit: Health and Care Standards. May 2020	Director of Nursing, Quality and Patient Experience	Audit and Risk Assurance Committee May 2020
Internal Audit: Medical Devices. Jan 2020	Director of Operations	Audit and Risk Assurance Committee Feb 2020
Internal Audit: Nursing Medication Administration & Errors. Mar 2020	Director of Nursing, Quality and Patient Experience	Audit and Risk Assurance Committee April 2020
Internal Audit: Rostering. Mar 2020	Director of Workforce & OD	Audit and Risk Assurance Committee April 2020
Internal Audit: Water Safety - Bronglais General Hospital. May 2020	Director of Operations	Audit and Risk Assurance Committee May 2020
Internal Audit: Water Safety Follow-Up - Withybush General Hospital. May 2020	Director of Operations	Audit and Risk Assurance Committee May 2020
Internal Audit: Research & Development Governance Review. Feb 2020	Medical Director	Audit and Risk Assurance Committee Feb 2020
MWWFRS: Enforcement Notice - The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverf ordwest, SA61 2PG, April 2020	Director of Operations	Health & Safety Assurance Committee May 2020
MWWFRS: Enforcement Notice - The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF, April 2020	Director of Operations	Health & Safety Assurance Committee May 2020
MWWFRS: Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital 002 Feb 2020	Director of Operations	Health & Safety Assurance Committee May 2020
MWWFRS: Enforcement Notice- The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital.003 Feb 2020	Director of Operations	Health & Safety Assurance Committee May 2020

MWWFRS: Enforcement Notice - The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital.004 Feb 2020	Director of Operations	Health & Safety Assurance Committee May 2020
PSOW 201803909 (Datix 8631)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201902393 (Datix 9905)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201905316 (Datix 10076)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201904831 (Datix 14088)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201804936 (Datix 9206)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
PSOW 201902238 (Datix 12260)	Director of Operations	Directorate Quality, Safety and Experience meetings (reinstated from June 2020)
Stratia Consulting: NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB). Oct 2017	Director of Planning, Performance & Commissioning	Information Governance Sub Committee, 2017
Welsh Language Commissioner: Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards (Ref CSG584)	Director of Partnerships and Corporate Services	Not reported

Appendix 4: 77 reports with recommendations that have exceeded their original completion date

Name of Report	Reviewing Body	Date of Report	Original Completion Date	No. of red recommendations (behind schedule)
A Comparative Picture of Orthopaedic Services - Hywel Dda	Audit Wales	Jun-15	Apr-17	1
Hospital Catering and Patient Nutrition Follow-up Review	Audit Wales	Feb-16	Dec-16	1 (outside the gift of the Health Board to currently implement)
NHS Consultant Contract Follow Up	Audit Wales	Jun-16	Apr-17	2
Review of Estates	Audit Wales	Jul-16	May-17	2
Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Peer review	Aug-16	Mar-17	1
All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Delivery Unit	Jul-17	May-19	2
NHS Wales External Security Assessment (Stratia Consulting) - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB)	Stratia Consulting	Oct-17	Not known	5 (3(outside the gift of the Health Board to currently implement)
Follow-up Outpatient Appointments: Update on Progress	Audit Wales	Dec-17	Sep-19	2 (1 rec is on the Strategic Log)
National Standards for Cleaning in NHS Wales	Internal Audit	Feb-18	Jun-18	1 (outside the gift of the Health Board to currently implement)
Theatres Directorate	Internal Audit	Apr-18	Jun-18	2
Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Audit Wales	May-18	Mar-16	1
“What’s your NHS like for you?” Hearing from people with a learning disability	Community Health Council	May-18	Mar-19	1
District Nursing: Update on Progress	Audit Wales	Jun-18	Jan-19	1 (outside the gift of the Health Board to currently implement)
National report- The Quality of Care and Treatment Planning - Assurance Review of Adult MH&LD Services	Delivery Unit	Jul-18	Apr-20	1
CHC Brynteg GP Practice, Ammanford Aug 2018	Community Health Council	Aug-18	Dec-19	2
Women and children’s services Visit report March 2018	Community Health Council	Aug-18	Apr-19	1
Radiology Directorate	Internal Audit	Oct-18	Oct-19	2
Primary care services at Hywel Dda	Audit Wales	Nov-18	Oct-19	5
Review of the Impact of Long Waits for Planned Care on Patients	Delivery Unit	Nov-18	May-20	5
Structured Assessment 2019	Audit Wales	Jan-19	Mar-20	1
Structured Assessment 2018	Audit Wales	Jan-19	Apr-20	1
Charitable Funds	Internal Audit	Feb-19	May-19	1
PC and Laptop Security (Follow Up)	Internal Audit	Feb-19	Feb-20	1
Records Management	Internal Audit	Feb-19	Sep-19	2
Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Health Inspectorate Wales (HIW)	Feb-19	Jul-19	2 (1 rec is on the Strategic Log)
North Ceredigion Community Mental Health Team (Gorwellion) 20-21 Nov 2018	Health Inspectorate Wales - (HIW) MHLD	Feb-19	Aug-19	1
Joint Thematic Review of Community Mental Health Teams 2017-2018	Health Inspectorate Wales - (HIW) MHLD	Feb-19	Mar-20	6
All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s LPMHSS	Delivery Unit	Mar-19	Nov-19	1
Primary care training and the Welsh language	Welsh Language Commissioner	Mar-19	Mar-20	3
How are healthcare services meeting the needs of young people? Thematic Review 2019	Health Inspectorate Wales - (HIW) MHLD	Mar-19	Dec-19	8
Clinical coding follow-up review	Audit Wales	Apr-19	Dec-15	4
Capital Follow Up (W&C Phase 2, and Bronglais Front of House)	Internal Audit	Apr-19	Sep-19	1
Cardigan Integrated Care Centre	Internal Audit	Apr-19	Jun-20	2
Data Centre Project	Internal Audit	Apr-19	Mar-20	1
Estates Follow Up (Residential Accommodation/ Fire Precautions Follow Up).	Internal Audit	Apr-19	Sep-19	1
Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Health Inspectorate Wales - (HIW) MHLD	Apr-19	Mar-20	3
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Delivery Unit	May-19	Dec-19	3
Integrated Care Fund – Follow Up	Internal Audit	May-19	Jul-17	1
Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. South Pembs Hospital	Mid and West Wales Fire and Rescue Service	May-19	Dec-19	1
Review of Discharge Processes (Follow-up)	Internal Audit	May-19	Sep-19	1
Review of operational quality and safety arrangements	Audit Wales	Jun-19	Apr-20	3

Name of Report	Reviewing Body	Date of Report	Original Completion Date	No. of red recommendations (behind schedule)
HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Health Inspectorate Wales (HIW)	Jun-19	Nov-19	3
Savings Planning & CIP	Internal Audit	Jun-19	Mar-20	1
Accident and Emergency Department Withybush Hospital 22 July 2019	Community Health Council	Jul-19	Dec-19	3
Environmental Sustainability Report	Internal Audit	Aug-19	May-20	4
Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Welsh Language Commissioner	Aug-19	Apr-20	3
HIW Amman Valley Hospital, Cysgod Y Cwm Ward, 20-21 May 2019 (Community)	Health Inspectorate Wales (HIW)	Aug-19	Dec-19	1
HIW Sunderland Ward, South Pembrokeshire Hospital 13-14/05/19	Health Inspectorate Wales (HIW)	Aug-19	Oct-19	1
Glangwili Neonatal Unit Peer Review Report	Peer review	Aug-19	Dec-19	3 (1 outside the gift of the Health Board to currently implement)
All Wales Review of progress towards delivery of Eye Care Measures	Delivery Unit	Sep-19	Mar-20	6
GP Surgery Visit: Neyland Surgery, September 2019	Health Inspectorate Wales (HIW)	Sep-19	Not stated	4
St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Health Inspectorate Wales - (HIW) MHLD	Sep-19	Sep-19	1
Implementing the Well-being of Future Generations Act – Hywel Dda Health Board	Audit Wales	Oct-19	Mar-20	5
Welsh Language Standards Implementation Estates Directorate Governance Review	Internal Audit Internal Audit	Oct-19 Oct-19	Dec-19 Jan-20	3 1
Llandovery Hospital August 2019	Community Health Council	Nov-19	Mar-20	4
PSOW 201900771 (Datix 10373)	Public Service Ombudsman for Wales	Nov-19	Feb-20	1
Out of Hours Peer Review 21-22 October 2019	Peer review	Nov-19	Mar-20	7
Consultant and SAS Doctors Job Planning	Internal Audit	Dec-19	Mar-20	2
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)	Mid and West Wales Fire and Rescue Service	Dec-19	Mar-20	5
PSOW 201901989 (Datix 13248)	Public Service Ombudsman for Wales	Dec-19	Mar-20	2
Ystwyth Ward, Bronglais General Hospital 3-4th September 2019	Health Inspectorate Wales (HIW)	Dec-19	Mar-20	2
GP Surgery Visit: Narberth Surgery 21/10/2019	Health Inspectorate Wales (HIW)	Jan-20	Apr-20	1
Withybush Hospital (Maternity), 3-4 December 2019	Health Inspectorate Wales (HIW)	Jan-20	Mar-20	1
Glangwili Hospital (Maternity), 7-9 October 2019	Health Inspectorate Wales (HIW)	Jan-20	Sep-20	5
Bronglais General Hospital Directorate Governance Review	Internal Audit	Feb-20	Apr-20	7
Llandovery, 26-27th November 2019	Health Inspectorate Wales (HIW)	Feb-20	May-20	2
Withybush General Hospital, Hywel Dda University Health Board - Wards 7 & 11	Health Inspectorate Wales (HIW)	Feb-20	Mar-20	3
Dental Practice Visit: {My}dentist, The Friars / Hywel Dda Unuiversity Health Board 12/12/2019	Health Inspectorate Wales (HIW)	Mar-20	Mar-20	2
Eye Care Services in Wales Follow Up	Community Health Council	Mar-20	Mar-20	2
Rostering	Internal Audit	Mar-20	Jun-20	2
HIW & CIW: Joint Community Mental Health Team Inspection (Announced) Llanelli Community Mental Health Team	Health Inspectorate Wales - (HIW) MHLD	Mar-20	Jun-20	7
PSOW 201803909 (Datix 8631)	Public Service Ombudsman for Wales	Apr-20	Apr-20	1
Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Mid and West Wales Fire and Rescue Service	Apr-20	Oct-20	3
Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF	Mid and West Wales Fire and Rescue Service	Apr-20	Oct-20	1
Review of PADR Process (Follow Up)	Internal Audit	May-20	Mar-20	3
Water Safety Follow Up - Withybush General Hospital	Internal Audit	May-20	Mar-20	7