Bundle Audit & Risk Assurance Committee 27 August 2019

4.8 WAO Review of Operational Quality & Safety Arrangements Update

Presenter: WAO/Mandy Rayani/Dr Philip Kloer

SBAR WAO Review of Operational Quality & Safety Arrangements ARAC August 2019

WAO Review of Operational Quality & Safety Arrangements: Final Report (with Mgmt Response)

7.3 Audit Tracker

Presenter: Joanne Wilson

SBAR Audit Tracker ARAC August 2019

Appendix 1 - List of Reports Past Original Completion Date

Appendix 2 - Audit Tracker

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	WAO Review of Operational Quality and Safety Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sian Passey, Assistant Director of Nursing, Assurance and Safeguarding

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Audit & Risk Assurance Committee the management response to the Wales Audit Office (WAO) report following the review of the operational quality and safety arrangements and the management response to the recommendations made by the WAO.

Cefndir / Background

As part of the WAO 2018 audit plan for the Health Board, WAO included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: Are the Health Board's operational quality and safety arrangements and structures effective?

In undertaking this work, WAO examined arrangements and structures at a directorate and corporate level. The arrangements and structures at a committee level were also considered.

Asesiad / Assessment

The WAO found that the Health Board has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements, however these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be. The final report (provided as an annex to this paper) made eight recommendations:

Recommendations	
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.

R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	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 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.
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.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

A meeting to consider the recommendations, and the Health Board response to the recommendations, was held with the Director of Nursing, Quality and Patient Experience, Medical Director and Director of Strategy, the Executive Director of Therapies and Health Science and the Board Secretary attending. The report has also been presented to the Quality, Safety & Experience Assurance Committee (QSEAC). The management response (appendix 1 of the annex) has been formulated, taking into account the discussions at the meetings.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to:

- Receive the WAO report following the review of operational quality and safety arrangements;
- Receive assurance that the findings of WAO have been considered and appropriate actions have been identified to address the recommendations; and
- Support the management response to the recommendations.

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 2. Safe Care 3. Effective Care
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	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Associate Medical Director (AMD) Operational Quality, Safety and Experience Sub-Committee (OQSEC) Quality, Safety and Experience Assurance Committee (QSEAC) Wales Audit Office (WAO)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Nursing, Quality and Patient Experience Medical Director and Director of Strategy Executive Director of Therapies and Health Science Board Secretary Assistant Director of Nursing, Assurance and Safeguarding

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Requirement to implement changes to strengthen Governance arrangements in relation to quality Governance committee arrangements
Gweithlu: **Workforce:**	Staff released to attend meetings – recommendations should streamline and enhance Governance arrangements
Risg: **Risk:**	Risks to concerns not being escalated adequately if arrangements are not in place
Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	Need strong Governance arrangements to ensure there is appropriate escalation of risks
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	All reports to new committee structure will complete EQiA as this becomes established

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Review of operational quality and safety arrangements – **Hywel Dda University Health Board**

Audit year: 2018

Date issued: June 2019

Document reference: the Publishing team assigns this

This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

The team who delivered the work comprised Anne Beegan and Phil Jones.

Contents

The Health Board now has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these are not yet consistent, and the flow of assurance from directorates to the Board.is not as effective as it could be

Summary report

Introduction

1 In our 2017 Structured Assessment report for Hywel Dda University Health Board (the Health Board), we identified that the operational directorate teams at that time needed to mature, and that the operational structures needed to be further developed, to support the Health Board's governance arrangement, particularly in relation to quality and safety.

2 We also identified that improvements were needed to ensure that the Board received the necessary assurances from its committees, in particular, from its Quality, Safety and Experience Assurance Committee (QSEAC), Work was underway to reconfigure the QSEAC and its supporting structures at that time, with the aim to improve assurance flows.

3 In our 2018 Structured Assessment report we further identified that the Health Board continues to strengthen governance and management arrangements, but there is recognition that there remain some weaknesses in quality and safety governance arrangements. We identified that work has taken place to revisit and refine the QSEAC supporting structures, but agendas remain long, duplication exists between sub-groups and many issues discussed are best placed at an operational level.

4 As part of our 2018 audit plan for the Health Board, we included local work to review the Health Board's operational quality and safety arrangements. This review commenced in September 2018 and asked the following question: **Are the Health Board's operational quality and safety arrangements and structures effective?**

5 In undertaking this work, we have examined arrangements and structures at a directorate[1] and corporate level. We have also examined the arrangements and structures at a committee level. This has included QSEAC and its supporting sub-committees, in particular, the Operational Quality, Safety and Experience Sub-Committee (Operational QSESC).

6 Our work has included interviews with all directorate senior management teams as well as senior leads for quality and safety across the Health Board. We have also reviewed documentation including minutes of meetings, committee papers, organisational structures and risk registers. We have observed the QSEAC and the Operational QSESC.

[1] We have reviewed ten directorates. These are the four hospital directorates (Bronglais, Glangwili, Prince Philip and Withybush), the three county directorates (Carmarthenshire, Ceredigion and Pembrokeshire), and the three Health Board wide directorates (Mental Health and Learning Disabilities, Scheduled Care, Women and Children).

Summary of findings

7 We conclude that the Health Board now has some good quality and safety arrangements at a directorate level, supported by developing corporate arrangements but these are not yet consistent, and the flow of assurance from directorates to the Board is not as effective as it could be.

8 In reaching this conclusion we have found that:

- Some directorate level arrangements are good, but they are not sufficiently consistent;
- Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be;
- The operational quality, safety and experience sub-committee is evolving with scope to take greater assurance from directorates and to focus more on key risks, but attendance is problematic; and
- The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and improve the quality of papers.

9 We explore these findings in more detail later in this report.

Recommendations

10 In undertaking this work, we have identified a number of recommendations. These are set out in Exhibit 1 below.

Exhibit 1: Recommendations

Recommendations	
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.
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.
R3	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;

Recommendations	
	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 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.
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.
R5	To improve quality and safety assurance flows to the QSEAC, the Health Board should: a) Support and encourage attendance at the Improving Experience sub-committee and Effective Clinical Practice sub-committee; and b) Revisit the scope of the Effective Clinical Practice sub-committee.
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.

Detailed report

Some directorate level arrangements are good, but they are not sufficiently consistently

11 Our work has identified that each of the directorates discuss quality and safety matters, but there is variation in the local quality and safety structures and the depth of the discussion.

12 Six of the directorates have separate governance meetings focusing solely on quality and safety. These meetings are at the highest level within the respective directorates and run alongside the routine business meetings which focus on finance and performance. With the exception of the Prince Philip directorate, meetings are on a monthly basis and cover a wide range of quality and safety aspects. Prince Philip directorate hold governance meetings twice a month.

13 Three of the directorates include quality and safety matters as part of the monthly business or management team meetings. These meetings are also on a monthly basis, but discussion is generally limited to concerns, complaints and risks.

14 For the Mental Health and Learning Disabilities Directorate, directorate level quality and safety is the focus of a dedicated sub-committee reporting directly to the QSEAC. This means that discussions for this directorate take place at a much higher level within the Health Board. This is an historical arrangement as a result of previous concerns, which are no longer evident. The agendas cover a wide range of quality and safety matters, but frequency of meetings is limited to every two months.

15 The arrangements across the directorates are set out in Exhibit 2.

Exhibit 2: Directorate arrangements for quality and safety

Directorate	Committee	Sole focus on quality and safety	Frequency
Bronglais	Hospital Management Committee	No	Monthly
Carmarthenshire	County Management Team	No	Monthly
Ceredigion	County Management Team	No	Monthly
Glangwili	Governance	Yes	Monthly
Mental Health & Learning Disabilities	Sub-committee of QSEAC	Yes	Every 2 months
Pembrokeshire	Governance	Yes	Monthly
Prince Philip	Governance	Yes	Twice a month
Scheduled Care	Governance	Yes	Monthly
Withybush	Governance	Yes	Monthly

Directorate	Committee	Sole focus on quality and safety	Frequency
Women & Children	Governance	Yes	Monthly

Source: Wales Audit Office analysis of interviews and documentation

16 In the six directorates with separate governance meetings, there is a good range of agenda items. As well as concerns, complaints and risks, agenda items include:

- compliance with Welsh Health Circulars;
- Healthcare Inspectorate Wales reports;
- results of audits, both internal and external;
- Royal College reports;
- results of Community Health Council visits;
- serious incidents;
- mortality reviews; and
- patient experience.

17 The range of discussion however is not consistent or standardised across the six directorate governance meetings.

18 In the three directorates where quality and safety is considered as part of wider business meetings, the relevant directorates are reliant on supporting assurance groups which sit below the directorate level. Reports from these groups however are not always available for the management team meetings. This is particularly the case for the Ceredigion directorate.

19 Across all of the county directorates, there is limited focus on the quality and safety aspects of primary care provision within the governance and management meetings. The quality and safety of primary care is instead managed through the central primary care team reporting directly to the Director of Primary Care, Community and Long-Term Care.

20 Over the last six months, the Health Board has been developing a quality and safety dashboard. Initially developed for the QSEAC, it is the intention to develop underpinning dashboards for each of the directorates. Our work has identified that the directorate dashboards are not yet in place, although the directorates are drawing on the relevant sources of information. There is however a bespoke dashboard available to support the Women and Children's Directorate, focusing predominantly on maternity services.

21 The directorate heads of nursing and general managers are largely driving the quality and safety agendas. Where quality and safety forms part of the routine business meetings, membership is largely based on the core directorate team. For directorates with governance meetings, membership is larger and more multidisciplinary. Representation from nursing and therapy professions is good,

and there is regular attendance by corporate teams including patient experience, clinical audit and redress.

22 Clinical directors and cluster leads are members of all quality and safety structures, but medical representation at meetings is generally limited with frequent part attendance or apologies sent. Directorates identified challenges engaging medics in the quality and safety agenda, including concerns, complaints and incidents largely because of time constraints around clinical commitments.

23 All directorates have their own professional nursing forums to bring together lead nurses from across the underpinning departments to consider quality and safety. These forums feed into the quality and safety discussions in the directorates and the senior nursing team meetings across the Health Board with the Director of Nursing, Quality and Patient Experience.

Corporate quality and safety arrangements are developing but capacity within the clinical audit and patient experience teams is an issue and shared learning is not as prominent as it could be

24 The Health Board has corporate teams in place to support key aspects of quality and safety, including concerns, complaints, serious incidents, patient experience and clinical audit. These teams report directly to the Director of Nursing, Quality and Patient Experience.

25 These corporate teams have previously worked in isolation. The Community Health Council, in particular, has raised concerns over the variability in the management of issues, and the differing approaches within each team. Through the senior nursing team meetings, these corporate teams have become more connected over the last twelve months, with approaches starting to become more consistent.

26 Capacity within some of the corporate teams however is an issue. The Audit and Risk Assurance Committee (ARAC) is sighted of the capacity constraints within the clinical audit team, and the Health Board's own benchmark indicates that patient experience capacity is the lowest in Wales. Although the Board supported a new patient experience framework in December 2018, funds have only recently been made available to support the rollout of the 'Friends and Family Test' system.

27 In July 2018, the Board approved the Health Board's Quality Improvement Strategic Framework. This places greater emphasis on sharing the learning from improvement activities. All of the corporate teams focus on learning; however, capacity is such that attention is drawn to supporting the directorates respond to incidents and events as they arise, restricting the ability of the corporate teams to share learning more widely to prevent the issues reoccurring. The Health Board formally launched the Quality Improvement Strategic Framework in March 2019 which should start to help promote the learning agenda more widely.

28 The number of directorates within the Health Board also places demands on the corporate teams' capacity, particularly in relation to attending governance meetings. The bringing together of some of the quality and safety arrangements within directorates, such as county and hospital directorates, may help alleviate the capacity constraints on the corporate teams. This would align with the approach taken within the Executive Performance Reviews which is increasingly considering the performance of county and hospital directorates on a joint basis.

29 Quality and safety is also the professional responsibility of the Medical Director and Director of Clinical Strategy. Amendments are currently being made to the Medical Directorate structure with a proposed new Associate Medical Director (AMD) lead for quality and safety. In addition, there are two new operational AMD posts for primary and secondary care, which are designed to provide day-to-day support to the directorates on medical related issues. It will be important for these posts to work together to make sure that quality and safety is not managed in isolation but collectively across operational and professional domains.

The operational quality, safety and experience sub-committee is evolving with scope to provide greater assurance from directorates and to focus more on key risks, but attendance is problematic

30 In July 2018, the Primary and Community Quality, Safety and Experience Sub-Committee merged with the Acute Quality, Safety and Experience Sub-Committee to become the Operational Quality, Safety and Experience Sub-Committee (QSESC).

31 The new Operational QSESC has met on six occasions and is still evolving. It meets on a bi-monthly basis and reports directly to the Quality, Safety and Experience Assurance Committee. It is one of eight sub-committees reporting to QSEAC, with plans to also merge the Mental Health and Learning Disabilities QSESC into the Operational QSESC once the current sub-committee is fully embedded.

32 The Operational QSESC however is not yet working effectively. Membership is large at 24 as it seeks to include representation from all directorates and corporate teams, but attendance by members is a problem. For the three meetings held between September 2018 and January 2019, significant numbers of members were not represented. There is however attendance from a wider group of staff outside those identified on the terms of reference (exhibit 3).

Exhibit 3: attendance at Operational QSESC

	Number of members (or representatives) in attendance	Number of members not present or represented	Total number of staff in attendance included members (or representatives)
September 2018	12	12	17
November 2018	12	12	20
January 2019	11	13	15

Source: Wales Audit Office analysis of documentation

33 The sub-committee aims to seek assurance from the directorates that actions are being taken to address quality and safety issues through exception reporting. However, directorates are not always present at the meetings to report back or there are frequently no issues to report. The sub-committee also seeks to monitor the management of operational risks but the number of risks that need to be considered has meant that this has become unmanageable within the time available in meetings.

34 Risks and action plans to address quality and safety issues however are increasingly being considered as part of the Executive Performance Reviews (EPRs) with the directorates, posing a risk of duplication between the EPRs and the business of the sub-committee. Risks and action plans are also being considered by relevant operational forums.

35 To reduce the risk of duplication, the sub-committee should focus its attention on taking assurance that learning from risks and action plans is being shared across directorates. This should include severe and high risks, as well as risks that are affecting a number of directorates.

36 Not all of the directorates however are represented at the sub-committee, with Mental Health and Learning Disabilities the focus of the separate sub-committee reporting to QSEAC.

37 Primary care is also not a key feature of the sub-committee despite its scope. Our work has identified that primary care quality and safety matters appear to be largely reported and managed through operational structures to the Director of Primary Care, Community and Long-Term Care, with limited scrutiny and assurance through any of the Board's committee structures. This is of particular concern given the recent changes to the GP indemnity scheme which requires health boards to have a much greater understanding of the level of quality and safety risks that they are carrying in primary care.

38 Like the directorate structures, there is some medical representation on the sub-committee but this is largely because they are chairs or representatives of sub-groups, for example, the Rapid Response to Acute Illness Learning Set (RRAILS) sub-group. Attendance can also be limited to part of the meetings due to other clinical commitments.

39 The sub-committee has a number of groups from which it takes assurances. Good assurances are taken from the Medical Devices Group and the Mental Capacity Act & Consent Group. Assurance is also taken from the Nutrition and Hydration Group although it is acknowledged that this group is only focused on inpatient care. Attendance at the Organ Donation Group and RRAILS Group however have been problematic resulting in cancelled meetings. Although assurances are taken from these groups, these are not as frequent as they should be.

40 As well as duplication with the EPRs, there is also some duplication between the sub-committee and QSEAC in relation to agenda item discussions. Some of this is on purpose by way of having initial discussions ahead of a more focused discussion at QSEAC, but this is not always a case.

41 The sub-committee however is not yet able to provide assurance to the QSEAC that operational quality and safety issues are being managed. There is currently no formal standardised reporting from the directorates to the sub-committee with reliance placed predominantly on exception reporting. Consequently, there is a gap between the QSEAC and the directorate teams.

42 The sub-committee has the potential to address this by seeking standardised assurances from all directorates, or combined directorates, on a range of quality and safety issues, by means of a standardised report. These can then be summarised to provide collective assurance to the QSEAC and ultimately the Board.

The functioning of QSEAC is improving but work is needed to address attendance at two of its other sub-committees and to improve the quality of papers

43 Historically, the attendance at the QSEAC has been large, agendas have been long, and the committee members have been unable to take assurance on a number of agenda items either due to the quality of the papers presented, or cancellations of sub-committee meetings.

44 Our recent observations of the committee during 2019 have identified that the functioning of the QSEAC has however started to improve. The committee attendance has now been refined to only include those who need to be there, and accounting officers are now called in to the meeting for specific agenda items as and when required. This has helped address the large attendance levels which largely consisted of representation from corporate teams.

45 The committee however still struggles to take assurance from a number of its sub-committees. This includes the operational QSESC, due to the reasons set out in paragraphs 32-42, but also the Effective Clinical Practice sub-committee and the Improving Experience sub-committee. Both of these sub-committees have struggled with attendance making it difficult to fully explore many of the agenda items for these meetings. On a number of occasions, these meetings have also had to be cancelled because of low attendance rates. The Effective Clinical Practice sub-committee has also struggled with a lack of clarity on its role. The Medical Director and Director of Clinical Strategy has recently taken over the chair of this committee to improve its effectiveness.

46 QSEAC papers also continue to be large with some concerns remaining that there is too much detail, which detracts attention away from the key issues and mitigating actions being taken. Some papers also focus too much on performance matters which are the separate consideration of the Business Planning and Performance Assurance Committee. This can in part be due to the authors not always being able to provide the right focus for the QSEAC.

47 The committee has undertaken a recent self-assessment exercise which reflects the issues raised through our work. An action plan is being put in place to take forward many of the improvement areas raised.

Appendix 1

Action plan

Exhibit 4: management response to recommendations

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
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.	Improved consistency across directorates, which also includes primary care where relevant.	Yes	Yes	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.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	To ensure a multidisciplinary approach is taken to considering quality and safety matters, the Health Board should encourage and support attendance by relevant medical staff at meetings across the structures.	Increased multi-disciplinary focus, drawing on the expertise of all professions.	Yes	Yes	A restructure of the Associate and Deputy Medical Directors has been undertaken. This new structure includes the appointment of a new Associate Medical Director for Quality and Safety and the proposal to strengthen quality medical lead roles throughout the services.	October 2019	Medical Director and Director of Strategy
R3a	To improve quality and safety assurance flows between the directorates and the Board, the Health Board should merge the Mental Health and Learning Disabilities Quality, Safety and Experience Sub-Committee with the Operational QSESC.	Improved use of staff time. Improved shared learning.	Yes	Yes	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.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Sciences Clinical Director for Mental health and Learning Disabilities

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
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.	Improved consistency across directorates.	Yes	Partial	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)	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
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.	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	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.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary
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	Improved flow of assurance from directorates to QSEAC and the Board.	Yes	Yes	Options for standardising the approach to quality and safety arrangements agreed. This includes templates for terms of reference and standardise reports (see recommendation 1).	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
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.	Improved effectiveness of meetings. Reduced duplication with Executive Performance Reviews.	Yes	Yes	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.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary Director of Therapies and Health Science. Director of Nursing, Quality and Patient Experience
R5a	To improve quality and safety assurance flows to the QSEAC, the Health Board should support and encourage attendance at the Improving Experience sub-committee and	Improved flow of assurance from sub-committees to QSEAC and the Board.	Yes	Yes	The appointments of a new AMD for Quality and Safety and the enhanced roles of clinical leads will support the wider medical engagement at sub-committees. The terms of reference for both the Improving Experience sub-committee and Effective Clinical Practice sub-committee	October 2019	Medical Director and Director of Strategy Director of Nursing, Quality and Patient

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	Effective Clinical Practice sub-committee; and				have been reviewed, including membership, with the aim of focussing membership and attendance at meetings.		Experience/Medical Director and Director of Clinical Strategy.
R5b	To improve quality and safety assurance flows to the QSEAC, the Health Board should revisit the scope of the Effective Clinical Practice sub-committee.	Improved effectiveness. Improved flow of assurance from sub-committee to QSEAC and the Board.	Yes	Yes	The terms of reference for the Effective Clinical Practice sub-committee have been reviewed including membership; with a paper to be submitted to the Audit & Risk Assurance Committee.	Complete	Medical Director and Director of Strategy
R6	To support effective use of limited corporate team resources, the Health Board should consider bringing together county and hospital directorate governance arrangements in line with the arrangements now in place for the Executive Performance Reviews. This can be done at specific intervals during the year.	Improved whole-system focus on quality and safety. Improved shared learning. Effective use of limited corporate team resources.	Yes	Yes	Whilst this recommendation is accepted the approach and arrangements to facilitate this will require further consideration with the Director of Operations and chairs of the various quality meetings. Meeting to be held to work through the arrangements and options to enable effective join up of governance meetings periodically throughout the year.	April 2020	Director of Nursing, Quality and Patient Experience / Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R7	To support the directorate governance arrangements, the Health Board should expedite the rollout of the directorate-based quality and safety dashboards.	Improved consistency across directorates.	Yes	Yes	Task and finish group established which is jointly chaired by Director of Nursing and Director of Planning. The work of the task and finish group has been expedited. A project plan is in place including agreement of the priority indicators to be populated and rolled out to directorates.	April 2020	Director of Nursing, Quality and Patient Experience
R8	To ensure that quality and safety is considered from both a professional and operational perspective, the Medical Director and Director of Clinical Strategy needs to ensure that the Associate Medical Director (AMD) for Quality and Safety in the new medical directorate structure works closely with the two new operational AMD posts for primary and secondary care.	Improved shared learning. Improved whole-system focus on quality and safety.	Yes	Yes	The appointments of a new AMD for Quality and Safety and clinical leads will work closely with the two new operational AMD posts for primary and secondary care. There will also be close working relationships with Assistant Director of Nursing for Quality and Assurance and Head of Goverance for Quality and Assurance	October 2020	Medical Director and Director of Strategy

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone.: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	UHB Central Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Claire Bird, Assurance Officer Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The University Health Board (UHB) Central Tracker is a high level log of all reports received from Internal Audit and external auditors, regulators and other bodies. These reports will generally include recommendations to address areas of improvement and/or gaps in controls. The tracker also includes the number of recommendations and records the current or reported status of these.

This report is presented to provide the Audit & Risk Assurance Committee (ARAC) with a current status report on progress on implementing the recommendations from audits and inspections, and to advise on work that has been undertaken and current monitoring arrangements.

Cefndir / Background

Audits 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 and reviews, both internal and external, are implemented in a timely way.

All reports and inspections which are carried out across the UHB are logged onto the UHB central tracker and progress on implementing recommendations should be monitored via the Board's committee structure.

Asesiad / Assessment

UHB Central Tracker

Below is a synopsis of activity since the last report to ARAC. Since the 81 reports open at the last ARAC meeting, a further 15 reports have been closed with 14 new reports received by the UHB, leaving 80 reports currently open, 30 of which have now passed their original completion date (please see Appendix 1 for the list of reports). At the last ARAC meeting 123 recommendations were overdue (i.e. the original implementation date had passed), which has decreased to 116.

	No of reports open at ARAC June 19	No of reports received since ARAC June 19	No of reports closed since ARAC June 19	No of reports open at ARAC August 19	No of reports that have passed their original implement-ation date	No of overdue recommend-ations i.e., implementation date has passed
HIW (Acute & Community)	5	0	0	5	1	6
HIW MHLD	5	1	0	6	1	13
HIW/CHC Contractors	4*	0	0	4*	0	2
WAO	13	2	3	12	8	22
Internal Audit	34	8	7	35	14	61
CHC	8	0	1	7	3	7
Royal Colleges	0	0	0	0	0	0
Coroner Reg 28	1	1	0	2	0	0
PSOW S16	0	0	0	0	0	0
PSOW S21	2	2	2	2	0	0
Delivery Unit (NHS)	6	0	2***	4	0	0
HEIW	0	0	0	0	0	0
Peer Review	2	0	0	2	2	3
Other	1	0	0	1	1	2
TOTAL	**81**	**14**	**15**	**80**	**30**	**116****

**Two HIW reports relate to GP practices which are managed by the UHB. The assurance officer obtains updates via the Quality Manager for Primary Care, who manages progress of actions on behalf of primary care. The remaining HIW and CHC reports relate to inspections at a GP and dental practice, who are independent contractors, and are accountable for implementing any recommendations made by HIW. The UHB maintains oversight of these through the Primary Care Team.*

*** Of the 116 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.*

**** The DU All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review has been removed from the audit tracker until the report has been received from the DU.*

The attached UHB Central Tracker (Appendix 2) provides the Committee with a current overview of the number of audits and reviews where there are recommendations outstanding. The following five reports are ready to be closed, pending Lead Executive approval, as all recommendations have been implemented:

- HIW Surgical Inspection (Trauma and Orthopaedic care) BGH - Pre-operative assessment clinic, Ceredig Ward (Trauma), Day Surgery Unit (DSU), September 2018
- HIW Radiology (X-ray) Department BGH, November 2018
- HIW Meddygfa'r Sarn, Pontyates, September 2018 (UHB Managed practice)
- Internal Audit HDUHB 1428 Review of Clinical Audit Follow up, April 2015
- Internal Audit HDUHB 1819-21 Safeguarding of Children & Vulnerable Adults, February 2019
- Internal Audit SSU HDDA 1819-03 Primary & Community Care Pipeline Projects Aberaeron Integrated Care Centre, April 2019

Reports Closed on the Audit Tracker since ARAC June 2019

The following 13 reports have all recommendations implemented and have been closed on the audit tracker following approval by the relevant lead Executive/Director, with the exception of the Public Service Ombudsman for Wales reports which are closed following confirmation by the Ombudsman:

- WAO Information Assurance Follow-Up, February 2012
- WAO Structured Assessment 2017, December 2017
- Internal Audit HDUHB 1819-13b Financial Ledger, February 2019
- Internal Audit HDUHB-1819-14 Treasury Management, February 2019
- Internal Audit HDUHB 1819-16 Accounts Receivable, February 2019
- Internal Audit SSU HDD 03 Cardigan Integrated Care Centre, February 2017
- Internal Audit HDD 14-15 08 IMT Infrastructure 14-15, July 2015
- Internal Audit SSU HDU 1819 07 Water Safety, April 2019
- Internal Audit SSU_HDU_1819_08 Sustainability Reporting (Mandated), August 2018
- PSOW 201702552, November 2018
- PSOW 201704112, October 2018
- CHC Ward 7 Withybush Hospital, January 2019
- Delivery Unit Older Persons Mental Health In-Patient Services, October 2016

The UHB received the WAO Integrated Care Fund report which has 6 recommendations for the Welsh Government to implement. The report contains no recommendations for the UHB to implement and therefore the report has been closed on the audit tracker.

The UHB received the Internal Audit HDUHB-1920-35 Carbon Reduction Commitment report which received a substantial assurance rating. No recommendations were made in the report and as a result the report has been closed on the audit tracker.

Reports Open on the Audit Tracker since ARAC June 2019

Below is a table of the reports added to the audit tracker since the ARAC June 2019 meeting:

Report name	Lead Executive/Director	Reporting Officer	Final report received at:
HIW NHS Learning Disability Service Inspection. Bro Myrddin 02 April 2019	Director of Operations	Interim Head of Nursing, Mental Health & Learning Disabilities	Quality Safety & Experience Assurance Committee August 2019

WAO Review of operational quality and safety arrangements	Director of Operations/ Director of Nursing, Quality & Patient Experience	TBC	Audit and Risk Assurance Committee August 2019
Internal Audit HDUHB-1819-24 Preparedness & Compliance with the Nurse Staffing Act	Director of Nursing, Quality and Patient Experience	Nurse Staffing Programme Lead	Audit and Risk Assurance Committee May 2019
HDUHB-1819-35 Review of PADR Process	Director of Workforce & OD	Head of Organisational Development	Audit and Risk Assurance Committee May 2019
HDUHB-1819-04 Health and Care Standards	Director of Nursing, Quality and Patient Experience	Head of Quality & Goverance	Audit and Risk Assurance Committee June 2019
HDUHB 1819-12 Savings Planning & CIP	Director of Finance	Turnaround Director	Audit and Risk Assurance Committee June 2019
HDUHB 1819-13a Budgetary Planning	Director of Finance	Assistant Director of Finance - Corporate Finance	Audit and Risk Assurance Committee June 2019
HDUHB-1920-11 A Regional Collaboration for Health (ARCH)	Director of Planning, Performance & Commissioning	Head of Strategy and Service Planning (Swansea Bay University Health Board)	Audit and Risk Assurance Committee August 2019
HDUHB-1920-15 Annual Quality Statement	Director of Nursing, Quality and Patient Experience	Assistant Director of Nursing Assurance & Safeguarding	Audit and Risk Assurance Committee August 2019
HDUHB-1920-34 Environmental Sustainability Report	Director of Operations	Senior Environmental Officer	Audit and Risk Assurance Committee August 2019
Regulation 28 inquest touching the death of EKI	Director of Operations	Interim Head of Nursing, Mental Health & Learning Disabilities	Improving Experience Sub Committee
PSOW 201800718	Director of Operations	Hospital Head of Nursing, Glangwili General Hospital	Improving Experience Sub Committee
PSOW 201807678	Director of Operations	General Manager, Withybush General Hospital	Improving Experience Sub Committee

Argymhelliad / Recommendation

The Committee are asked to:

- Note the tracker presented to ARAC demonstrates where progress of implementing recommendations is behind schedule, and to ask that the appropriate action is taken to address these areas.
- Note that 15 reports have been closed on the audit tracker since ARAC June 2019 and 80 reports are currently open, 30 of which have now passed their original completion date.

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:	WAO Structured Assessment 2016 & 2017 WAO Annual Audit Report 2017
Rhestr Termau: Glossary of Terms:	HIW- Health Inspectorate Wales WAO- Wales Audit Office WRP- Welsh Risk Pool CHC- Community Health Council PSOW- Public Services Ombudsman for Wales
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

Information on the 30 reports that have now passed their original completion dates can be found below. Further details can be found in UHB Central Tracker (Appendix 2).

Name of Report	Reviewing Body	Date of Report	Original Completion Date	No. of red recommendations (behind schedule)
Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Health Inspectorate Wales (HIW)	February 2019	July 2019	5
Unannounced Inspection of Greville Court Learning Disabilities - 14 Jul 16	Health Inspectorate Wales (HIW)	October 2016	December 2016	1
A Comparative Picture of Orthopaedic Services - Hywel Dda	Wales Audit Office	June 2015	April 2017	1
NHS Consultant Contract Follow Up	Wales Audit Office	June 2016	April 2017	2
Hospital Catering and Patient Nutrition Follow-up Review	Wales Audit Office	February 2016	December 2016	1
Review of Estates	Wales Audit Office	July 2016	May 2017	2
Radiology Service	Wales Audit Office	April 2017	May 2018	1
Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Wales Audit Office	May 2018	March 2016	6
District Nursing: Update on Progress	Wales Audit Office	June 2018	January 2019	1
Clinical coding follow-up review	Wales Audit Office	April 2019	December 2015	3
Concerns Follow Up	Internal Audit	April 2015	May 2015	2
Health & Safety	Internal Audit	September 2016	November 2016	5
Wales for Africa Programme	Internal Audit	April 2017	May 2018	3
Low Vision Service Wales - Review of New Arrangements	Internal Audit	August 2017	Not stated	1
National Standards for Cleaning in NHS Wales	Internal Audit	February 2018	June 2018	1
Theatres Directorate	Internal Audit	April 2018	June 2018	2
Governance in Primary Care Clusters	Internal Audit	May 2018	July 2018	1
Charitable Funds	Internal Audit	February 2019	May 2019	2
Concerns	Internal Audit	October 2018	December 2018	1

Procurement and Disposal of IT Assets (Follow-Up)	Internal Audit	November 2018	January 2019	1
Integrated Care Fund – Follow Up	Internal Audit	May 2019	July 2017	1
Management of Controlled Drugs	Internal Audit	April 2019	July 2019	5
National Standards for Cleaning in NHS Wales	Internal Audit	April 2019	July 2019	5
Withybush General Hospital Refurbishment of Wards 9 & 10	Internal Audit	April 2019	May 2019	3
The fragility of GP Out of Hours services in Wales	Community Health Council	May 2018	December 2018	3
"What's your NHS like for you?" Hearing from people with a learning disability	Community Health Council	May 2018	March 2019	2
Women and children's services Visit report March 2018	Community Health Council	August 2018	April 2019	1
Out of hours Peer review 23/08/18	Peer review	December 2018	March 2019	1
Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Peer review	August 2016	March 2017	2
External Governance Review	Commissioned report	April 2015	April 2016	3

HEALTH INSPECTORATE WALES

Report Ref	Name of Report (External only)	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Director:	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed arrangements for monitoring progress: (eg 6 monthly at Acute QSEAC)	Total No of recommendations within report/Actions on action plan (IA= Immediate Assurance recs, R= Report recs):	Red (behind Schedule	Amber (on schedule	Green (completed)	Additional Information
18155	Unannounced Hospital Follow-up inspection: Surgical Inspection (Trauma and Orthopaedic care) BGH - Pre-operative assessment clinic, Ceredig Ward (Trauma), Day Surgery Unit (DSU), 11 Sept 2018	Health Inspectorate Wales (HIW)	13/12/2018	Open	Director of Operations	Unscheduled Care (BGH)	Karen Barker/ Dawn Jones	Nov-19	Nov-19	Executive Team Performance Reviews - planned Care/ BGH (USC)	15	0	0	15	20/11/18- Draft improvement plan sent to HIW. 18/12/18- Final report published on HIW website. 04/01/19- requested update from reporting officers by 11/01/19 for PMAF review. 08/01/19- Update provided by service, 10 recs completed and 5 recs being implemented within agreed timescales. 21/03/19- Requested update on implementation of recommendations in w/b 01/04/19 for PMAF review in April 2019. 26/03/19- Update provided by reporting officer. 13 recs completed. Rec 6 (UHB to fully implement a shared care pathway for patients with a fractured neck of femur across the 3 hospitals managing T&O) to be completed by 30/09/19 and rec 14 (actively support the local recruitment process) to be completed by 30/06/19. 03/07/19- Assurance officer emailed reporting officer for conformation rec 6 is on track for completion date of 30/09/19 and rec 14 was completed by 31/06/19. 10/07/19- Reporting officer confirmed rec 14 is complete. Assurance officer requested confirmation that rec 6 (fractured neck of femur care pathway) will be completed by 30/09/19 or if an extension will be required. 17/07/19- Reporting officer confirmed rec 6 is now complete. Report to be approved by Director of Operations to be closed. 06/08/19- Assurance officer emailed Director of Operations for approval for report to be closed.
No Ref	Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018	Health Inspectorate Wales (HIW)	Aug-18	Open	Director of Operations	Unscheduled Care	Alison Bishop	Apr-20	Apr-20	Unscheduled Care Board/ Formal Exec Team meeting performance review (quarterly)	13	1	1	11	19/10/18- Director of Operations stated the report crosses both operation and primary areas, but asked that he is stated as Exec Lead. The report will be covered at Unscheduled Care Board. Action plan to follow. Awaiting confirmation of reporting officer. 13/11/18- reporting officer has drafted action plan and requested responses from colleagues by 23/11/18. 5 out of 13 recs already completed. 27/11/18- Assurance officer requested timescales be added to outstanding recommendations in action plan to track that actions are completed on schedule. 02/01/19- Service Delivery Manager,SDM confirmed 9 recs completed. The action plan will be monitored and reported through the USC Board. Assurance officer requested timescales be added to those recs not yet completed. 04/02/19- Assurance officer requested action plan with timescales included from reporting officer. 19/03/19- Reporting officer confirmed 9 recs completed with 4 recs to be implemented as follows: Rec 1 (implementation of USC Care Program) to be completed April 2020. Rec 2 (implementation of SAFER patient bundle) to be completed by April 2020. Rec 5 (Pilot being undertaken with PKB in respiratory patients) to be completed July 2019. Rec 9 (Further implementation of Mted Facility) is dependent on allocation of additional funding as part of IMTP. 18/07/19- Assurance officer emailed reporting officer for update on remaining recs by 25/07/19 for next formal Exec Team meeting. Reporting officer confirmed only outstanding recs are 5 and 9, and requested updates from Head of Improvement & Transformation and Head of Medicines Management. 24/07/19- Updates provided by Assistant Director of Informatics. Rec 5 (NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations)- A pilot is fully live of PKB with respiratory patients. Patients are now receiving appointment, cancellations letters to their PKB account. The Health Board are also looking to expand the pilot to all patients within respiratory in order to provide a larger evaluation base. Rec 9 (NHS Wales needs to clarify timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations) - The MTeD facility is available across the Health Board (and ICT support) however further implementation is subject to agreement to increase pharmacy resource. This forms part of the Health Board IMTP.
18262	Hospital Inspection (Unannounced) WGH, Ward 1, 10 & 12 20-21 November 2018	Health Inspectorate Wales (HIW)	22/02/2019	Open	Director of Operations	Unscheduled Care (WGH)	Carol Thomas	Jul-19	Sep-19	Executive Team Performance Reviews - WGH (USC)	40 (6=IA, 34=R)	5	0	35	11/03/19- Assurance office requested update on improvement plan from reporting officer. 12/03/19- Reporting office now Carol Thomas, Interim Head of Nursing (Janice Cole-Williams is now in the General Manager post for WGH). 21/03/19- Service confirms all immediate improvement plan recommendations have been completed. 26/04/19- Update provided from service. 6 recommendations have timescales that have slipped including one recommendation 'Signage to be reviewed, to include patient representation of those with visual impairment and alterations agreed as appropriate' requiring extension to 31/08/19 to fit in with ward 10 refurbishment dates. Assurance office to request approval of extensions from Director of Operations. 30/04/19- Director of Operations requested recommendations that have slipped to be reviewed by the service to ensure realistic timescales are provided as some feel optimistic. 24/05/19- Update provided by service and Business Support Manager. 34 recs are completed, rec 12 (Pressure area care training sessions) is on track to be completed by the original date of 31/07/19 and the following recs are behind schedule as follows: - Rec 4 (Signage to be reviewed)- timescale slipped from 30/04/19 to 31/08/19. Revised date of 31/08/19 fits in with Ward 10 refurb. General Manager, WGH will be meeting CHC to obtain reps and review. -Rec 5 (Lift to be repaired.)- timescale slipped from 31/01/19 to 17/06/19. Software update ordered (4-6 weeks delivery). -Rec 23 (review potential to allocate elective admissions for joint replacements into a designated area within Ward 1)- Awaiting narrative from service in respect of the review and to close down recommendation. Director of Operations to agree closure. -Rec 27 (Head of Nursing to request that supervisors and managers ensure their staff are compliant with their mandatory Information Governance e-learning and provide evidence of this.) timescale slipped from 30/04/19 to 30/09/19. -Rec 33 (Rostering policy to be reviewed and updated to reflect the requirements of the Nurse staffing Levels (Wales) Act 2016)- Policy going to Partnership forum w/c 27/05/19 and then onto next Workforce and OD Sub Committee. timescale slipped from 30/04/19 to 30/06/19. New timescales to be agreed with Director of Operations. 26/06/19- Update provided by service and Business Support Manager: -Rec 5 (Lift to be repaired.)- further timescale slipped to 31/08/19. -Rec 23 (review potential to allocate elective admissions for joint replacements into a designated area within Ward 1)- narrative has been sent to Director of Operations on why this can't be achieved, awaiting response from Director. -Rec 33 (Rostering policy)- further timescale slipped to 30/09/19. 30/06/19- Director of Operations has been informed via email of the slippage in timescales by Business Support Manager. Two of the five recommendations are currently being reviewed to determine if they are appropriate for the Strategic Log.
18157	Radiology (X-ray) Department/ BGH 20-21/11/18	Health Inspectorate Wales (HIW)	22/02/2019	Open	Director of Operations	Radiology	Amanda Evans	Jun-19	Aug-19	Executive Team Performance Reviews - Radiology	9	0	0	9	12/03/19- Assurance officer met with reporting officer to obtain update. 4 recs are completed with the remaining 5 recs on track to be completed by their individual completion dates. 29/05/19- Head of Radiology confirmed all recs completed apart from rec 8 (Relevant service leads to complete documentation developed by the MEC to demonstrate training records are complete)- This was discussed at the last MEC meeting but the documentation was not agreed. Head of Radiology requested extension to 31/08/19 to discuss with team leads when she returns from leave in late June 2019. Extension to be agreed by Director of Operations. 11/07/19- Head of Radiology confirmed last rec has been implemented. Assurance officer responded 15/07/19 requesting Head of Radiology to review improvement plan one last time before this is sent to Director of Operations for his approval to close.
18264	Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Health Inspectorate Wales (HIW)	10/06/2019	Open	Director of Operations	Unscheduled Care (GGH)	Bethan Lewis	Oct-19	Oct-19	Executive Team Performance Reviews - GGH (USC)	23	0	23	0	02/05/19- Improvement plan and factual accuracy response submitted to HIW. Awaiting confirmation that HIW are assured by the improvement plan. 03/10/19- HIW confirmed they are assured by the improvement plan. 11/06/19- Final report published on 10/06/19. Improvement plan has recommendations with implementation dates ranging from 30/07/19 to 30/11/19. 08/08/19- Assurance officer requested update from reporting officer for confirmation that the recommendations with an implementation date of 30/07/19 have now been completed.

***Key**

Open- recommendations to be implemented

Closed- all recommendation implemented and report closed following approval by the relevant Executive Director

Strategic log- a recommendation requiring a long term/strategic solution to be addressed as part of a long term strategy e.g. Capital prioritisation plan, Digital Strategy, Ward refurbishment programme, etc.

External rec- a recommendation that is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

HIW MHLD

Report Ref	Name of Report (External only)	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Director:	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed arrangements for monitoring progress: (eg 6 monthly at Acute QSEAC)	Total No of recommendations within report/Actions on action plan (IA= Immediate Assurance recs, R= Report recs):	Red (behind Schedule	Amber (on schedule	Green (completed)	Additional Information
No Ref	Unannounced Inspection of Greville Court Learning Disabilities - 14 Jul 16	Health Inspectorate Wales (HIW)	18/10/2016	Open	Director of Operations	Mental Health & Learning Disabilities	Melanie Evans	Dec-16	N/K	Executive Team Performance Reviews - MH&LD	18 (includes recs from IA report) recommendations (96 actions)	1	0	17	MHLD QSESC 12/11/18- remaining outstanding action is in relation to the recommendation that the UHB ensures that DOLS are in place for the residents in the home, current DOLs Legislation does not cover people who are living in their own home, this is because it is determined that by the nature of only being in receipt of supported living and having their own tenancy they are not subject to a deprivation of their liberty. The DOLS co-ordinator is currently identifying resources so that a thorough review of the residents can be undertaken, so that the UHB can be assured that there are no deprivation practices taking place in the home. 23/11/18- Assurance officer requested revised timescale of review from reporting officer. Director of Operations informed. 07/12/18-Head of Learning Disabilities and Older Adult Mental Health advised another factor to consider is the review of the Mental Health Act in England and Wales which was published yesterday, so to clarify the delay isn't within our service but reflective of Countrywide review ongoing, MHLD QSE exception report to QSEAC 05/02/19 -In regard to Greville Court, there is an outstanding action in relation to the recommendation that the UHB ensures that Deprivation of Liberty Safeguards (DOLS) are in place for the residents in the home. Current DOLS legislation does not cover people who are living in their own home, this is because it is determined that by the nature of only being in receipt of supported living and having their own tenancy they are not subject to a deprivation of their liberty. The DOLS co-ordinator is currently identifying resources in order that a thorough review of the residents can be undertaken, therefore the Health Board can be assured that there are no deprivation practices taking place in the home. Up to date legal advice (as of December 2018) has also been sought which indicates the residents are indeed subject to a deprivation of liberty and therefore submissions to the Court of Protection will be made. 13/03/19 - emailed Service Manager Learning Disabilities for update if DOLS assessments have been undertaken. Service Manager Learning Disabilities confirmed NWSSP Solicitor transferring all relevant information from care plans, risk assessments, management plans, witness statements,etc into the court forms. Capacity assessments currently being typed up to be included into the court forms. . Once all this is in place the UHB will need to arrange finance for the applications and the solicitor will submit the applications to the CoP for consideration. 18/03/19- assurance officer requested approximate timescale for completion of this action. 25/03/19 - Service Manager Learning Disabilities confirmed All information for the eight clients now submitted to Solicitor. Seven of the eight deemed not to have capacity. All information is now sitting with Solicitor therefore Service Manager Learning Disabilities not able to give a definitive date. 16/05/19- Capacity assessments are being revised by the Consultant Psychiatrist for a more person centred approach. The service is currently chasing the Consultant and once the capacity assessments are revised the submissions will be made to the court of protection for consideration. Completion will be dependent on direction and actions required by the court and a timescale cannot currently be provided. 21/06/19- Assurance officer requested update from Head of Learning Disabilities and Older Adult Mental Health, no response received as of 26/06/19. 08/07/19- Head of Learning Disabilities and Older Adult Mental Health provided update that there was a delay in providing additional information regarding updated care plans due to the retirement of the Team Manager, additional nursing hours have been agreed to take forward the updating of plans and the new Manager will commence in September 2019.
18173	North Ceredigion Community Mental Health Team (Gorwellion) 20-21 Nov 2018	Health Inspectorate Wales (HIW)/ Care Inspectorate Wales (CIW)	22/02/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees	Mar-20	Mar-20	Executive Team Performance Reviews - MH&LD	15	4	4	7	13/03/19- Assurance officer requested update on improvement plan from service. 15/03/19- Reporting officer confirmed recommendations with timescales passed (5 recs) have been completed. 21/05/19- Update from service confirmed 8 recs are complete, 2 being progressed on schedule and the following 5 recs have now slipped. Director of Operations to be informed of slippages for approval: Rec 3 'Undertake transporting service pilot consisting of two staff members utilising an existing Health Board vehicle to transport patients. This will improve the availability of appropriate transport and inform the mapping out of the current and future transport need'- timescale slipped from 30/05/19 to 31/07/19. Rec 6 'Design and Cost point of ligature action plan' initial improvement plan was noted as completed but following review by new Interim Head of Nursing the timescale has now been revised to 31/07/19. Rec 10- 'Action plan to be progressed to allow resuscitation equipment being made available, with actions being monitored via the Quality Safety governance structure', initial improvement plan was noted as completed but following review by new Interim Head of Nursing the timescale has now been revised to 31/08/19. Rec 15- 'Develop and implement supervision guidelines for directorate to include standardised supervision template, frequency and type of supervision' timescale slipped from 31/08/19 to 31/12/19. 25/06/19- Update from service confirmed 7 recs are complete, 4 being progressed on schedule and the following 4 recs have now slipped. Director of Operations to be informed of slippages to rec 3,6,10 & 15 (see above) for approval. 17/07/19- Director of Operations has approved extensions.
190417	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Health Inspectorate Wales (HIW)	17/04/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees	Mar-20	Mar-20	Executive Team Performance Reviews - MH&LD	20	4	4	12	13/03/19- Still awaiting improvement plan from HIW. 09/04/19- HIW have confirmed they are assured by the action plan, UHB waiting for report to be published. 17/04/19- report published. 17/05/19- Update provided by service. 6 recs completed. 6 recs have timescales that have now slipped. Director of Operations to be informed of slippages for approval: Rec 1- 'applying sodium hypochlorite/moss killer in grounds' timescale slipped from 30/04/19 to 30/06/19. Rec 6- 'Review room usage and current signage' timescales slipped from 30/04/19 to 31/05/19. Rec 8- 'New lighting to be installed outside the main entrance'. Original timescale 30/04/19 slipped to 17/05/19. Rec 9- 'Glass roof cleaning works to be arranged and completed'. Original timescale 30/04/19 slipped to 17/05/19. Rec 17- 'To develop a system for identifying and recording unmet needs'- timescale revised from 30/09/19 to 31/03/19 by new Interim Head of Nursing, as a wider piece of work needs to be undertaken to review against the Mental Health measure. Rec 19- 'Meeting with Care and Treatment Plan (CTP) lead and Mental Capacity lead to discuss and agree assessment process'- timescale revised from 30/09/19 to 31/03/19 by new Interim Head of Nursing, as a wider piece of work needs to be undertaken to review against the Mental Health measure. 26/06/19- Update provided by service. Director of Operations to be informed of revised timescales for approval: Rec 3- 'Latent defect following new observation panel installation – estates department to contact contractor/manufacturer to resolve defect'- timescale currently unknown as the projects manager for the UHB is now in a formal dispute with the manufacturer. Rec 6- 'Cost any new signage required' and 'Submit request for funding to purchase required signage to MH/LD Business Performance and Planning Assurance Group (BPPAG)' - timescale slipped from 31/05/19 to 31/07/19. Rec 17- 'To develop a system for identifying and recording unmet needs'- timescale revised from 30/09/19 to 31/03/19 by new Interim Head of Nursing, as a wider piece of work needs to be undertaken to review against the Mental Health measure. Rec 19- 'Meeting with Care and Treatment Plan (CTP) lead and Mental Capacity lead to discuss and agree assessment process'- timescale revised from 30/09/19 to 31/03/19 by new Interim Head of Nursing, as a wider piece of work needs to be undertaken to review against the Mental Health measure. 17/07/19- Director of Operations has approved extensions but has queried the delay in obtaining a quote for signage. Assurance officer emailed Business Manager 18/07/19 for update on this.
No Ref	Joint Thematic Review of Community Mental Health Teams 2017-2018	Health Inspectorate Wales (HIW)/ Care Inspectorate Wales (CIW)	07/02/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees	Dec-22	Dec-22	Executive Team Performance Reviews - MH&LD	22	3	11	8	25/03/19- completed improvement plan returned to HIW 28/03/19, awaiting confirmation that improvement plan has been accepted. Report published prior to improvement plan being completed by UHB. 17/05/19- HIW confirmed they haven't responded to the improvement plan as yet as they are still in the process of considering all HB / national improvement plans. If they require further clarification they will be in touch. The assurance officer has requested an update from the service on the improvement plan and to be informed if any recommendations may slips (earliest timescale on the improvement plan is 30/06/19). 26/06/19- Update provided by service. The following 3 recs have timescales that have slipped. Director of Operations to be informed of revised timescales for approval: Rec 2 -'Ensure out of hours access in the event of a crisis or serious concern is captured in the care and treatment plan (of which a copy is given to the service user)'- Timescale has slipped. Revised timescale from 30/06/19 to 30/08/19 to allow this action to be captured within the new CMHT service specification. Rec 6- 'Audit Results to be scrutinised and discretionary capital bids submitted following approval at MH/LD Business Performance and Planning Assurance Group (BPPAG)'- Timescale has slipped, Service Manager needs more time to complete this. Timescale slipped from 30/06/19 to 31/08/19. Rec 23-'As CMHT premises do not currently have defibrillators as standard equipment, the service will consider the introduction of this equipment taking into account the additional cost and training implications with the MH/LD BPPAG ratifying the final decision as to whether this provision is introduced'. - Interim Head of Nursing reviewed and confirmed timescale needs to match the others under this recommendation, therefore timescale needs to be moved from 30/06/19 to 30/11/19.

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No Ref	How are healthcare services meeting the needs of young people? Thematic Review 2019	Health Inspectorate Wales (HIW)	29/03/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees	Sep-20	Sep-20	Executive Team Performance Reviews - MH&LD	37 (21 for MHLD)	0	21	0	21/05/19- Assurance Officer has emailed published report to service and requested improvement plan to be completed for those actions within the thematic report that the UHB needs to address. 26/06/19- actions relating to CAMHS are being finalised. Assurance officer has also contacted Assistant Director (Acute services) for those recommendations relating to general admission. 26/06/19- actions relating to CAMHS received from Head of Service sCAMHS & Psychological Therapies, Assurance Officer requested Interim Head of Nursing, Mental Health & Learning Disabilities to review. 05/07/19- Assurance officer sent email chase to Interim Head of Nursing, Mental Health & Learning Disabilities to review, as well as email chaser to Assistant Director (Acute services) for those recommendations relating to general admission.
19008	NHS Learning Disability Service Inspection. Bro Myrddin 02 April 2019	Health Inspectorate Wales (HIW)	03/07/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees/ Melanie Evans	Nov-19	Nov-19	Executive Team Performance Reviews - MH&LD	16	1	3	12	26/06/2019- report due to published by HIW on 03/07/19. Assurance officer has requested update on recommendations from Head of Learning Disabilities and Older Adult Mental Health. 04/07/19- Chaser email sent to Head of Learning Disabilities and Older Adult Mental Health for update on recommendations. 05/07/19- Assurance officer requested update on outstanding recommendations from Head of Learning Disabilities and Older Adult Mental Health. 01/08/19-Update provided by service. 12 recs completed. 3 recs on track for completion dates of 30/11/19. Rec 13 (Directorate Support Manager to provide dedicated administrative support to rationalise the patient record files) has now passed the original completion date of 30/06/19. Work is underway to rationalise the paper records but not complete. Team Manager has had a lengthy period of leave which has extended initial plans to complete. Extension requested to 31/08/19. Assurance officer to request Director of Operations to approve extension.

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External rec- a recommendation that is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

HIW/CHC CONTRACTORS

Report Ref	Name of Report (External only)	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Lead:	Service	Reporting Officer:	Committee & Date Final Report received at:	Original Completion Date:	Current Completion Date	Agreed action/ arrangements for future reporting: (eg 6 monthly at Q&S, develop combined Service Action Plan, etc)	Total No of recommendations within report/Actions on action plan (IA= Immediate Assurance recs, R= Report recs):	Red (behind Schedule	Amber (on schedule	Green (completed)	Additional Comments
GPs	Meddygfa Minafon, Kidwelly 18/08/18 (UHB Managed practice)	Health Inspectorate Wales (HIW)	19/10/2018	Open	Director of Primary, Community and Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	QSEAC December 2018	Sep-19	Sep-19	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	15 (IA=4,R=11)	1	1	13	27/07/18- response to Immediate improvement plan returned to HIW. Awaiting final report and main improvement plan. UHB managed practice. 20/09/18- Main improvement plan accepted by HIW, includes 11 recommendations. 19/10/18- Final report published. 09/11/18 - Lead Officer confirmed that all IA Recs completed with 8 completed and 3 underway by completion date of September 2019. 12/03/19- Primary Care officer confirmed he has chased for an update on the improvement plan. 25/04/19- Assurance officer requested update on recommendations by 08/05/19 for the next PMAF review in May 2019. 30/04/19- update provided by Primary Care Officer on behalf of practice- Rec 1 (look into extending and refurbishing the waiting area) has timescales slipped from 30/06/19 to 30/09/19. Rec 7 (a programme of audit is introduced) is on track to be completed by 30/09/19. 09/05/19- Director of Primary Care, Community and Long Term Care informed of slippage of rec 1 timescale by Assurance Officer. 10/07/19- requested update from reporting officer by 25/07/19 for next PMAF review. 12/07/19- Primary Care officer reported that he has received confirmation from the Practice Manager that all actions are to be completed by 30/09/2019.
GPs	Meddygfa'r Sarn, Pontyates, 05/09/18 (UHB Managed practice)	Health Inspectorate Wales (HIW)	06/12/2018	Open	Director of Primary, Community and Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	QSEAC February 2019	Apr-19	Jun-19	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	13	0	0	13	29/10/18- Final report due to be published on 06/12/18. 06/12/18- Report published. 03/01/19- Assurance officer emailed Quality Manager Primary Care for update. 21/01/19- Update improvement plan received. 4 recs completed and 6 recs have slipped to April 2019 due to manager staff sickness. Recs still within overall timescale of report. 12/03/19- Update received from reporting officer. 6 recs in progress to be delivered by the slipped timescale of 30/04/19. 25/04/19- Assurance officer requested update on recommendations by 08/05/19 for the next PMAF review in May 2019. 09/05/19- Primary Care Officer provided update from practice. 5 recs are behind schedule to be completed by 28/05/19. 09/05/19- Director of Primary Care, Community and Long Term Care informed of slippage of the 5 recommendations by Assurance Officer. 10/07/19- requested update from reporting officer by 25/07/19 for next PMAF review. 12/07/19- update provided by Primary Care officer. Assurance officer liaising with Quality Manager Primary Care to confirm all recommendations are completed. Improvement plan will then be sent to Director of Primary Care, Community and Long Term Care for approval to close. 29/07/19- Assurance officer emailed Director of Primary Care, Community and Long Term Care for confirmation she is happy for report to be closed. Director of Primary Care, Community and Long Term Care responded that she is not happy to close and is requesting the dates at which all individual actions were complete. 30/07/19- Quality Manager Primary Care responded that she will confirm the action completion dates with the practice manager.
GPs	Brynteg GP Practice, Ammanford Aug 2018	Community Health Council (CHC)	01/08/2018	Open	Director of Primary, Community and Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Sonia Luke	QSEAC August 2018	Dec-19	Dec-19	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	11	1	2	8	03/01/19- Assurance officer emailed Quality Manager Primary Care for update on action plan, awaiting response. 31/01/19- Assurance officer spoke to Quality Manager Primary Care requesting copy of action plan. 18/03/19- action plan received. 8 recs completed and 3 in progress. Quality Manager Primary Care going back to practice to request timescale for rec 8 (Practice requesting grant support to change seating arrangements to suit all needs) and rec 11 (Introduction of Patient Participation Group being progressed) as timescales are not clear. 20/03/19- Quality Manager Primary Care confirmed contact made with practice and is awaiting response as practice manager is currently on leave. 08/09/19-Quality Manager Primary Care currently on leave, clarification of timescales to be confirmed on her return. 15/04/19- Update from Quality Manager Primary Care. Rec 1 (decision on telephone system providers) to be completed by April 2019. Rec 8 (request grant support to change our seating arrangements) practice manager is the process of obtaining quotes for the work to be done. Rec 11 (Practice should consider introducing a Patient Participation Group)- Practice Manager is leaving the practice in October 2019 and it is likely that this task will be passed on to his replacement to organise. 25/04/19- Assurance officer requested update on recommendations by 08/05/19 for the next PMAF review in May 2019. 08/05/19- Update provided from Primary Care Officer- Practice manager confirmed rec 1 and rec 8 will be completed by 31/07/19. 10/07/19- requested update from reporting officer by 25/07/19 for next PMAF review. 24/07/19- Update provided Primary Care Officer- Practice manager confirmed rec 1 (telephone booking) will now be completed by 30/07/19- Rec 1 (Telephone booking)- As the practice are developing Tegfan Centre they are trying to liaise with IT team to establish a system that is fit for purpose and compatible for both the practice and the centre but so far have not had much success. They have now decided on their phone system and have given their notice in for the previous phone line provider so a new system will be in place within 3 months. Timescale extended to 31/10/19. Rec 8 (request grant support to change our seating arrangements) - have not had success in obtaining quotes but the assistance practice manager will make this a priority and will hopefully be in within the next few months. Timescale 30/09/19. Rec 11 (Practice should consider introducing a Patient Participation Group)- This task will be given to the new practice manager of Brynteg. But as a part of developing Tegfan, the practice will be discussing with the public and giving them the opportunity to say what they would like to see in the new centre. Timescale 31/12/19.
Dental																
Dental	Celtic Dental Practice, Llandeilo, 05/11/18	Health Inspectorate Wales (HIW)	06/02/2019	Open	Director of Primary, Community and Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Sophia Todaro		Dec-19	Dec-19	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	7	0	1	6	The practice provides a range of NHS and private general dental services. 12/03/19- Reporting officer confirmed she has spoken to the practice who have verbally informed her they have been working through the action plan and the majority are now complete. She has requested a written update on the remaining action plans as soon as possible. 19/03/19- Chaser email sent to reporting officer to confirm recommendation is complete. 10/04/19- Primary Care Manager confirmed response from Celtic has been received and currently being reviewed. 25/04/19- Assurance officer requested update on recommendations by 08/05/19 for the next PMAF review in May 2019. 29/04/19- Update received from Dental Services Officer. 6 recs completed and remaining rec (All staff must undertake Protection of Vulnerable Adults training) to be completed by original timescale of December 2019. 23/07/19-Primary Care Officer confirmed he had been in contact with the surgery and they have confirmed the remaining action is on schedule to be completed by December 2019 (staff have this training booked for October).

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WAO

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684A2014	A Comparative Picture of Orthopaedic Services - Hywel Dda	Wales Audit Office	Jun-15	Open	Director of Operations	Scheduled Care	Lydia Davies	Apr-17	2021/22	Executive Team Performance Reviews - Planned Care	4 recs (16 sub recs)	1	0	15	Reviewed as part of WAO Structured Assessment 2017. The Health Board has undergone a significant change to its management structure. The General Manager, Scheduled Care was formally appointed in April 2016, with Service Delivery Managers in post between October and December 2017. To oversee transformation requirements within the Board as required in response to WAO and HIW reports, as well as others, a Director of Transformation and subsequent team have also been created with appointees still to commence. Consequently the response to this Review has been updated in accordance with identified work streams and the Orthopaedics Transformation Project Initiation Document. Much of the initial work undertaken to address the recommendations is being reviewed under the new management regime to ensure on-going improvement. 04/06/18- Service Manager (Scheduled Care) confirmed via phone that the update on this currently going through Scheduled Care governance process, and will then be reported to new operational QSE SC meeting in July 2018. Service Manager to share information with assurance officer once signed off at Scheduled Care governance meeting. 22/08/18- assurance officer emailed Service Manager (Scheduled Care) for update on outstanding recommendations and to confirm that this will be monitored at the Operational Services Quality, Safety & Experience Sub Committee. 22/08/18-Service Manager (Scheduled Care) confirmed report being reviewed on 24/08/18, and will update the assurance officer after the review. 06/09/18- Service Manager (Scheduled Care) update, remaining issues relate to Ref10 (rate of cancelled operations). New timescale 2021/2022. Linked to Clinical Services Strategy. Reconfiguration of services which is tied to TCS. 27/09/18- Director of Operations informed of suggestion for outstanding recommendation to be moved to the strategic log, awaiting response. ARAC 21/08/18 minutes- Orthopaedics Follow-up review will commence in the New Year. 24/10/18- Update from GM (Scheduled Care) following meeting with Director of Operations and Service Manager (Scheduled Care). Rec10 (rate of cancelled operations) to remain open. Linked to Clinical Services Strategy. 10/01/19- Assurance officer requested to be informed of any updates prior to next PMAF review on 30/01/19. 04/04/19- Assurance officer requested update from service prior to next PMAF review on 08/05/19. 11/04/19- No further update provided by the service- Rec 10 (rate of cancelled operations) linked to reconfiguration of services which is tied to TCS. 13/06/19- Assurance officer asked Service Manager (Scheduled Care) for any update on remaining risk by 18/06/19. 18/06/19- Service Manager (Scheduled Care) provided update for rec 10- There is a Transformation work stream being pursued linking / reviewing Orthopaedic service provision on all UHB sites. An implementation plan in is development as part of the 2019/20 PID / Transformation process for interim change ahead of Clinical Services Strategy.
380A2016	NHS Consultant Contract Follow Up	Wales Audit Office	Jun-16	Open	Medical Director	Medical	Helen Williams	Apr-17	Nov-19	Audit and Risk Assurance Committee	24	2	0	22	ARAC 07/11/17 update- Remaining recommendations should be implemented by 01/04/18. Majority of outstanding recommendations are linked to LNC agreement of local job planning guidance and SPA tariffs. ARAC asked for update in Mar18 to assure them of 100% job plans in place & completion of Improvement Plan. ARAC 17/04/18 update- 3 recs are still being implemented. ARAC requesting update in 6 months (October 2018) to confirm SAS job planning completion and consultant job planning uptodate within their quarter (rec. no.16). 25/04/18- Updated action plan and proforma received. 2 outstanding recs to be completed by December 2018. 1 outstanding rec has no specific date at present at it relates to future redesign of services and the need for job plans to be updated and agreed to reflect new service models. ARAC 25/10/18 update- 3 recs remain outstanding. Rec 1&2 (annual job plans) with end date of 31/03/19 (timescale has slipped several times). Rec 16 (following public consultation, consultant job plans should be updated and agreed to reflect new service models.) has no specific deadline. In future, the redesign of services will consider the job planning process as integral. 28/01/19- Assurance officer emailed reporting officer for update on recommendations by 04/02/19 for reporting to the next Formal ET meeting. 06/02/19- Reporting officer confirmed Rec 16 (consultant job plans should be updated and agreed to reflect new service models) completed. Outstanding rec 1 & 2 (accurate job plan reviewed annually) to be completed by 31/03/19. 12/04/19- Assurance officer requested confirmation from reporting officer that the two outstanding recommendations have now been completed. 16/04/19- reporting officer confirmed rec 1 & 2 have been completed. Assurance officer emailed Medical Director for confirmation that he is happy for this report to be closed. 09/05/19- Assurance officer requested clarification from Medical Director that he is happy for report to be closed. 30/05/19- Medical Director and reporting officer requesting report to remain open with rec 1 & 2 having an extension to November 2019 to get those outstanding job plans where there are no extenuating circumstances reported completed.
651A2015	Hospital Catering and Patient Nutrition Follow-up Review	Wales Audit Office	Feb-16	Open (external rec 4b)	Director of Nursing, Quality & Patient Experience	Nursing	Sharon Daniel	Dec-16	N/K	Formal Exec Team meeting performance review (quarterly)	17	1	0	16	Acute QSE SC 15/11/17 progress update- 12 recs currently outstanding with completion date of July 2018. ARAC 21/08/18 update - 2 recs are outstanding- R1c (Audit of nutritional care pathway) and R4b (Computerised Catering information system). R1c- Full audit of the pathway, and streamlining of audits, has not taken place due to staffing pressures. Investment required for patient feedback, little data currently available. Completion date of April 2019. R4b- an All Wales IT catering solution is being developed. Subsequent to this the UHB will need to consider the Capital & Revenue implications of procuring the system from the All Wales Framework. Completion date of December 2018 is aspirational. 13/11/18- Nutrition and Hydration Task Group report to the Operational Quality Safety Experience Assurance Sub Committee confirmed 2 recs outstanding: R1c- a paper is due to be tabled at the Patient Experience sub-committee setting out the work being undertaken in relation to patient experience and audit along with recommendations for further developments to ensure robustness and adequate reach of activities. It is expected that this will provide the required evidence to meet this recommendation. R4b- Compliance will be partly determined by the pace of the AW work and then a UHB decision on whether to buy the system from the framework. Operational QSE 24/01/19 progress update - R1c- a paper was presented to the Improving Patient Experience Sub Committee meeting on 28 /11/2018 focusing on patient experience and audit activity in relation to catering and nutrition, and a proposed action plan was supported. The monitoring of the action plan will be agreed at January's NHTG meeting. R4b- pending All Wales IT Catering system being procured centrally and is being considered by the Head of Estates and Facilities. 13/03/19- Assurance officer requested update on remaining recs by 25/03/19. 28/03/19- Assurance officer sent chaser email, reporting officer on leave until 04/04/19. 09/04/19- Director of Nursing, Quality & Patient Experience confirmed rec1c completed and suggested rec 4b may be appropriate for the Strategic Log. 08/05/19- Head of Assurance and Risk emailed reporting officer to confirm recommendation 4b does not fit the strategic log, however this recommendation is waiting for an external organisation to do something for the UHB to implement this recommendation. The assurance officer will be look at the recs that are outstanding on the tracker where the UHB are reliant on external organisations in June/July 2019 and how this is managed/shown on the tracker going forward. 17/07/19- Assurance officer requested to receive any update, if applicable, from the reporting officer by 25/07/19 for next PMAF review.

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385A2016	Review of Estates	Wales Audit Office	Jul-16	Open	Director of Operations	Estates	Rob Elliott	May-17	Sep-19	Executive Team Performance Reviews - Estates	8	2	0	6	29/08/18- Assurance officer emailed reporting officer (Director of Operations cc'd) to request completion date for the outstanding recs. 18/09/18- CEIMT paper- R6 (KPIs)- The revised HTM Gap Analysis Paper is currently with the Director of Operations. Discussions are taking place to move from RAM4000 to RAM5000 due to its better functionality, however other estates-friendly systems are currently being looked at. Implementation of new system to be in place by April 2019. R8- staff/skill mix)- workforce succession planning, Workforce succession plans are being considered now as part of the IMTP process. This is expected to be finalised within the next 3-4 weeks as part of the Facilities check and challenge process. This is linked to the GAP Analysis Paper on HTM PPMs currently being considered by the Executive Team. Recommendation to be reviewed in 6 months. 27/09/18- Director of Operations agreed to extensions. 24/01/19- Assurance officer met with Estates colleagues- Rec 6 (KPI) requires extension to September 2019 to allow staff training of new system to take place. Rec 8 (staff/skill mix) Estate Operational Maintenance Workforce Modernisation and Succession Plan Update' paper is currently being drafted for IMTP. Assurance office to discuss remaining recommendations with Director of Operations. 12/03/19- Director of Operations agreed extension to September 2019 for rec 6 (KPIs) but has concerns regarding the implementation of rec 8 (staff/skill mix). 10/04/19-Head of Facilities Information & Capital Management confirmed that Director of Estates, Facilities and Capital Management has had recent discussions with Director of Operations. Service is relooking at recommendation. 02/05/19-Head of Facilities Information & Capital Management meeting with Director of Estates, Facilities and Capital Management to discuss workforce succession planning. RAM4000 upgrade needs approval for funding and was not prioritised at equipment group. 04/06/19 -Head of Facilities Information & Capital Management confirmed a draft succession planning action plan has been written and requires to be signed off Director of Estates, Facilities and Capital Management before being sent out for comment. Following comments being incorporated into the report this will be shared with Director of Operations who will decide next steps (e.g. paper to be discussed at Operations Business meeting. 04/07/19- Head of Facilities Information & Capital Management informed assurance officer that she is hoping to confirm the purchase of a new system to enable KPIs to be developed, however funding has still not yet been agreed for RAM4000 upgrade (rec 6 KPIs). For rec 8 (staff/skill mix) the draft succession planning report is still out for comment and will then be sent to Director of Operations to consider. 08/08/19- Update on outstanding recommendations is being reported to ARAC August 2019 meeting.
175A2017	Radiology Service	Wales Audit Office	Apr-17	Open	Director of Operations	Radiology	Amanda Evans	Mar-18	TBC	Executive Team Performance Reviews - Radiology	11	1	0	10	Acute QSESC 14/03/18- 4 recs outstanding (Two of the outstanding actions linked to implementation of RADIS which NWIS are unable to support implementation of until July 2018). 31/07/18- Update being reported to ARAC August 2018 meeting. 5 recs currently outstanding (R4- the quality of referrals, R6- increase appraisal rates for non-clinical radiology staff, R7- increase mandatory training rates, R8- establish a baseline level of demand, R11- Strengthen performance management) completion date for overall action plan is November 2019 as 2 recs dependant on NWIS (improving referrals and baseline level of demand). 21/08/18 ARAC update- Push back on RADIS implementation slot due to staff sickness to be highlighted to Board. Head of Radiology working on mandatory training and appraisal rates. 19/12/18- Update provided from reporting officer. Rec 7 and 8 remains outstanding. Rec 7 (Over the next year, increase mandatory training rates for all radiology staff to at least 85%) has revised completion date of February 2019 and Rec 8 (establish a baseline level of demand for the service so that the Health Board is in a position to better understand and quantify the challenges it faces) - Single Radis due to be implemented April 2019. 31/01/19- reporting officer confirmed rec 7- Mandatory training rates continue to improve but still fall short of 85%. Reporting officer to undertake risk assessment to include specific actions to address shortfall and increase mandatory training rates within the next 6 months (July 2019). Rec 8 (Radis) still on track to be implemented by April 2019, however this is out of the control of this service and is dependent on NWIS implementing the system. 13/02/19- Director of Operations reluctant to agree the extension of Mandatory training recommendation to July 2019 without seeing a plan of how achieving 85% training rate will be delivered in the next 6 months. Head of Radiology to provide training plan for achieving this to Director of Operations. 12/03/19- Director of Operations noted actions taken to increase training rates (currently at 80%) but wants to see improvement. 28/05/19- Head of Radiology confirmed Rec8 is now complete. Rec 7 (Mandatory training rates continue to improve but still fall short of 85%) is now unlikely to be implemented by July 2019 as Consultant Radiologists are now coming under the Head of Radiology and this is impacting on the % numbers (currently now 69.55%). Risk assessment has been undertaken (no. 694). Head of Radiology to speak to the Clinical Director of Radiology Dr Khan who line manages the Consultant Radiologists to ensure this is picked up and provide assurance officer with a revised timescale which will then need to be agreed by the Director of Operations. 15/07/19- Assurance officer requested reporting officer to to look at what the mandatory training % would be if staff members currently off sick were removed, to see if this will reach the 85% figure.
238A2017-18	Follow-up Outpatient Appointments: Update on Progress	Wales Audit Office	Dec-17	Open (rec 9 Strategic log)	Director of Operations	Scheduled Care	Keith Jones	Sep-19	TBC	Quality, Safety & Experience Assurance Committee/ Executive Team Performance Reviews - Planned Care	10	2	0	8	ARAC 09/01/18 discussion- As this is a follow up this will be monitored by QSEAC, and not passed to subcommittees. 2 new recommendations following Update on Progress report. 9 recommendations outstanding to be completed by Sept 19. 04/06/18- Service Manager (Scheduled Care) confirmed she is chasing reporting officer for confirmation on who is leading on this report going forward. Directorate linking with the transformation team to provide updates. 25/07/18- Update being reported to the next QSEAC meeting in August 2018. 10/08/18- WAO provided All Wales summary draft report to Director of Operations for information. The report is currently being cleared through national contacts, which includes Steve Moore as the Lead CEO for Planned Care. 15/08/18- Service Manager (Scheduled Care) confirmed Assistant Director, Acute Services is now the responsible officer for this piece of work. 22/08/18- Assurance officer emailed new reporting officer requesting update on implementation of recommendations. 23/08/18- Update being reported to the next QSEAC meeting in October 2018. 18/10/18- assurance officer requested reporting officer to provide clarification on no. of recommendations outstanding following paper to QSEAC. 10/01/19- Assurance officer requested update prior to next PMAF review on 30/01/19. 02/04/19- Assurance officer met with reporting officer. Rec 6 (robust quality controlled systems to be developed across the process for usage of outcome forms to ensure reduce errors) to be checked with Head of Improvement and Transformation that this is complete. Assurance officer emailed Head of Improvement and Transformation requesting confirmation. Rec 9 (to ensure that the Health Board delivers against its improvement and modernisation outcomes) is still within the design phase as part of the TCS strategy. 03/04/19- Head of Improvement and Transformation confirmed Rec 6 (Robust quality controlled systems to be developed across the process for the usage of outcome forms to ensure reduce errors) is in progress with a meeting arranged to develop an action plan specifically around the outcome forms. Assurance officer requested realistic timescale for completion. 05/04/19- Head of Improvement and Transformation out of office until end of April 2019 due to unforeseen circumstances. Assurance officer to contact Head of Improvement and Transformation for timescale in May 2019. 02/05/19- Assurance officer requested further information on rec 9 from reporting officer so it was be requested to Exec Team for approval to the Strategic Log. 07/05/19- Assurance officer requested realistic timescale for rec 6 from reporting officer. 12/06/19- Agreed to formal Exec Team 10/06/19 to move rec 9 to the Strategic Log. Rec 6 remains outstanding- situation was reviewed via the Outpatient Improvement Group with agreement confirmed for outpatient nursing staff to formally review and monitor completion of outcomes of each clinic. Compliance will be monitored through the group. Reporting officer will confirm with colleagues for revised date and inform assurance officer shortly. 30/07/19- Chaser email sent to reporting officer for timescale to rec 6.

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No ref	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Wales Audit Office	Mar-18	Open	Director of Planning, Performance & Commissioning	Informatics	Anthony Tracey	Mar-16	N/K	Information Governance Sub Committee/ Formal Exec Team meeting performance review (quarterly)	11 (9 previous recs, 2 new recs)	6	0	5	Follow on to: 270A2015 Information Back-up Review, 141A2012, Review of ICT Disaster Recovery & Business Continuity Arrangements and 373A2012 Data Quality. Overall 9 recs outstanding from these reports. 09/10/18- Informatics Business Manager confirmed 4 of the 7 outstanding recommendations are planned to be completed by January 2019. Assurance officer has requested timescales for the 3 recommendations. 02/11/18- Informatics Business Manager confirmed 1 recommendation regarding failover has not yet been completed as unable to undertake a planned outage for national systems. However it would be possible for a local failover to be undertaken, this has been put forward against the recommendation. Awaiting decision. 2 additional recommendations are currently outstanding, but progress has been made. Due to resources this has been delayed but work to be undertaken in November with completion in January 2019 to ensure disaster recovery plans are in place. 22/01/19- Informatics Business Manager confirmed update on recs will be reported to the Information Governance Sub Committee on 15/02/19. 15/02/19- IGSC paper reported 7 recs still behind schedule. 4 recs will be requested to close once fall over is undertaken which is due by April 2019. 15/04/19- Interim Informatics Business Manager provided update. 6 of the 7 recs are to be completed by end of June 2019. For rec 11 (Introduce continual monitoring of the Solarwinds software to identify network issues before they become critical) - the UHB is awaiting confirmation of two Cyber posts from Welsh Gov to provide resource. Timescale unknown. 07/05/19- Director of Planning, Performance & Commissioning informed of slippages in timescales. 04/06/19- Rec 3,4,5,8 & 12 still under development and due to be completed by June 2019. Interim Informatics Business Manager to check if rec 5 (Information Assurance Strategy) is completed. Timescale for rec 11 still unknown. 20/06/19- Assistant Director of Informatics provided updates which were also shared with Director of Planning, Performance & Commissioning. Rec 3,4,5,8 (DRBC Report)- A new date for the fail over is due to be finalised with NWIS and each of the service areas, however the anticipated date is September 2019. Rec 5 (Data Quality) As a result of additional requested changes to the strategy, the paper was not presented at the May 2019 IGSC. The finalised strategy will be presented at the 15/07/19 meeting for approval. Rec 11 (new recs from follow up report) - The UHB has formally requested an update from Welsh Government to the availability of funding as outlined in the management response. To date no response has been received. If funding is not made available, the ICT Team will be required to divert resources from other projects to ensure this recommendation is completed. Rec 12- All staff have been trained (07/06/19), and following completion, the daily rota will be implemented in time for the completion date of 30/06/19. 04/07/19- Interim Informatics Business Manager confirmed rec 12 is complete. 09/07/19- Assurance officer emailed Business Manager for confirmation if rec 5 (Data Quality) has now been completed. No response received as of 29/07/19. 06/08/19- Assurance officer met with Business Manager who agreed to obtain confirmation if rec 5 (Data Quality) is now complete.
603A2018-19	District Nursing: Update on Progress	Wales Audit Office	Jun-18	Open (external rec 6)	Director of Operations	Community & Primary Care (Ceredigion)	Tracey Evans/ Ceri Griffiths	Jan-19	Dec-20	Executive Team Performance Reviews - Ceredigion (Community)	4	1	0	3	Follow up report to 614A2014 Review of District Nursing Services. ARAC update 19/06/18- 3 recs remain outstanding from previous WAO report . Follow up report also includes 1 new rec (R9: specification for district nursing services is regularly updated and changes to referral criteria are reflected in updates to the referral form) which has a completion date of January 2019. 16/08/18- Update to be provided to QSEAC following report being presented to ARAC 19/06/18 meeting. 10/01/19- Update provided from Community & Primary Care Nurse Manager. From previous WAO report: Rec3- The UHB has developed and rolled out a DN Referral form to try and capture referrals into the service. Once this is embedded into practice an audit tool to monitor key themes of any inappropriate referrals will be developed. Timescale April 2019. Rec6- 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. This National work is ongoing and likely to 2020. Rec7- develop a comprehensive approach of reporting the quality and safety and overall performance of the district nursing service to the Board at least annually. Draft annual report complete and sent for comments. Completion aimed for February 2019. New rec 9- Ensure that the specification for district nursing services is regularly updated and that any changes to referral criteria are reflected in updates to the referral form. Draft service specification has been completed and sent for comments. Completion aimed for Feb 2019. 11/01/19- Assurance officer sent update to Director of Operations to confirm agreement of extensions. 13/02/19- Director of Operations agreed to extensions but would have liked more notice that there was a problem with delivering within agreed date. Assurance officer advised lead officers. 25/03/19- Reporting officer provided update. Rec 7 and rec 9 completed. Rec 3 (Regularly audit compliance with the criteria and checklist of information) is on track to be completed by the revised timescale of 30/04/19 and the Rec 6 (all-Wales dependency tool) is national work that is ongoing to 2020. 25/04/19- emailed reporting officer for confirmation rec 3 still on track to be completed by 30/04/19. Reporting officer confirmed it is on track and will inform the assurance officer once this is completed. 13/06/19- Assurance officer emailed reporting officer for confirmation rec 3 has been completed. 14/06/19- Head of Community Nursing (Ceredigion) confirmed rec 3 is complete. Only outstanding recommendation is rec 6 (all-Wales dependency tool) which is national work that is ongoing to 2020.
946A2018-19	Primary care services at Hywel Dda	Wales Audit Office	Nov-18	Open	Director of Primary, Community and Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Rhian Bond	Oct-19	~~01/10/2019~~ 31/05/2020	Executive Team Performance Reviews - Primary Care, Pharmacy, LTC, LVSW	14	3	3	8	02/10/18- WAO requesting comments on drat report by 22/10/18. Rhian Bond is leading the response but will need to be signed off by Jill. 24/10/18- Jill Paterson meeting with WAO 5/11/18 to discuss reports- need comments by 09/11/18 to allow time for WAO to finalise report before it is presented to next ARAC meeting in December 2018. 30/11/18- Final report and management response received. Management response does not include timescales, Head of Assurance and Risk has contacted reporting officer requesting timescales as soon as possible. 04/12/18- Final version of management response received. 23/04/19- Assurance officer emailed reporting officer requesting update on implementation of recommendations in early May for the next PMAF review. 07/05/19- Chaser email sent to reporting officer. 08/05/19- Update provided. 3 recs are behind schedule: Rec 3a (Calculate a baseline position for its current investment and resource use in primary and community care) slipped from April 2019 to May 2019, once 2018/19 accounts have been audited and finalised. Rec 3b- (Review and report its investment in primary and community care) slipped from April 2019 to May 2020. The shift will be reported in the primary care annual report which can't be undertaken until the 2019/20 annual accounts have been audited next year. Rec 7a- (Work with the clusters to agree a specific framework for evaluating new ways of working) slipped from April 2019 to June 2019. 09/05/19- Director of Primary Care, Community and Long Term Care informed of slippage of recs by assurance officer. 13/06/19- Assurance officer emailed Head of Financial Planning to confirm if rec 3a has now been completed. 10/07/19- Assurance officer emailed reporting officer for update on recommendations. 23/07/19- Reporting officer confirmed Rec 6a is complete. Awaiting confirmation if rec 3a and Rec 7a are complete as timescales have now passed. Rec 3b and 7c are on track. No further update on Rec 5b & 7b, awaiting All Wales toolkit. 29/07/19- Head of Financial Planning confirmed he has discussed rec 3a (Calculate a baseline position for its current investment and resource use in primary and community care) with the primary care finance lead and it has now been referred to the All Wales Technical finance Group for discussion.
1033A2019-20	Structured Assessment 2018	Wales Audit Office	Jan-19	Open	Board Secretary	Governance	Board Secretary	Mar-20	Mar-20	Audit and Risk Assurance Committee	5	1	1	3	19/02/19- Management response provided. Rec 4 and 5 completed. Rec 2 (effectiveness of committees) to be completed by April 2019, Rec 1 (Board effectiveness) and rec 3 (Operational meetings) to be completed by September 2019. 23/04/19 ARAC update- Rec 2 is now competed. Rec 1 (Board effectiveness) is still on track to be completed by September 2019. Rec 3a (streamline operational meetings) - the review of the Performance Management Assurance Framework is unlikely to be completed by June 2019 and a revised timescale will be agreed following a workshop arranged by the Chief Executive Officer in May 2019 to determine the organisational goals. 25/06/19 ARAC update- Rec 2, 4 & 5 completed. Rec 1 on track for September 2019 and rec 3 (specifically section 3a streamline operational meetings) is behind schedule. An Executive workshop took place in May19 however Director of Planning, Performance and Commissioning will be meeting the Chief Executive on 25/06/19 to discuss the enhancement of the PMAF.

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175A2019-20	Clinical coding follow-up review	Wales Audit Office	Apr-19	Open	Director of Planning, Performance & Commissioning/ Director of Operations	Informatics	Anthony Tracey	Dec-15	Sep-19	Information Governance Sub Committee/ Formal Exec Team meeting performance review (quarterly)	3	3	0	0	15/04/19- Of the 15 recommendations from the original 2014 report (under 4 overarching recommendations), 4 had been implemented, 6 were in progress and 5 were overdue. Report to be reported to ARAC April 2019 meeting. 01/05/19- ARAC requested 6 monthly updates on progress of actions and future plans. Tracker to be updated once timescales are confirmed. Assurance officer to update tracker once ARAC minutes are received. 23/05/19- Assurance officer emailed reporting officer for timescales against the outstanding recommendations within the follow up report. 13/06/19- Reporting officer shared action with timescales that was reported to formal Exec Team and BPPAC. Timescales for several actions are unclear as some are required to be incorporated into the wider action plan for Health Records (to be agreed by September 2019). The Director of Planning, Performance and Commissioning will oversee the implementation of recommendations contained within the WAO review; however the Director of Operations will retain Executive Accountability for Medical Records.
xx2019-20	Review of operational quality and safety arrangements	Wales Audit Office	Jun-19	Open	Director of Operations/ Director of Nursing, Quality & Patient Experience	Quality & Safety	TBC	TBC	TBC	TBC	8	TBC	TBC	TBC	17/06/19- Final version of report received and management response being prepared. Director of Nursing, Quality and Patient Experience will be attending ARAC on 28/06/19 to provide an unapproved initial response to the findings. The draft management response will then be reported to QSEAC on 01/08/19. 17/07/19- Assurance officer emailed Director of Nursing, Quality & Patient Experience for confirmation if management response has been drafted ready for QSEAC. 09/08/19- Management response to be reported to ARAC August 2019 meeting.

***Key**

Open- recommendations to be implemented

Closed- all recommendation implemented and report closed following approval by the relevant Executive Director

Strategic log- a recommendation requiring a long term/strategic solution to be addressed as part of a long term strategy e.g. Capital prioritisation plan, Digital Strategy, Ward refurbishment programme, etc.

External rec- a recommendation that is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

INTERNAL AUDIT

Report Ref	Name of Report	Assurance rating	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Director	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed action/ arrangements for future reporting: (eg 6 monthly at Q&S, develop combined Service Action Plan, etc)	Total No of recommendations within report	Red (behind schedule)	Amber (on schedule)	Green (completed)	Additional Information
HDUHB 1420	Concerns Follow Up	Reasonable	Internal Audit	Apr-15	Open	Director of Nursing, Quality and Patient Experience	Nursing	Louise O'Conner/ Sian Passey	The Follow Up Audit did not include specific dates	Dec-20	Improving Experience Sub Committee/ Formal Exec Team meeting performance review (quarterly)	5	2	0	3	25/01/18 and 12/03/18- Reporting officers contacted requesting update, response not yet received. 12/03/18- reporting officer provided update, assurance officer has contacted Assistant Director of Nursing Assurance & Safeguarding for updates on the incident related issues. 25/04/18- email chaser sent to Assistant Director of Nursing Assurance & Safeguarding. 25/06/18- Assurance officer emailed Assistant Director of Nursing Assurance & Safeguarding requesting update on implementation of recommendations by 20/07/18 for ARAC August 2018 meeting. 27/07/18- Assistant Director of Nursing Assurance & Safeguarding provided updated on outstanding recs (Rec 1, 6 and 7). Rec 1 has a completion date of January 2019, following service changes historic incidents have now been aligned to the correct managerial structure, and the targeted approach through performance management will see an improvement in the closure of older incidents. Rec 6 (amendment of 'Guidance on the Investigation of Concerns policy') has a completion date of October 2018. The UHB will be adopting a SOP which will be taken to the Improving Experience Sub Committee (IESC) in September 2018. Rec 7 has a completion date of 2020 as the Datix system is being reviewed from an All Wales perspective and as such it would not be appropriate to amend system to include MYRDDIN data. 18/10/18- Assistant Director confirmed monitoring of this report will take place at the Improving Experience Sub Committee. This report is not superseded by HDUHB 1819-22. To remain open. 18/03/19- Assurance officer requested update from reporting officers by 27/03/19 for April formal exec team meeting. 02/04/19- Updates received from reporting officers. Rec 6 (amendment of 'Guidance on the Investigation of Concerns policy) is now complete and reporting officers requested remaining rec 1 (All concerns should, wherever possible, be acknowledged and responded to within the timescales set out in the NHS (Concerns, Complaints & Redress Arrangements) (Wales) Regulations 2011) and rec 7 (comprehensively populating Datix with investigation information) to be closed. Assurance officer emailed Director of Nursing, Quality and Patient Experience for confirmation if she is happy for the report to be closed. 09/04/19- Head of Assurance and Risk met with Director of Nursing, Quality and Patient Experience. Director confirmed she will be contacting reporting officer to discuss report. 13/06/19- Assurance officer emailed Director of Nursing, Quality and Patient Experience to enquire if this report has been discussed and what was the outcome.
HDUHB 1428	Review of Clinical Audit Follow up	Substantial	Internal Audit	Apr-15	Open	Director of Nursing, Quality and Patient Experience	Nursing	Ian Bebb	Aug-15	Aug-19	Formal Exec Team meeting performance review (quarterly)	1	0	0	1	25/01/18- Reporting officers contacted requesting update. 29/01/18- Update provided: The remaining 2 of 30 items in recommendation 1 are items that need to be fulfilled. The UHB have never had sufficient capacity to implement them fully although attempts have been made. The UHB are still looking to complete them in the future but unfortunately they are deferred through necessity. 25/04/18- The 2 remaining items outstanding relate to: 7b. completion rate of total HB forward Audit Plan (when in place), the 7c. outputs of the department, quality of audits undertaken and completion rate of audits initiated. 25/06/18- Assurance officer emailed reporting officer requesting update on implementation of the rec by 20/07/18 for ARAC August 2018 meeting. 27/06/18- Reporting officer confirmed that at the June 2018 ARAC meeting it was agreed that a report highlighting the outstanding actions (completion rate of total HB forward Audit Plan (when in place) and outputs of the department, quality of audits undertaken and completion rate of audits initiated), would be produced to ARAC at the end of the 2018/19 financial year. 18/03/19- Assurance officer requested update on the implementation of the outstanding recommendation from the reporting officer. 02/04/19- reporting officer confirmed the planned outcomes on the action points are still the same. The outstanding recommendation within the internal audit report will be completed once the annual report is presented to ARAC in August 2019. Director of Nursing, Quality and Patient Experience informed of completion date. 01/05/19- Clinical audit plan to be reported to ARAC August 2019. 17/07/19- Assurance officer requested to receive any update, if applicable, from the reporting officer by 25/07/19 for next PMAF review. Reporting officer provided update and believes the recommendation can now be closed. 22/07/19- Assurance officer emailed Director of Nursing, Quality and Patient Experience for confirmation that she is happy for the report to be closed.
HDUHB 1617-08	Health & Safety	Reasonable	Internal Audit	Sep-16	Open	Director of Operations	Estates	Rob Elliott / Tim Harrison	Nov-16	N/K	Executive Team Performance Reviews - Estates	7	5	0	2	14/03/18- Reporting officer provided update. Rec 3 and 4 are due to be complete by May18 and Jul18 respectively. 25/06/18- Assurance officer emailed reporting officer requesting update on implementation of the recs by 20/07/18 for ARAC August 2018 meeting. 20/07/18- Update from reporting officer confirmed Rec 3 has been competed (Control of Substances Hazardous to Health (COSHH) Policy approved May 2018). Rec 1, 4 and 5 have not progressed. A paper to support staffing resource has been produced for Director of Operations to consider w/b 23/07/18. If supported this will enable some of the outstanding actions to be progressed. 29/08/18- 4 recs (1,4,5& 6) currently remain outstanding. A paper is going to the Exec team for discussion. Assurance officer has requested reporting officer to provide update following paper going to Exec team. 29/08/18- Assurance officer emailed reporting officer (Director of Operations cc'd) requesting update on implementation of recommendations. 13/09/18- Assurance officer met with Estates Colleagues- Rec 1 (Governance) and 7 (Training) have been completed. 5 recs remain outstanding (2/3/4/5 & 6) and cannot be achieved within current staffing resource. H&S team requested recommendation is reviewed in 12 months as they will be in better position in terms of staffing resources to establish when this action can be completed. 28/09/18- Director of Operations agreed to recommendations being reviewed in 12 months. 24/01/19- Assurance officer met with Estates colleagues who are currently updating the management responses. Progress has been made on recs 2,3 and 4. Recs 5 and 6 cannot be achieved at present within current staffing resources. 13/02/19- Director of Operations has requested a brief from the reporting officer as soon as possible. 14/03/19- Assurance officer sent chaser email to reporting officer requesting to send brief to Director of Operations. 22/03/19- Head of Health, Safety & Security provided update to Director of Estates, Facilities and Capital Management on implementation of recommendations. 5 recommendations remain outstanding with no clear timescale. 08/08/19- Update on outstanding recommendations is being reported to ARAC August 2019 meeting.
HDUHB 1639	Wales for Africa Programme	Limited	Internal Audit	Apr-17	Open	Director of Public Health	Public Health	Director of Public Health	Mar-18	Nov-19	Formal Exec Team meeting performance review (quarterly)	7	3	0	4	26/03/18- Comments received on recommendations have been received by the reporting officer. Assurance officer has responded requesting clarification on how many of the recs are outstanding. 06/07/18- Assurance officer emailed Director of Public Health and Head of Hywel Dda Health Charities for updates on recommendations. 06/07/18- Head of Hywel Dda Health Charities confirmed the charitable fund T607 (recommendation 3) will be closed once the outcome of ongoing investigations is communicated to the Charitable Funds Committee. 20/07/18- Assurance officer sent email reminder to Director of Public Health for updates. 26/07/18- chaser email sent to reporting officer requesting update by 30/07/18. 09/08/18- No update received. 15/08/18- Update from reporting officer, 5 recommendations remain outstanding (3 of the recs the UHB are compliant with, but recommendations are not yet fully completed). 11/10/18- Following agreement with Board Secretary, due to the internal investigation updates won't be sought until April 2019. 12/04/19- requested update from Director of Public Health by 30/04/19 for formal ET meeting in May. 03/05/19- Assurance officer sent chaser email to Director of Public Health for update by 08/05/19. 24/05/19- Update from Partnership Governance Officer. Following recs remain outstanding: - Rec 1 (Memorandum of Understanding) -A MoU template is in the process of being agreed and will be in place for sign off at Board in November 2019. - Rec 3 (Charitable Fund)- Discussions are in place between finance, Charitable Funds and Partnership Governance Officer to establish clear policy and guidance regarding the UHB CF holding external funds and the management of these funds. This will be an element of the International Partnership Governance Framework (IPGF) and approved by CFC prior to Board in November 2019. The fund T607 has not yet been closed as the CFC has received no formal notification regarding the outcome of the internal investigation. - Rec 4 (Expense Record Keeping and Reporting to Grant Funders) - An element of the IPFG will be for reports to be made to the International Health Group. The terms of reference are the International Health Group being worked up now and will be approved at Board in November 2019. 10/06/19- The report was discussed at formal ET meeting and it was agreed that the Board Secretary, Director of Finance, Director of Public Health and Director of Partnerships and Corporate Services will meet to discuss and agree the closure of the outstanding actions. 08/08/19- Assurance officer emailed Director of Finance, Director of Public Health and Director of Partnerships and Corporate Services for update on recommendations.
HDUHB 1636	Low Vision Service Wales - Review of New Arrangements	Reasonable	Internal Audit	Aug-17	Open (external rec 2,5 & 6)	Director of Primary, Community & Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Donna Martin	Not stated	TBC once Ministerial Direction published.	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	6	1	3	2	01/02/18- Update provided by Reporting Officer. Most of the recs are expected to be covered off by the creation of new Ministerial Directions which is currently with the Welsh Government legal branch. Date for the next draft for comment has yet been announced. 22/06/18- Assurance officer emailed reporting officers requesting update on completion of recommendations by 20/07/18 for ARAC August 2018 meeting. 04/07/17- Reporting officer confirmed revised Ministerial Directions have not yet been received from WG, therefore 5 recommendations remain outstanding. 13/09/18- Director of Primary Care, Community and Long Term Care reiterated this report is dependent on a WG resolution. 07/05/19- Assurance officer requested confirmation from Director of Primary Care, Community and Long Term Care that the UHB is still awaiting WG guidance to complete recommendations. 28/05/19- emailed reporting officer for update on recommendations and if the Ministerial Direction has been received. 30/05/19- Reporting officer confirmed the new draft of the Ministerial Direction in relation to LVSW has not yet been shared by WG. 11/07/19- Assurance officer emailed reporting officer requesting all recommendations in the report to be reviewed to check if any of within the gift of the service to currently complete. 12/07/19- Update provided by reporting officer. Rec 1 & 4 are complete. Rec 3 (The MOU requires reviewing and updating)- Entire Clinical lead role and employment to be reviewed in Sept 19 as part or all of role may be tuped across to HEIW. Rec 2,5 & 6 are awaiting the new Ministerial Direction from WG before these can be completed.

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HDUHB-1718-34	National Standards for Cleaning in NHS Wales	Reasonable	Internal Audit	Feb-18	Open (external rec 4)	Director of Operations	Estates	Mark Lewis/Rob Elliott	Jun-18	N/K	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	4	1	0	3	20/07/18- Reporting officer confirmed Rec 3 has been completed while Rec 4 has an extended completion date of October 2018. Rec 4 update is as follows: Actions have been implemented to ensure appropriate attendance of all parties when Audits are undertaken. Cover arrangements are also in place. The introduction of the updated MICAD software is being facilitated by Shared Services who have recently indicated that this roll-out will not be undertaken until after Summer 2018. It is currently anticipated that this will be implemented in Sept/October 2018. 29/08/18- Assurance officer emailed reporting officer (Director of Operations cc'd) requesting update on outstanding rec. 06/09/18- Assurance officer meeting with estates colleagues next week to discuss outstanding recommendation (credits for cleaning). 18/09/18 CEIMT paper- Rec4- It was noted at the meeting that the planned implementation of the new version of MICAD software which would allow the functional area to be modified has been delayed again; this implementation includes the whole of England and Wales. December is now being discussed as the start but this has yet to be officially confirmed plus there would be staff training thereafter. In light of this it's proposed that the deadline be moved to April 2019. 28/09/18- Director of Operations agreed to extension. 11/01/19- Follow up audit currently taking place, however this does not supersede this report which will remain open until the final recommendation (Rec 4- Inconsistent Practices- credits for cleaning) is implemented. 24/01/19- Assurance officer met with Estates colleagues - Rec 4 is beyond the control of the Estates department. Last update received from Shared services provided April 2019 as implementation date for C4C upgrade, therefore currently on track but this has been delayed several times in the past year therefore further delay could be possible. 04/03/19-Head of Facilities Information & Capital Management reported no update received from shared services. 10/04/19- Head of Facilities Information & Capital Management confirmed no update from shared services. Internal Audit follow up report currently being finalised. 02/05/19- Head of Facilities Information & Capital Management confirmed no update from shared services. Director of Operations informed of delay on 30/04/19. Internal Audit follow up report does not review the outstanding recommendation 4 therefore this report is to remain open. Welsh Government have yet to make a decision regarding the C4C upgrade and other sites are looking at alternatives. 04/06/19- Head of Facilities Information & Capital Management confirmed no update from shared services. 04/07/19- Head of Facilities Information & Capital Management confirmed no update from shared services and is outside the gift of the UHB. 06/08/19- Head of Facilities Information & Capital Management confirmed no update from shared services and is outside the gift of the UHB.
HDUHB1718-35	Theatres Directorate	Reasonable	Internal Audit	Apr-18	Open	Director of Operations	Scheduled Care	Stephanie Hire /Diane Knight	Jun-18	Dec-19	Executive Team Performance Reviews - Planned Care	10	2	0	8	ARAC 17/04/18- 4 recs outstanding to be implemented by June 2018. 23/05/18- Service Manager (scheduled care) confirmed action plan is on target for completion. 21/06/18- Assurance officer emailed Director of Operations requesting dates in management response be reviewed following ARAC meeting on 30/05/18 and requesting update be sent to Chief Internal Auditor by 31/07/18 ready for ARAC August 2018 meeting. Assurance officer to update audit tracker following ARAC August 2018 meeting. 21/08/18 ARAC meeting- revised management response provided. R3 (e-roster) and R10 ('rest days' issues) remain outstanding. Actions being led by Service Delivery Manager Diane Knight and working group established to address issues and new site manager appointed. Complex issues involved including staff grievances. ARAC requesting progress in February 2019. 24/10/18- Update from GM (Scheduled Care) following meeting with Director of Operations and Service Manager (Scheduled Care). R3 (e-roster) and R10 ('rest days' issues) remain outstanding- Exec Team have approved an option to put in place a roistered team in Theatres out of hours. Meeting held 23/10/18 with team to feedback. An implementation plan is being worked up which aims to address the removal of compensatory rest at BGH Theatre and thereby enable implementation of the E roster. 11/01/19- Head of Nursing Scheduled Care confirmed R3 (e-roster) and R10 ('rest days' issues) remain outstanding due to delay in Exec sign off of the Organisational Change Policy (OCP). Formal consultation to commence on 16/01/19. This will be a full 90 day process to achieve a change in Terms and Conditions so the completion date has been pushed back to April 2019. 15/01/19- Assurance officer emailed Director of Operations for agreement of extension. 07/02/19- Director of Operations agreed to extensions citing these are tied up in HR issues so unavoidable. 19/02/19 ARAC- paper states 3 recs outstanding. Rec 3 (Evidence to support call-out hours claimed) has completion date of June 2019. Rec 4 (Operating Department Practitioner overnight on call shifts not being compliant with Agenda for Change on-call agreement at Glangwili Hospital) has completion date of September 2019, and rec 10 (Compensatory rest arrangements in Bronglais Hospital not managed in compliance with the Agenda for Change on-call agreement) has completion date of 31/04/19 subject to continued staff support for OCP process. 11/04/19- Rec 3 and 4 are on track to be completed by the revised dates of June 2019 and September 2019 respectively. Rec 10 delayed due to completion of the OCP process, now to be completed by end of June 2019. Director of Operations to be informed of delay by assurance office. 30/04/19- Director of Operations agreed to extension of rec 10 to 30/06/19. 06/06/19- Head of Assurance and Risk met with Director of Operations and Service Delivery Manager. Rec 3 has now been completed. Rec 4 (Operating Department Practitioner overnight on call shifts not being compliant with Agenda for Change on-call agreement at Glangwili Hospital) to be completed by 31/12/19 and rec 10 (Compensatory rest arrangements in Bronglais Hospital not managed in compliance with the Agenda for Change on-call agreement) to be completed by 30/06/19. 18/07/19- Reporting officer confirmed rec 10 has not been achieved, and currently she is uncertain as to when this will be met. The reporting officer recommended a revised timescale of 30/10/19 and advised that the Director of Operations is aware of the position and the background behind it, as she met with him w/b 08/07/19.
HDUHB 1718-20	Governance in Primary Care Clusters	Reasonable	Internal Audit	May-18	Open	Director of Primary, Community & Long Term Care	Primary Care, Pharmacy (community), LTC & LVWS	Kelly White	Jul-18	TBC	Executive Team Performance Reviews - Primary Care, Pharmacy (community), LTC & LVWS	3	1	0	2	1 recommendation (Recommendation 2- successful PCC projects) is scheduled to be completed by July 2018, subject to identification of a University Partner. 08/08/18- reporting officer working with Swansea university to develop an evaluation framework and has been tasked to update at the University Partnership Board meetings on the progress of this work. There was a delay with staff moving roles but the framework is now being developed. Assurance officer responded requesting approximate timescale for completion. 10/08/18- reporting officer confirmed they are working to the date of the next UPB meeting which is on the 01/11/18, so will therefore be able to provide an update by then. 25/09/18- Assurance officer emailed reporting officer for any further update and if the outstanding rec (rec 2) is still on track to be completed by November 2018. Reporting officer confirmed she will liaise with the Head of the College of Human and Health Sciences at Swansea University on its progress. 27/11/18- Chaser email sent to reporting officer for update on outstanding rec. 10/12/18- Primary Care Manager Service Improvement is the new lead for this report and will be having a handover meeting with Senior Primary Care Locality Development Manager shortly. 03/01/19- Assurance officer requested revised timescale from new reporting officer. 07/01/19- Reporting officer is waiting for the University to get back to her to get up to speed on the development of the evaluation tool and some concerns from clusters about the effectiveness of the tool and some amendments that will need to be made. As such reporting officer not currently in a position to give timescales. Once reporting officer has spoken to the University and reviewed the information from the clusters she will be better positioned to gauge timescales. 10/01/19- reporting officer informed Director of Primary, Community & Long Term Care the will be discussing a more detailed discussion around how the UHB take this forward with the Assistant Director of Primary Care shortly. 31/01/19- Swansea University Professor has offered to run an evaluation workshop for cluster leads and LDM's, this will allow him the opportunity to explain the Evaluation Tool that has been devised to standardise the Evaluation Process for Clusters. In addition exit strategies can be discussed as part of this meeting with LDM's and Cluster Leads for information to be taken back and shared within each cluster. Assurance officer has requested date for workshop once scheduled. 23/04/19- Assurance officer emailed reporting officer for update on evaluation workshop by 08/05/19 for next PMAF review. 29/04/19- reporting officer confirmed evaluation workshop organised for 20/06/19 which was the earliest date Professor Phillips at Swansea University was able to do. 07/05/19- Director of Primary Care, Community and Long Term Care informed of slippage of rec by Assurance Officer. 05/07/19- Reporting officer confirmed the Evaluation Workshop had taken place with Professor Phillips. Assurance officer responded 08/07/19 requesting further information in order to close report.
HDUHB1819-17	Charitable Funds	Substantial	Internal Audit	Feb-19	Open	Director of Finance	Finance	Fiona Powell/ Jennifer Thomas	May-19	~~01/07/19~~ 09/08/19	Formal Exec Team meeting performance review (quarterly)	3	2	0	1	08/04/19- Assistant Director of Finance (Finance Systems and Statutory Reporting) confirmed she is obtaining updates from reporting officer. 11/04/19- Assistant Director of Finance (Finance Systems and Statutory Reporting) confirmed Rec 1 and 2 are complete. Rec 3 (The expenditure authorisation list on the intranet site should be changed to the most up to date version available) is on track to be completed by May 2019. 24/05/19- Rec 1 (Legacy Register) with Finance Directorate to approve rec through TeamCentral system. TeamCentral system issues currently being resolved with assistance from the Internal Audit team. Rec 2 (Expenditure Authorisation List)- to be completed by original timescale of 31/05/19. Rec 3 (Financial Procedures)- currently under review, revised date of 31/05/19. 08/06/19- Rec 1 has been completed. Assurance officer to meet with Director of Finance to assist in closing the rec on TeamCentral. Rec 2 timescale has been revised to 07/06/19. Rec 3 timescale has been revised to 30/06/19. 17/06/19- Rec 3 timescale further extended to 30/06/19 07/08/19- Rec 2 has a revised timescale of 09/08/19 and rec 3 has now passed its revised timescale of 30/06/19.
HDUHB 1819-21	Safeguarding of Children & Vulnerable Adults	Reasonable	Internal Audit	Feb-19	Open	Director of Nursing, Quality and Patient Experience	Nursing	Mandy Nichols-Davies	Jun-19	Jun-19	Formal Exec Team meeting performance review (quarterly)	3	0	0	3	12/02/19- IA report received. Outstanding recommendation' Action plans to improve compliance are to be developed by Directorate/Sites/Service areas and discussed at Strategic Safeguarding Sub Committee quarterly' to be completed by June 2019. 03/07/19- Assurance officer emailed Head of Safeguarding for confirmation that final recommendation has now been completed. 04/07/19-Head of Safeguarding confirmed final recommendation is complete. Assurance officer emailed Director of Nursing, Quality and Patient Experience for confirmation that she is happy to close the report.

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HDUHB 1819-22	Concerns	Reasonable	Internal Audit	Oct-18	Open	Director of Nursing, Quality and Patient Experience	Nursing	Louise O'Conner	Dec-18	Dec-18	Improving Experience Sub Committee/ Formal Exec Team meeting performance review (quarterly)	2	1	0	1	15/10/18- Assurance officer requested clarity from Audit Manager if this report supersedes HDUHB 1420 Concerns Follow Up, or are both reports to remain open. 18/10/18- Assistant Director confirmed monitoring of this report will take place at the Improving Experience Sub Committee. This report doesn't not supersede HDUHB 140 (Concerns Follow up). Both reports to remain open. 11/12/18 ARAC- report noted by ARAC and requested that a further update be provided in 6 months. 28/11/18- Report taken to Improving Experience Sub Committee, Assurance officer awaiting copy of minutes for any discussion/updates provided at the meeting. 04/02/19- Rec 2 (incident testing) has been completed and approved. Rec 1 (Failure to comply with Welsh Government timescales) has been completed but is awaiting approval by Director of Nursing, Quality and Patient Experience on Teamcentral audit system before report can be closed. 09/04/19- Head of Risk and Assurance met with Director of Nursing, Quality & Patient Experience- agreed to close report. Director of Nursing, Quality and Patient Experience to approve rec 2 through TeamCentral before report can be closed on the audit tracker. 13/06/19- Assurance officer emailed Director of Nursing, Quality and Patient Experience to remind that rec 2 needs to be approved through the TeamCentral system. Rec to remain as red RAG status until this is approved.
HDUHB-1819-25	Review of Discharge Processes (Follow-up)	Reasonable	Internal Audit	May-19	Open	Director of Operations	Unscheduled Care	Carol Cotterell/ Alison Bishop	Sep-19	Sep-19	Formal Exec Team meeting performance review (quarterly)	2	0	1	1	This report supersedes HDUHB1718-12 Review of Discharge Processes. Rec 2 completed and rec 1 to be implemented by September 2019. This report, having previously received a Limited Assurance rating, had been rated as Reasonable Assurance, reflecting the progress made. ARAC 29/05/19- Rec 1 is impacted/affected by Local Authority partners and therefore the timescale of September 2019 is somewhat optimistic. The recommendation would need to be considered by the Lead Director and if the timescales were not achieved these would be subject to scrutiny through the Executive Performance Reviews and ARAC. 08/08/19- RAG status updated to reflect TeamCentral. Recs remain red until the Director of Operations has approved the recommendations as closed through the system.
HDUHB-1819-29	PC and Laptop Security (Follow-Up)	Limited	Internal Audit	Feb-19	Open	Director of Planning, Performance & Commissioning	Planning, Performance & Commissioning (Informatics)	Tim Harrison/ Rob Elliot/ Anthony Tracey	Feb-20	Feb-20	Formal Exec Team meeting performance review (quarterly)	4	3	1	0	Supersedes Internal Audit HDUHB 1718-32 PC / Laptop Security Arrangements. 12/02/19- Clear dates not provided in Management response, Head of Assurance and Risk to query with Head of Internal Audit. ARAC 19/02/19- Timescales unclear from management response submitted to ARAC February 2019 meeting- ARAC requested further clarity around both ownership and timescales for completion is required and that the management response should be amended and resubmitted. ARAC 23/04/19- Management response resubmitted: Rec 1 (Physical security awareness programme) - Work on the scoping has begun w/c 01/04/19- completion date of recommendation is 28/02/20. Rec 2 (South Pembrokeshire Hospital)- completion date of 30/06/19. Rec 3 (Bro Cerwyn)- completion date of 31/05/19. Rec 4 (Amman Valley Hospital)- completion date 31/05/19. 28/06/19- Assurance officer emailed Assistant Director of Informatics for confirmation if rec 3 and 4 have been completed. 04/07/19- Interim Informatics Business Manager confirmed he will check if rec 2,3 & 4 are now complete. 09/07/19- Assurance officer emailed Business Manager for confirmation if recs have now been completed. No response received as of 29/07/19. 06/08/19- Assurance officer met with Business Manager who agreed to obtain confirmation if rec 2,3 & 4 are now complete.
HDUHB1819-32	Radiology Directorate	Reasonable	Internal Audit	Oct-18	Open	Director of Operations	Radiology	Amanda Evans	Sep-19	Oct-19	Executive Team Performance Reviews - Radiology	8	7	1	0	17/10/18- report includes 8 recommendations: 1 rec to be completed by October 2018, 2 recs by November 2018 and 4 recs by March 2019. Rec 3 (Payroll On Call Arrangements/Agreements) has implementation (where required) by September 2019. ARAC 11/12/18 - updated management response received. Rec 1 & 5 completed. Remaining 6 recs to be completed by April 2019. It was agreed at ARAC there should be a further update on progress at the April 2019 meeting, with the reporting officer invited to attend. 31/01/18- reporting officer advised for Rec 2 (Income Ante natal scan photos), due to discrepancies in the procedure not fully appreciated when the management response was initially completed, there is further work involved in completing this recommendation than first anticipated and it was reported to ARAC in December 2018 with a revised timescale of April 2019 (initial timescale was November 2018). 13/02/19- Director of Operations agreed to extension of Rec 2 (Income Ante natal scan photos) to April 2019, however lead officer advised no further extension will be agreed. 23/04/19 ARAC update: ARAC made aware of outstanding recommendations and realistic timescales for completion. It was agreed that there should be a further update to ARAC in October 2019 to assess progress. If this is satisfactory, no further review will be required; if not, a further update will be required at ARAC. 23/04/19- Update from Teamcentral following ARAC shows Rec 1, 4,5,6 & 7 completed. Rec2 (Income Ante natal scan photos) to be implemented by 31/05/19. Rec 3 (Payroll On Call Arrangements/Agreements) has implementation (where required) by 30/09/19. Rec 8 (excessive on call hours) to be completed by revised date of 16/10/19. 11/07/19- Reporting officer confirmed rec 2 completed via TeamCentral. RAG status updated to reflect TeamCentral. Recs remain red until the Director of Operations has approved the recommendations as closed through the system.
HDUHB1819-33	Records Management	Limited	Internal Audit	Feb-19	Open	Director of Operations	Records management	Steven Bennett/ Sian-Marie James	Sep-19	Sep-19	Executive Team Performance Reviews - Health records	9	5	1	3	05/03/19-Health Records Manager provided update. Rec 2 (Information Asset Owners questionnaire to be circulated), Rec 5 (Access to Health Records Policy to be reviewed and updated), Rec 7 (possibility of introducing joint IG/Health Records training sessions), Rec 8 (review the Health Records Management Policy and Health Records Committee terms of reference) and Rec 9 (ensure that the Health Records Committee regularly meet as per the frequency detailed in their terms of reference) have timescales that have slipped to March 2019. All other recs (1,3,4 and 6) are currently within original completion dates. 16/04/19- updates provided by reporting officers: -Rec 2 (Information Asset Owners questionnaire to be circulated)- The distribution of the questionnaire has been slightly delayed whilst a site visit was completed to Worcestershire NHS Trust and a review undertaken of their offsite scanning solution. It was agreed by the Deputy Director of Operations that following the visit an additional report should be presented to the Executive time identifying both the immediate actions required to deal with the current storage arrangements and long term actions for implementing a scanned patient record. As part of the paper it will be acknowledged that the IAO's will be required to answer several questions before scanning arrangements can be progressed. The paper will be finalised in May 2019. -Rec 3 , 4, 6 & 8 are complete. -Rec 5 (Access to Health Records Policy to be reviewed and updated) timescale slipped until end of April 2019. -Rec 7 (possibility of introducing joint IG/Health Records training sessions) has revised timescale of May 2019. -Rec 9 (ensure that the Health Records Committee regularly meet as per the frequency detailed in their terms of reference) has revised timescale of June 2019. 30/04/19- Paper going to June BPPAC (and Executive Team prior to this) setting out the records management plan with realistic timescales. Audit tracker to be updated following BPPAC paper. BPPAC 27/06/19 update- Rec 5,8 & 9 are complete. Rec 1 is to be completed by Sept 2019. Rec 2,3,4,6 & 7 have timescales that slipped as these elements will be included in a wider action plan for Health Records to be agreed by September 2019.
HDUHB1819-27	IM&T Directorate	Reasonable	Internal Audit	Nov-18	Open	Director of Planning, Performance & Commissioning	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Mar-22	Mar-22	Information Governance Sub Committee/ Formal Exec Team meeting performance review (quarterly)	8	1	1	6	21/11/18- Internal Audit includes 8 recommendations however recommendation 8 (WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to) was rejected by the service. The Assistant Director of Informatics advised that this has a long standing issue that he has been working with HR / Unions to ensure that the staff have their comfort breaks. Unfortunately, due to the nature of the work, structures etc the UHB 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. 11/12/18 ARAC- ARAC requested that the report be reviewed in terms of assurance rating and content, and requested that the management response be updated and resubmitted to the next meeting. 15/02/19 IGSC meeting- Rec 3 to 7 requires formal communication to be provided to all staff / managers detailing their responsibilities to ensure that due process is adhered to. The deadline for these recs range from November 2018 to February 2019, but the Informatics Business Manager has confirmed that formal communication will be sent out in due course by March 2019. 10/04/19- Assurance officer met with new Interim Informatics Business Manager, who will seek a progress updates on the outstanding recommendations. 15/04/19- update provided by Interim Informatics Business Manager. Rec 1 and 2 on track to be completed by May 2019. Rec 3 to 7 (formal communication to be provided to all staff / managers detailing their responsibilities to ensure that due process is adhered for on call) have now been completed. Rec 8 (WOD advice for compulsory breaks) is on track for March 2022 part of switchboard modernisation plan. ARAC 23/04/19- Rec 8 (WOD advice for compulsory breaks) was reported as accepted and revised management response presented with a timescale of 31/03/22. 04/06/19- Interim Informatics Business Manager confirmed he will check if rec 1 and 2 have been completed. Rec 8 has been highlighted by Exec Team to be progressed, proposals are being drafted for consideration by the Board. 20/06/19- Update from Assistant Director of Informatics which has also been shared with Director of Planning, Performance & Commissioning. Rec 1 (Stores asset register) complete. A further module of KACE has been purchased and implemented. Further internal ICT audits are planned for August, and October to ensure all staff are complying with the agreed internal process. Rec 2 (Stores Key Code Changes) to be completed by 30/06/19. There is a 1 month delay to the project. The completed audit of all communications rooms will be completed by June 2019. The result of the review will establish a replacement programme of equipment, and provide a review of the room's infrastructure, with detailed pictures. Where non-ICT equipment is being stored in the comms rooms (i.e. chairs / decorations) the site management team will be tasked to remove these items. 09/07/19- Assurance officer emailed Business Manager for confirmation if recs have now been completed. No response received as of 29/07/19. 06/08/19- Assurance officer met with Business Manager who agreed to check for confirmation if rec 2 is complete.

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HDUHB-1819-37	Procurement and Disposal of IT Assets (Follow-Up)	Reasonable	Internal Audit	Nov-18	Open	Director of Planning, Performance & Commissioning	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Jan-19	Sep-19	Information Governance Sub Committee/ Formal Exec Team meeting performance review (quarterly)	1	1	0	0	12/11/18- Follow up report to HDUHB1617-26. 1 recommendation (02- Disposal of IT Assets) from previous report remains partially implemented and now has a timescale of 01/01/19. Due to a lack of resources there is currently no capacity to complete asset management on all equipment UHB wide which is why an incremental approach is being put in place. By 30/11/18 work will be completed on a new SOP for asset management. By 01/01/19 the SOP will be active in all ICT teams and will include any equipment the service comes into contact with across the UHB (e.g. when a job is logged etc). 11/12/18 ARAC- ARAC noted the Follow-Up report and requested that the management response be updated and resubmitted to the next meeting in February 2019. 15/02/19- update to IGSC- Request will be made to close recommendation 'Health Board should revisit its arrangements for the disposal of IT assets,' once SOP is initiated. Timescale not currently known. ARAC 19/02/19 - Updated Management Response provided to ARAC. Timescale for completion of recommendation unclear. 10/04/19- Assurance officer met with new Interim Informatics Business Manager, who will seek timescale for the outstanding recommendation. 15/04/19- Interim Informatics Business Manager provided update. Scope is to be completed by the end of may 2019 with procurement process completed by August 2019. Full implementation to be achieved by end of September 2019. 07/05/19- Director of Planning, Performance & Commissioning informed of revised timescale of September 2019.
HDUHB-1819-05	Single Tender Actions	Reasonable	Internal Audit	Mar-19	Open	Director of Finance	Finance	Director of Finance/ Head of Procurement	Sep-19	Sep-19	Formal Exec Team meeting performance review (quarterly)	5	0	1	4	28/03/19- Rec 1, 2 and 4 completed. Rec 3 (STAs awaiting approval) to be completed immediately by Head of Procurement. Rec 5 (System for approval of STAs) to be completed by September 2019 by Director of Finance. 03/05/19- Rec 3 has been submitted to Director of Finance via teamcentral for approval. 24/05/19- TeamCentral system shows that rec 1 to 4 are with Director of Finance to approve recommendations through TeamCentral system. TeamCentral system issues currently being resolved with assistance from the Internal Audit team. 12/06/19- Rec 1, 2, 3 & 4 completed. Assurance officer to meet with Director of Finance to assist in closing the rec on TeamCentral. Rec 5 to be implemented by Sept 2019. 13/06/19- Director of Finance approved closure of rec 1 to 4 on TeamCentral.
HDUHB-1819-11	Integrated Care Fund – Follow Up	Reasonable	Internal Audit	May-19	Open	Director of Operations	Community & Primary Care (Carmarthenshire)	Rhian Dawson/ Jill Paterson	Jul-17	~~01/07/2019~~ 30/09/2019	Formal Exec Team meeting performance review- Carmarthenshire	2	1	0	1	20/05/19- Rec 9 and 14 from previous HDUHB 1617-28 Intermediate Care Fund (ICF) have been assessed as not addressed. Two new recs have been produced to cover the outstanding issues as follows: Rec 1- 'We would recommend that assessment is undertaken to establish the requirements for finance representative attendance at all ICF panels'- to be completed by July 2019. Rec 2- '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' to be completed by July 2019. 18/06/19- minutes from ARAC 29/05/19 shows terminology has changed from 'Intermediate Care Fund' to 'Integrated Care Fund'. 24/06/19- County Director & Commissioner Carmarthenshire (Interim) confirmed rec 1 is complete. 25/06/19- Assurance officer emailed Director of Primary Care, Community and Long Term Care to obtain update on rec 2. 27/06/19- Assurance officer emailed Head of Regional Collaboration (Carmarthenshire County Council) to confirm if rec 2 is completed. 19/07/19- Head of Regional Collaboration (Carmarthenshire County Council) confirmed the revised Agreement is still being drafted and it is expected to be completed by mid August 2019, thereafter they will be working closely with RPB colleagues to ensure deadlines are met internally and that they are therefore able to submit quarterly reports on time.
HDUHB-1819-20	Management of Controlled Drugs	Reasonable	Internal Audit	Apr-19	Open	Medical Director	Medicines Management	Jenny Pugh-Jones	Jul-19	TBC	Executive Team Performance Reviews - Medicines Management	6	5	0	1	16/04/19- Rec 2, 4 and 6 have been completed. The following recs are to be completed by the following timescales: Rec 1 (Management should consider the introduction of a version control system on the controlled drugs standard operating procedures) to be completed by July 2019. Rec3 (Tregaron and South Pembrokeshire Hospitals should liaise with the Pharmacy Department to agree a controlled drugs stock list that should be retained locally, whilst the Pharmacy Department will undertake periodic reviews of the stock list as per Health Board policy) to be completed by April 2019. Rec 5 (Hospital management should ensure authorised signatory lists for the ordering and receipting of controlled drugs by nursing staff are updated on a periodic basis) to be completed by May 2019. 03/05/19- Assurance officer emailed South Pembs Hospital Manager for clarification if rec 3 has now been completed. 07/05/19- Assurance officer emailed reporting officer for update on recommendations. 22/05/19- Chaser email sent to service for update on implementation of recommendations. Reporting officer confirmed rec 3 and 5 are complete. 12/07/19- RAG status of recs has been amended by assurance officer to reflect TeamCentral system. Only 1 rec has been approved by the Medical Director.
HDUHB-1819-34	National Standards for Cleaning in NHS Wales	Limited	Internal Audit	Apr-19	Open	Director of Operations	Estates	Stephen John/ Heather Williams	Jul-19	Jul-19	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	5	5	0	0	23/04/19- Reported to ARAC April 2019 meeting. 5 recommendations have all been actioned. 01/05/19- Director of Operations to meet with Director of Estates, Facilities and Capital Management to discuss clarification of management response. Amended management response to be reported to ARAC in June 2019. Assurance officer to reflect updates on tracker following ARAC meeting. ARAC 25/06/19- Management response updated: Rec 1 (Unresolved Cleaning and Estates Fails) - completed. Estates audits experience far more repeat fails, due to funding shortage and available access. These are identified at each performance review and where possible associated works to correct the item is planned. There is limited funding within the DCP, the list of schemes/works are agreed and prioritised jointly between Hard FM team and the site general manager (GM). Current estates and backlog figures show an estimate of £65m backlog across the HB estate. Rec 2- (Frequency of Internal Technical Audits) - timescale July 2019. Rec 3- (Uploading of Data and Scoring) - timescale July 2019. Rec 4 (IPad Usage)- completed. Rec 5 (Audits at Peripheral Sites) - timescale July 2019. 11/07/19- emailed reporting officer to inform them to update TeamCentral. 08/08/19- Assurance officer emailed reporting officers to ask for convenient time to meet to go through the TeamCentral system. RAG status updated to reflect TeamCentral. Recs remain red until the Exec Lead has approved the recommendations as closed through the system.
HDUHB-1819-24	Preparedness & Compliance with the Nurse Staffing Act	Substantial	Internal Audit	May-19	Open	Director of Nursing, Quality and Patient Experience	Nursing	Chris Hayes	Aug-19	Aug-19	Formal Exec Team meeting performance review (quarterly)	1	0	1	0	20/06/19- report has one recommendation (Management must ensure that nurse staffing level information is visibly displayed and made available for all patients and visitors) to be completed by 31/08/19. A re-audit will be scheduled for late 2019. 17/07/19- Assurance officer requested to receive an update from the reporting officer by 25/07/19 for next PMAF review. Reporting officer confirmed that the action in b) was taken and so this action point is completed. Action point a) is well on track for completion by end of August 2019.
HDUHB-1819-35	Review of PADR Process	Limited	Internal Audit	May-19	Open	Director of Workforce & OD	Workforce & OD	Christine Davies/ Robert Blake	Mar-20	Mar-20	Formal Exec Team meeting performance review (quarterly)	3	1	2	0	20/06/19- Report has 3 recommendations. Rec 1 (SMART Objectives) to be completed by 30/11/19, rec 2 (PADR Training) to be completed by March 2020 and rec 3 (PADR Compliance Figures) to be completed by 31/07/19. Follow up audit will take place during early 2020. 11/07/19- Rec 3 completed on TeamCentral. 22/07/19- Reporting officers updating TeamCentral. Rec 1 and 2 on track to be completed by the original timescales set. Rec 3 has a revised completion date of 01/10/19. The PADR guidance documents now include how to upload the correct information into ESR to ensure accuracy. The two bespoke training sessions on performance management have also included a session with ESR team to complete 121 training on uploading the information. The training and guidance documents will be reviewed to assess impact and then any further progression agreed.
HDUHB-1819-04	Health and Care Standards	Reasonable	Internal Audit	Jun-19	Open	Director of Nursing, Quality and Patient Experience	Nursing	Cathie Steele	Oct-19	Oct-19	Formal Exec Team meeting performance review (quarterly)	3	0	3	0	ARAC 25/06/19- Report includes 3 recommendations: Rec 1 - (Assurance and Scrutiny Matrix fully completed on a timely basis.) to be completed by October 2019. Rec 2- (assurance and scrutiny matrix is completed in line with an agreed time scale, so relevant information can be utilised for year-end reporting) to be completed by October 2019. Rec 3- (Mapped Reporting of Standards) to be completed by October 2019. 17/07/19- Assurance officer requested to receive any update, if applicable, from the reporting officer by 25/07/19 for next PMAF review. 18/07/19- Reporting officer confirmed the recs are on track for the completion dates with a paper going to OQSEC in October 2019.
HDUHB 1819-12	Savings Planning & CIP	Reasonable	Internal Audit	Jun-19	Open	Director of Finance	Finance	Andrew Carruthers	Mar-20	Mar-20	Formal Exec Team meeting performance review (quarterly)	3	1	2	0	ARAC 25/06/19- Report includes 3 recommendations: Rec 1 - (CIP Management Training) to be completed by March 2020. Rec 2- (CIP Scheme Delivery Plans) to be completed by September 2019. Rec 3- (PID's/EQA's) to be completed by June 2019. 17/07/19- Reporting officer revised timescale for rec 3 from 30/06/19 to 06/09/19. This action remains ongoing to ensure that we have PIDS and Quality Impact Assessments in place. There 24 savings schemes over the value of 200,000. PIDS have been received for 21 of those schemes and Quality Impact Assessments received for 14 schemes. In some cases this is because some needed to be returned as they were not completed to a standard that would enable them to be approved. A training session has been held by the Director of Nursing on completion of the Quality Impact Assessments in particular. There should be PIDS and QIA's in place for all these schemes by September 2019.

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HDUHB 1819-13a	Budgetary Planning	Reasonable	Internal Audit	Jun-19	Open	Director of Finance	Finance	Rhian Davies	Aug-19	Aug-19	Formal Exec Team meeting performance review (quarterly)	2	1	1	0	ARAC 25/06/19- Report includes 2 recommendations: Rec 1 - (Financial Procedure) to be completed by August 2019. Rec 2- (Budget Accountability Letters) to be completed by June 2019. 08/08/19- TeamCentral has not been updated for rec 2, Director of Finance to be informed.
HDUHB-1920-11	A Regional Collaboration for Health (ARCH)	Reasonable	Internal Audit	Jul-19	Open	Director of Planning, Performance & Commissioning	Planning, Performance & Commissioning	Karen Stapleton	TBC	TBC	TBC	2	TBC	TBC	TBC	23/07/19- report added to tracker. 2 recommendations in report, management response to be confirmed following discussion through relevant ARCH committee structure.
HDUHB-1920-15	Annual Quality Statement	Reasonable	Internal Audit	Aug-19	Open	Director of Nursing, Quality and Patient Experience	Quality	Sian Passey	Oct-19	Oct-19	TBC	4	0	4	0	06/07/19- Report includes 4 recommendations all with a timescale of 31/10/19.
HDUHB-1920-34	Environmental Sustainability Report	Reasonable	Internal Audit	Aug-19	Open	Director of Operations	Facilities	Terri Shaw	Mar-20	Mar-20		5	0	5	0	13/08/19- Report includes 5 recommendations all with a timescale of 31/03/19.
SSU_HDU_1819_01	Estates Follow Up (Residential Accommodation/ Backlog Maintenance/ Fire Precautions Follow Up).	Reasonable	Internal Audit SSU	Apr-19	Open	Director of Operations	Estates	Rob Elliot/ Paul Williams	Sep-19	Sep-19	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	8	7	0	1	09/04/19- Supersedes Fire Precautions Follow Up SSU_HDU_1718_11, and Estates Follow Up (Residential Accommodation and Backlog Maintenance) SSu HDU 1718- 07. All recs will be displayed as red RAG status as the original dates from the previous reports are still outstanding. Residential Accommodation - 3 outstanding recs: Rec 6- Ledger booking of residential costs and revenues will be reviewed to ensure accurate and traceable recording. April 2019 timescale. Rec 5- A report comparing occupancy charges and ledger income will be produced, reporting on significant variances. April 2019 timescale. Rec 10- Management will consider the viability of accommodation both with and without SIFT monies. June 2019 timescale. Backlog Maintenance - 3 outstanding recs: Rec 1 - A review of the potential links between RAM and the backlog database should be undertaken on a pilot basis to assess the significance of possible benefits. September 2019 timescale. Rec 2- Impending backlog will be reported (i.e. assets approaching end of economic life), to enhance management information and financial planning. September 2019 timescale. Rec 4- Reporting will include operational implications for the Health Board should the 'high' and 'significant' risks of the backlog maintenance plan not be addressed as planned. September 2019 timescale. Fire Precautions Follow Up- Rec 7- The required site plan and fire zone information will be appropriately situated, and displayed, in accordance with site plans held by the fire brigade for these locations. May 2019 timescale. Rec 5- The UHB will comply with the stipulated review frequencies for completion of fire risk assessments. August 2019 timescale. 04/06/19- Update provided by Head of Facilities Information & Capital Management, extensions to be requested from Director of Operations: Residential Accommodation -Rec 6- Complete. 2 outstanding recs: Rec 5- timescale has slipped from April 2019 to June 2019. Head of Health, Safety & Security is arranging a meeting with Discretionary Capital Projects Manager to agree the timescale for a site by site report for the Quarter (Jan-March 2019) with the planned review of this report to be completed by the end of June 2019. It is the intention going forward that these reports will be received and reviewed on a quarterly basis for the previous quarter. Rec 10- Management will consider the viability of accommodation both with and without SIFT monies. Original June 2019 timescale. Backlog Maintenance - 3 outstanding recs on track to be completed by new report date of September 2019. Fire Precautions Follow Up- Rec 7- The fire zone information has been completed but site plans are still being updated by the service and requires a replacement post (Estates Surveyor) to be in place to complete this. Timescale extension requested from May 2019 to December 2019. Rec 5- August 2019 timescale on track. 17/06/19- Assurance officer emailed Senior Finance Business Partner for update on Residential Accommodation rec 10. 01/07/19- Residential Accommodation rec 10 requires extension to September 2019. 04/07/19- Head of Facilities Information & Capital Management confirmed she will check Residential Accommodation rec 5 is complete. Other recs are still on target. 17/07/19- Director of Operations not happy to approve extension of Fire Precautions rec 7 to December 2019. Head of Facilities Information & Capital Management has agreed to pick this up with Assistant Head of Operational Facilities Management. 06/08/19- Head of Facilities Information & Capital Management confirmed rec 5 (residential accommodation) is behind schedule and will check and provide a revised timescale.
SSU HDU 1819 02	Withybush General Hospital Refurbishment of Wards 9 & 10	Reasonable	Internal Audit SSU	Apr-19	Open	Director of Planning, Performance & Commissioning	Estates	Emma Cadman/ Paul Williams/ Phillip Astles	May-19	N/K	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	10	3	0	7	09/04/19- Rec 3,4,8 and 10 completed. Following recs to be completed by May 2019: Rec 1- Sub Group Terms of Reference should be approved and included within the project governance document. Rec 2- The Project Group should meet with sufficient regularity (monthly) to ensure appropriate control and oversight. Rec 5- Contract details should be fully completed, including the contract date, and contracts should be fully executed prior to works commencing. Rec 6-project team submitting a monthly progress report to the Project Director, or similar approach. Rec 7- Project progress meetings should be recognised in the project governance document. Rec 9- Key project documents should be held securely in a central electronic location. 02/05/19- Assurance officer emailed Health Planning Manager for update that amber recommendations are on target to be completed by 31/05/19. 15/05/19- Health Planning Manager emailed Assistant Director of Strategy & Planning for advise on how this could be taken forward given the limited planning support at the moment. 04/06/19- Assurance officer sent reminder email to service for update on outstanding recommendations which have now passed their original timescales. 13/06/19- The outstanding recommendations will be formally reviewed at the next Project Board meeting on the 02/07/19 with a view to agreeing the recommendations are completed and the report closed. 04/07/19- the recommendations were not closed at the Project Board meeting on 02/07/19 and remain outstanding. 26/07/19-Assurance officer met with Project Manager for update. Rec 2, 5 & 6 complete. Rec 1,7 & 9 outstanding. Due to the redeployment of planning resource from W9 and 10 to major Trauma, whilst the remaining recommendations are all in hand, they are yet to be formally signed off for closure. 07/08/19- Project Manager confirmed the next project group is meeting on 20/08/19 where the remaining recommendations will be discussed.
SSU_HDDA_1819_03	Primary & Community Care Pipeline Projects Aberaeron Integrated Care Centre	Substantial	Internal Audit SSU	Apr-19	Open	Director of Operations	Estates	Peter Skitt	May-19	Jun-19	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	4	0	0	4	09/04/19- 4 recs to be completed by May 2019 as follows: Rec 1- Terms of reference of the Project Group should be further defined. Rec 2- Terms of Reference for key workgroups should be defined within the project governance document to facilitate planning of project roles. Rec 3- The Project Group should receive cost reporting of variances to date against spend profile sums where they are available. Rec 4- At future projects, management should ensure contract documentation is appropriately completed. 02/05/19- Project Manager, Planning will check that recommendations are on track and inform Assurance Officer. 04/06/19- Planning Officer confirmed rec 3 & 4 are completed. Rec 1 & 2 timescales slipped from May 2019 to June 2019 - Review of TOR's was discussed at May Project Group with final draft to be submitted for approval June 2019. 24/06/19- Assurance officer emailed reporting Officer for confirmation if rec 1 & 2 have now been submitted. 04/07/19- Planning officer agreed to check with reporting officer that rec 1 & 2 are now complete. 26/07/19- Assurance officer met with Project Manager for update. Rec 1 & 2 are completed and were signed off at the July project group meeting. Director of Operations to approve closing of report.

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SSU_HDU_1819_04	Data Centre Project	Reasonable	Internal Audit SSU	Apr-19	Open	Director of Planning, Performance & Commissioning	Planning, Performance & Commissioning (Informatics)	Anthony Tracey	Mar-20	Mar-20	Capital, Estates & IM&T Sub Committee/ Formal Exec Team meeting performance review (quarterly)	8	1	1	1	09/04/19- Rec 2, 4, 5, 6 & 7 are complete. The following 3 recs require implementation: Rec 1: At the WGH solution, a business case should be prepared (Timescale not clear- Assurance officer to clarify timescale with Interim Informatics Business Manager). Rec 3: Lessons learnt in respect of items omitted from the specification for the GGH solution should be given due consideration at the WGH solution. Timescale August 2019. Rec 8: The remaining two outstanding actions identified at the action log will be prioritised for completion. Timescale May 2019. 10/04/19- Assurance officer met with new Interim Informatics Business Manager, who will check with Assistant Director of Informatics for confirmation of timescale of recommendation 1. 15/04/19- Interim Informatics Business Manager confirmed recommendation 1 (At the WGH solution, a business case should be prepared) is to be implemented by part of 2019/2020 discretionary capital. 04/06/19- Interim Informatics Business Manager confirmed he will check with Assistant Director of Informatics if rec 8 has been completed. 20/06/19- Update from Assistant Director of Informatics copied to Director of Planning, Performance & Commissioning. Rec 8 (Progress Monitoring) has a one month delay from May 2019 to June 2019, , due to unforeseen technical difficulties regarding the biometric entry system. The supplier has guaranteed that this will be resolved by 30/06/19. Rec1 to be completed by March 2020 and rec 3 to be completed in August 2019. 04/07/19- Interim Informatics Business Manager confirmed rec 8 has been further delays due to sorting contractor issues, but will be completed by 31/07/19. 06/08/19- Assurance officer met with Business Manager who confirmed rec 8 is completed.
SSu_HDU_1819_11	Cardigan Integrated Care Centre	Reasonable	Internal Audit SSU	Apr-19	Open	Director of Planning, Performance & Commissioning	Estates	Peter Skitt /Jason Wood	Jun-20	Jun-20	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	11	0	3	8	09/04/19- Supersedes SSU HDD 03 report. Rec 5 (The project governance framework will be updated to reflect changes in assignment of key roles. Appointment confirmation certificates will be included within the document) and Rec 7 (An overarching management control plan will be prepared, to programme key Health Board tasks and outputs, including those assigned to sub-groups/workstreams) from previous report remain outstanding. 11 additional recommendations are included in the new report. Assurance officer to clarify with Project Manager, Planning, of timescale for post completion of project. 10/04/19- Project Manager, Planning, agreed to check timescale for recommendations 8-10 re. Post completion deadline date. 14/05/19- Project Manager, Planning confirmed project due to be completed December 2019 therefore post completion timescale (rec 8-10) is set to June 2020, and will request this be included under APB at next project meeting w/b 20/05/19. 04/06/19- Project Manager has chased for update- recs 1-7 have a completion date of May 2019 and will therefore be reported as behind schedule. 05/06/19- Estates confirmed rec 4 & 5 completed. Assurance officer awaiting update from County Director Ceredigion to confirm if recs 1,2,3,6 & 7 are now completed as these have passed their implementation dates. 25/06/19- Assurance officer sent email chaser to County Director Ceredigion to confirm if recs 1,2,3,6 & 7 are now completed as these have passed their implementation dates. 04/07/19- Planning Manager to check with planning officer for update on outstanding recs. 26/07/19-Assurance officer met with Project Manager for update. Rec 1,3,6 & 7 complete. Rec 2-Project Director to request the SRO (Director of Operations) to attend future project group meetings from August 2019 onwards. Rec 8-10 to be completed at post completion of project (June 2020). 06/08/19- Project Manager confirmed rec 2 has been completed.
SSU_HDA_1819_01	Capital Follow Up (W&C Phase 2, and Bronglais Front of House)	Reasonable	Internal Audit SSU	Apr-19	Open	Director of Planning, Performance & Commissioning	Estates	Rob Elliot, Paul Williams	Sep-19	Sep-19	Capital, Estates & IM&T Sub Committee / Executive Team Performance Reviews - Estates	2	1	0	1	09/04/19- report is follow up and supersedes the following reports: SSU_HDDA_1718_02 Glangwili Hospital Women & Children's Development Phase 2. 1 Rec (The cost per meter squared of the target cost adjusted for abnormal will be provided for scrutiny) to be completed by April 2019. SSU_HDU_17/18_04 Digital Health Strategy. No recommendations outstanding. SSu HDU 1718 01 Capital Follow up -Neonatal Phase 1- No recommendations outstanding. SSu HDU 1718 01 Capital Follow up -Bronglais Front of House - 1 rec outstanding (planned post project evaluation (PPE) exercise) is now anticipated during 2019/20. Assurance officer to gain clarify on timescale. 02/05/19- Head of Facilities Information & Capital Management confirmed outstanding rec for Bronglais Front of House (planned post project evaluation (PPE) exercise) will be completed by September 2019. 10/05/19- Assurance officer emailed Head of Service Modernisation for update confirmation if rec from Women & Children's Development Phase 2 is now complete. 16/05/19- Senior Business Partner confirmed outstanding rec from Women & Children's Development Phase 2 is complete. 06/08/19- Head of Facilities Information & Capital Management confirmed remaining rec is on track.

***Key**

Open- recommendations to be implemented

Closed- all recommendation implemented and report closed following approval by the relevant Executive Director

Strategic log- a recommendation requiring a long term/strategic solution to be addressed as part of a long term strategy e.g. Capital prioritisation plan, Digital Strategy, Ward refurbishment programme, etc.

External rec- a recommendation that is outside the gift of the Health Board to currently implement, i.e. reliant on an external organisation (e.g. NWIS) to implement.

CHC

Report Ref	Name of Report	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Director:	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed arrangements for monitoring progress: (eg 6 monthly at Acute QSEAC)	Total No of recommendations within report/Actions on action plan:	Red (behind schedule)	Amber (on schedule)	Green (completed)	Additional Information
No Ref	The fragility of GP Out of Hours services in Wales	Hywel Dda Community Health Council	May-18	Open	Director of Operations	Central operations (Out of hours)	Nick Davies	Dec-18	Sep-19	Executive Team Performance Reviews - Out of hours	6	3	0	3	27/07/18- Report sent to Deputy Director of Operations, cc. Business Support Manager Central Operations requesting response to the report findings and completed action plan to be returned to assurance office by 03/08/18. 13/08/18- Action plan sent to Director of Operations for sign off. 04/09/18- Action plan submitted to CHC. 25/09/18- 4 recommendations to be completed by the end of August and September 2018 have requested extensions to November 2018, due to being linked to TCS and GP advisory panel outcomes. 28/09/18- Director of Operations has agreed to the extensions to November 2018 (still within overall completion date of report). 23/11/18- 4 recommendations have further slippage of timescales ranging up to 31/03/19. Improvement plan sent to Director of Operations to approve extensions. 06/12/18- Director of Operations responded that slipped dates aren't ideal but understands the reasons why and happy to agree. 05/02/19- Assurance officer met with reporting officer. 4 recs have passed their original implementation dates, 2 to be completed by March 2019 and a further 2 do not have clear timescales at present. 12/02/19 - Director of Operations agreed the extension as is fully aware of issues within service. 01/05/19- Assurance officer emailed reporting officer requesting to review and provide realistic timescales for the Director of Operations to approve. 10/05/19- Assurance officer sent chaser email for update on realistic timescales, information requested by 17/05/19 for next QSEAC report. 13/05/19- Reporting officer provided timescale of 31/07/19 for rec 3 and 5 given the complexity and need for paper to be presented to Exec Team. Rec 6 has revised timescale of 30/09/19. Initial meeting to discuss with Director of Primary Care, Community and Long Term Care scheduled for 26/05/19. 30/9/19 timescale provided to give a 3 month window for incorporating the changes, with confirmation to be sought at that session. Revised timescale of 30/09/19 to be agreed with Director of Operations. 16/07/19- Reporting officer confirmed rec 3 & 5 currently on track for 31/07/19. Rec 6 - dates for meeting with GPs now 5 & 9 Sept 2019, invites being sent w/b 15/07/19 (dates delayed by annual leave of 3 key members). Implementation now likely by winter at earliest. Dates will partly depend on the meetings and their outcomes. 17/07/19- Director of Operations not happy to agree extensions.
No Ref	"What's your NHS like for you?" Hearing from people with a learning disability	Hywel Dda Community Health Council	May-18	Open	Director of Operations	Unscheduled Care	Carol Cotterell	Mar-19	Apr-20	Operational Services Quality, Safety & Experience Sub Committee/ Formal Exec Team meeting performance review (quarterly)	9	2	0	7	27/07/18- Report sent to Interim Head of Nursing, Mental Health & Learning Disabilities, cc.Head Of Learning Disabilities and Older Adult Mental Health, and Interim Director of Mental Health and Learning Disabilities, requesting response to the report findings and completed action plan to be returned to assurance office by 03/08/18. 02/08/18- report sent to Assistant Director Operational Nursing & Quality Acute Services requesting response to the report findings and completed action plan. The recommendations within the report relating to how people with a learning disability access/ experience a range of services across the Health Board. Assistant Director confirmed the draft action will be taken to the Learning Disabilities Liaison Group meeting for acute hospitals on 15/08/18. 03/09/18- Action plan received from reporting officer. 13/11/18 - Lead Officer confirmed Recs 1-3 have been completed. Work is in progress to implement the remaining 6 recommendations within agreed timescales. 14/03/19- Assurance officer emailed reporting officer for update on implementation of improvement plan. 28/03/19- chaser email sent. 01/04/19- Update provided by reporting officer. Rec 5 (standards of practice for annual health checks including training programmes for GPs) is dependent on All Wales Working Group developing standards of practice, timescale of April 2020 provided. Rec 6 (Development of Easy Read information leaflets on bereavement for people with a Learning Disability) outstanding with timescale slipped to December 2019 due to staff resource. Director of Operations informed of slippage in timescales. 29/04/19- Director of Operations expects rec 6 to be completed sooner than December 2019. Reporting officer informed and new amended timescale requested by assurance officer. 01/05/09- Reporting officer confirmed she is exploring if anyone is available to take on the initiative which includes sourcing specialist visual aids, and will inform the assurance officer of progress. 10/05/19- Assurance officer emailed for update on person taking on initiative and revised timescale for rec 6, information requested by 17/05/19 for next QSEAC report. 14/05/19- Revised timescale of 30/09/19 provided for rec 6. 17/07/19- Director of Operations agreed to extension of 30/09/19 for rec 6. Assurance officer informed reporting officer to let her know if rec is completed in advance of this date. Reporting officer confirmed the leaflet is being progressed and the LD Team are currently sourcing appropriate Symbols. They are hoping to meet the September deadline.

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No Ref	Women and children's services Visit report March 2018	Hywel Dda Community Health Council	Aug-18	Open	Director of Operations	Women and Children's services	Keith Jones/ Julie Jenkins	Apr-19	TBC	Executive Team Performance Reviews - Women and Children	5	1	0	4	28/08/18- Report emailed to reporting officer requesting action plan to be completed by 04/09/18. 05/09/18- Action plan received from Head of Midwifery & Women's Services. 4 recs to be completed by 30/11/18 with 1 rec (resolve the current temporary reduced hours arrangements in PACU) to be completed by 30/04/19. 27/09/18- Action plan sent to CHC via Director of Nursing, Quality & Patient Experience. 07/11/18 - Reporting officer confirmed Recs 3&4 have been completed. 22/11/18- reporting officer confirmed recs 1 to 4 completed. Rec 5 (resolve the current temporary reduced hours arrangements in PACU) , is being actioned through a Task and Finish Group who are currently exploring alternative models of care, with a completion date of 04/04/19. 05/12/18- Assurance officer requested update on implementation of final rec 7 for PMAF review. 10/12/18- Reporting officer confirmed PACU opening hours are due to be considered by the Board in January 2019 therefore rec 5 is on track for final resolution by April 2019. 05/03/19- Assurance officer emailed reporting officer for confirmation we are still on track for April 2019 completion date of final recommendation. 02/04/19- Assurance officer met with reporting officer. Paper to be presented to July 2019 Board which will include PACU opening hours. Currently PACU opening hours are still temporary and will require formal consultation. Reporting officer requested if report can be closed as PACU recommendation (rec 5) is underway. 07/05/19- Director of Operations advised that he thinks the PACU recommendation needs to stay open as its still in progress and can probably be closed once consultation is underway. Assurance officer requested realistic timescale from reporting officer for PACU consultation (rec 5). 12/06/19- update from reporting officer- There is meeting scheduled between HB Engagement Team & the CHC on 18/06/19 to discuss the nature of and process by which engagement and consultation will progress in the event of a Board decision to either formalise the current PACU operating hours of 10am to 6pm or alternatively pursue a different model. Until this process is worked through, the service cannot offer a definitive timescale. The original intention to take proposals to the July 2019 Board is now subject to revision as this will not be possible due to the requirements of any resultant engagement / consultation process. Reporting officer to provide further update once consultation process has been agreed.
No Ref	Phlebotomy Clinic, Prince Philip Hospital & the Antioch Centre, Llanelli, November 2018	Hywel Dda Community Health Council	Nov-18	Open	Director of Operations	Pathology	Ann Mann/ Jane Elsom	May-20	May-20	Executive Team Performance Reviews - Pathology	10	0	9	1	15/05/19- Rec 9 has been completed. All other recs have timescales ranging from 26/07/19 to 31/05/20.
No Ref	Cadog Ward, Glangwili Hospital, November 2018	Hywel Dda Community Health Council	Nov-18	Open	Director of Operations	Unscheduled Care (GGH)	Bethan Lewis	Sep-19	Sep-19	Executive Team Performance Reviews - GGH (USC)	9	0	9	0	13/06/19- Report received late into assurance office. Assurance officer has emailed Director of Nursing, Quality and Patient Experience to ask if she wants the assurance office to co-ordinate the action plan responses on her behalf. 19/06/19- Letter and action plan sent to CHC. Rec 1 to be completed by 30/06/19, rec 2 to 8 to be completed by 31/08/19 and rec 9 to be completed by 30/09/19.
No Ref	Teifi Ward, Glangwili Hospital, December 2018	Hywel Dda Community Health Council	Dec-18	Open	Director of Operations	Unscheduled Care (GGH)	Bethan Lewis	Sep-19	Sep-19	Executive Team Performance Reviews - Scheduled Care/ GGH (USC)	18	0	18	0	13/06/19- Report received late into assurance office. Assurance officer has emailed Director of Nursing, Quality and Patient Experience to ask if she wants the assurance office to co-ordinate the action plan responses on her behalf. 19/06/19- Letter and action plan sent to CHC. 10 recs are to be completed by 31/08/19 and 8 recs to be completed by 30/09/19.
No Ref	Bronglais Hospital, Dyfi ward and Clinical Decisions Unit February 2019	Hywel Dda Community Health Council	Feb-19	Open	Director of Operations	Unscheduled Care (BGH)	Dawn Jones	Mar-20	Mar-20	Executive Team Performance Reviews - BGH (USC)	13	1	4	8	13/06/19- Report received late into assurance office. Assurance officer has emailed Director of Nursing, Quality and Patient Experience to ask if she wants the assurance office to co-ordinate the action plan responses on her behalf. 21/06/19 - Draft action plan has been reviewed by Director of Nursing, Quality and Patient Experience and has gone back to reporting officer for further review. 16/07/19- Response sent to CHC. 5 recs completed with 8 to be implemented by various timescales ranging from 31/07/19 to 19/03/20. 06/08/19- Assurance officer requested update on the implementation of actions by 09/08/19 for next performance review. 08/08/19- Update provided by reporting officer. Rec 2 (Minor works form submitted to create extra storage within ward area) is behind schedule due to a more urgent estates issues, extension requested from 24/07/19 to 30/09/19. Director of Operations to approve extension. Rec 5,6,7, & 9 are on track for their scheduled timescales and the remaining recs have been completed.

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CORONER REGULATION 28

Report Ref	Name of Report	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Lead:	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed action/ arrangements for future reporting: (eg 6 monthly at Q&S, develop combined Service Action Plan, etc)	Total No of recommendations within report/Actions on action plan:	Red (behind schedule)	Amber (on schedule)	Green (completed)	Additional Comments
reg 28 GJT	Regulation 28 inquest touching the death of Gerwyn Thomas	HM Coroner for Pembrokeshire and Carmarthenshire	06/11/2018	Open	Director of Operations	Unscheduled Care (GGH)	Karen Thomas/ Bethan Lewis	Dec-19	Dec-19	Executive Team Performance Reviews - GGH (USC)	3	0	2	1	24/01/19 Assurance office made aware of report on 24/01/19. Coroners report received by HB on 06/11/18. CEO letter sent 21/12/18 responding to concerns. Closed. 24/06/19- report re-opened as action plan still being implemented. Rec 3 completed. Rec 1 to be completed by July 2019 and rec 2 to be completed by December 2019. 12/08/19- Assurance officer emailed Hospital Head of Nursing GGH and Joint Head of Dietetics for confirmation which service is leading on this action plan for reporting purposes.
Reg 28 EKI	Regulation 28 inquest touching the death of Emily Katherine Inglis	HM Coroner for Pembrokeshire and Carmarthenshire	30/05/2019	Open	Director of Operations	Mental Health & Learning Disabilities	Sara Rees	TBC	TBC	Executive Team Performance Reviews - MH&LD	2	0	2	0	31/05/19- Coroners report received requesting details of action taken or proposed to be taken, setting out the timetable for action, by 25/07/19. 29/08/19- Assurance officer requested copy of response to Coroner, received 31/07/19. 12/08/19- Assurance officer emailed reporting officer requesting copy of improvement plan.

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PSOW

PSOW No.	Datix No.	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Lead Executive	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed action/ arrangements for future reporting: (eg 6 monthly at Q&S, develop combined Service Action Plan, etc)	Total No of recommendations within report/Actions on action plan:	Red (behind schedule)	Amber (on schedule)	Green (completed)	Additional Comments
201800718	5085	Public Services Ombudsman (Wales)	28/06/2019	Open	Director of Operations	Unscheduled Care (GGH)	Bethan Lewis	28/09/2019	28/09/2019	Improving Experience Sub Committee/ Executive Team Performance Reviews - GGH (USC)	3	0	1	2	28/06/19- Report from Ombudsman includes 2 recommendations to be completed by 28/07/19 and one recommendation to be completed by 28/09/19. 02/08/19- Update from Ombudsman Liaison Manager. Apology letter and payment evidence submitted 17/07/19 (within timescales).
201807678	11231	Public Services Ombudsman (Wales)	03/07/2019	Open	Director of Operations	Unscheduled Care (WGH)	Janice Cole-Williams	03/01/2020	03/01/2020	Executive Team Performance Reviews - WGH (USC)	4	0	2	2	03/07/19- Letter from Ombudsman stipulates 2 recs to be completed by 05/08/19 and a further 2 to be completed by 03/01/20. 02/08/19- Update from Ombudsman Liaison Manager. Apology letter and payment evidence submitted 31/07/19.

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DELIVERY UNIT (NHS)

Report Ref	Name of Report (External only)	Reviewing Body	Date of Report	Report status (open/ closed/ strategic log/ external rec)*	Executive Lead:	Service	Reporting Officer:	Original Completion Date:	Current Completion Date	Agreed arrangements for monitoring progress: (eg 6 monthly at Acute QSEAC)	Total No of recommendations within report:	Red (behind schedule)	Amber (on schedule)	Green (completed)	Additional Information
No Ref	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services - Hywel Dda University Health Board	Delivery Unit	Jul-17	Open	Director of Operations	Mental Health and Learning Disabilities	Sara Rees	Mar-23	Mar-23	Executive Team Performance Reviews - MH&LD	5	0	3	2	QSEAC 16/01/18- minutes state action plan is out for comment and will be considered by the Mental Health Act Scrutiny Group on 01/05/18, followed by a Health and Social Care Workshop on the 04/05/18. Head of Learning Disabilities and Older Adult Mental Health to share action plan with Assurance Officer following workshop in May. 05/09/18- Service Manager, Learning Disabilities provided assurance officer with the draft action plan following hosting of the workshop with local authorities and third sector colleagues on 04/05/18. The service manager will be shortly meeting with the Head of Learning Disabilities and Older Adult Mental Health and Interim Director Mental Health and Learning Disabilities to confirm responsible officers and timescales for actions. 18/10/18- Assurance officer emailed reporting officers for responsible officers and timescales. 21/11/18- This action plan will incorporate recommendations from the National report- The Quality of Care and Treatment Planning - Assurance Review of Adult Mental Health & Learning Disability Services. The action plan will be tabled at the MHLD QSE Sub Committee in January 2019. The action plan will also be taken to the MH Scrutiny Group. 17/01/19- Assurance officer requested service to confirm when action plan will be finalised, as the action plan being reported to the January MHLD QSE Sub Committee does not include timescales or responsible officers. 28/01/19- Interim Director, MHLD confirmed she will chase service for action plan to have responsible officers and timescales included. 08/02/19- action plan received, Head of service confirmed several timescales to be confirmed. Assurance officer to meet with service shortly to confirm action plan timescales. 21/02/19- Assurance officer met with reporting officer. Rec 1 (improve integration across Health and Social care in Learning Disability services) related to TCS, discussions to take place if appropriate for moving to the Strategic log. Rec 2 (bespoke training programme to support improvement of CTPs. CTPs related to transforming Mental Health agenda and national report. Completion date March 2023. Rec 3 (systematically applied process for determining relevant patient status in LD services) is complete, Service Manager has developed criteria in partnership with CTLD Managers and implemented within each area in LD services. Rec 4 (improve auditing of CTP compliance) is complete- audit tools are in place and ongoing audit of compliance is underway. Rec 5 (improvements required in recording MDT involvement in care and treatment planning/streamline IT systems used to record assessments). IT system being implemented by WCCIS, unclear on timescale for this. 25/03/19- Service Manager Learning Disabilities confirmed Interim Head of Nursing for Mental Health and Learning Disabilities is the reporting officer for this report. 16/05/19- Rec 1 (improve integration across Health and Social care in Learning Disability services) given timescale of March 2023 by new Interim Head of Nursing for Mental Health and Learning Disabilities. Work is currently underway through the MH scrutiny group for the MH training to be aligned to the MH measure. CRP guidance will be developed to align with this training. 21/06/19- Assurance officer requested update from Head of Learning Disabilities and Older Adult Mental Health.
No Ref	National report- The Quality of Care and Treatment Planning - Assurance Review of Adult Mental Health & Learning Disability Services	Delivery Unit	Jul-18	Open	Director of Operations	Mental Health and Learning Disabilities	Melanie Evans/ Eleanor O'Connor	Mar-23	Mar-23	Executive Team Performance Reviews - MH&LD	3 (1 rec for Welsh Govenment, 2 recs for UHB)	0	2	0	21/11/18- The outcomes of this national report are to be incorporated into the UHB action plan following the All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services (please see above). The action plan will be tabled at the MHLD QSE Sub Committee in January 2019. The action plan will also be taken to the MH Scrutiny Group. The action plan will be monitored and updates on recommendations will be displayed through the All Wales Review report above. 13/08/19- the recommendations have been reviewed by the assurance officer and it has been decided to track 2 of the 3 recommendations (rec 2 and 3) within the report that are for the UHB to implement (and no longer monitored though the All Wales Review report above). Assurance officer to inform service and obtain updates in time for the next performance review. Rec1 is to be implemented by Welsh Government and therefore will not be tracked.
No Ref	Review of the Impact of Long Waits for Planned Care on Patients	Delivery Unit	Nov-18	Open	Director of Operations	Scheduled Care	Stephanie Hire	May-20	May-20	Executive Team Performance Reviews - Planned Care	10	0	4	6	04/02/19- report dated November 2018 but was sent to the UHB until 01/02/19. Action plan response to be submitted to QSEAC April 2019. 26/04/19- SBAR reported to QSEAC 04/04/19. The Committee considered the report and supported the establishment of a Project Group to progress the development of an implementation plan for consideration by the Committee in August and October 2019. Assurance officer emailed reporting officer requesting copy of improvement plan. Reporting officer confirmed she will need discuss with the Director of Operations and will inform the assurance officer once discussions have taken place. 18/06/19- Service Manager (Scheduled Care) update- The action plan is still in development and is receiving input from both Director of Operations and Assistant Director, Acute Services, in terms of aligning with Quality Improvement Outpatient Strategy. However it is important to recognise that the impact on Long Waits has been reduced / improved within the UHB due to the achievement of zero 36 week breeches in 2018/19. 26/07/19- Action plan being reported to QSEAC on 01/08/19. Action plan shows rec 1,3,6,7,8 & 10 are complete. Rec 2 (mortality review process) has a timescale of 31/08/19, rec 9 (improved management of patient expectations) has a timescale of 31/03/20 and rec 4 & 5 have a timescale of May 2020.
No Ref	All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s LPMHSS	Delivery Unit	Mar-19	Open	Director of Operations	Mental Health and Learning Disabilities	Angela Lodwick/ Sarah Burgess	Nov-19	Nov-19	Executive Team Performance Reviews - MH&LD	5	0	5	0	24/04/19- Confirmed to Phill Chick, Assistant Director – Mental Health Delivery Unit that there is no factual accuracy comments. Service are currently drawing up the improvement plan. 01/05/19- Final version of report received from DU. 14/05/19- Assurance officer emailed Service Manager for update if improvement plan has been written. 22/05/19- Draft action plan currently being reviewed by service with a view to finalising by 31/05/19. 26/06/19- Finalised action plan received from service. Rec 2,3 & 4 to be completed by 31/08/19 and rec 1 & 5 to be completed by 30/11/19.

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PEER REVIEWS

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	Out of hours Peer review 23/08/18	Peer Review	Dec-18	Open	Director of Operations	Central operations (Out of hours)	Nick Davies	Mar-19	Sep-19	Executive Team Performance Reviews - Out of hours	9	1	0	8	20/03/19- Draft report received and draft improvement plan in development with clarification being sought from authors. The total number of recommendations reflected in the tracker only refers to those attributable to Health Board and Out of Hours team. 09/04/19- The Out of Hours Peer review draft report and recommendations were issued without consultation with the UHB. The lead officer has contacted the report author and has been advised that the report will not be issued as a final report, however the service is working to implement the recommendations. 01/05/19- Assurance officer emailed reporting officer requesting to review and provide realistic timescales for the Director of Operations to approve. 13/05/19- Reporting officer confirmed rec 2 is complete and Rec 5 has a completion date of 30/09/19. Revised timescale of 30/09/19 to be agreed with Director of Operations. 16/07/19- Reporting officer confirmed rec 5 (Maximise the attractiveness of the Urgent Primary Care/OOHs service with a workforce blue print that encourages and enables career progression) - service changes to be governed by TCS and PPH agendas. Timescales remain fluid unfortunately. 17/07/19- Director of Operations not happy to agree extensions.
No Ref	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Children and Young People's Wales Diabetes Network	Nov-16	Open	Director of Operations	Women and Children's services	Keith Jones	Mar-16	N/K	Executive Team Performance Reviews - Women and Children	2	2	0	0	15/01/19- This 2016 peer review report supersedes the 2014 National Diabetes Paediatric Peer Review. 2 actions remain outstanding- lack of Paediatric Dietetic capacity (not yet recruited) and absence of a 24 hour on-call advise system (this is being addressed across the Network at an all Wales level). 2019 peer review to take place. 05/03/19- Assurance officer emailed reporting officer for update on 2 outstanding recommendations. 02/04/19- Assurance officer met with reporting officer. Peer review visit took place in the last couple of weeks. No immediate concerns raised. Outcome of new peer review will be received in the next couple of weeks to determine recommendations required by the service. 12/06/19- reporting officer confirmed the report from the peer review visit will be received imminently. 30/07/19- Chaser email sent to reporting officer for copy of new peer review.

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OTHER

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No Ref	External Governance Review	ARAC	Apr-15	Open (rec 7.3 Strategic log)	Director of Nursing, Quality & Patient Experience / Director of Operations / Director of Partnerships & Corporate Services	Patient Experience/ records management/ Performance	Sian Passey/ Steven Bennett	Apr-16	Feb-20	Business Planning & Performance Assurance Committee /Quality, Safety and Experience Assurance Committee	58	3	0	55	20/09/18- Reporting officer amended from Board Secretary to Director of Nursing, Quality & Patient Experience (Rec 4.7), Director of Planning, Performance & Commissioning (Rec 5.7, 7.3), Director of Operations (Rec 5.7) and Director of Partnerships & Corporate Services (Rec 7.3). 29/10/18- Director of Partnerships & Corporate Services confirmed Rec 7.3 moved to the strategic log. 11/01/19- Assurance officer emailed Assistant Director of Nursing Assurance & Safeguarding for update on Rec 4.7. 14/01/19- Assurance officer emailed Deputy Director of Operations for update on Rec 5.7. 17/01/19- Reporting officer confirmed Rec 4.7 has revised date of September 2019. Director of Nursing, Quality and Patient Experience and Director of Planning, Performance & Commissioning meeting to discuss the presentation options for the dashboard and also how the informatics team can give added support the triangulation by supporting the electronic development of the quality dashboard. In the interim there is a hybrid dashboard, which is manually developed and concentrates on key indicators, which are linked to the QI strategy, again updated in document. 23/01/19- Rec 5.7 (records management) sits under Director of Operations- Health Records Manager advised February 2020 for appropriate progress. Director of Operations agreed to lead the records management project across the Health Board with the first meeting to be arranged in February 2019. The records management project is a considerable amount of work and will also require a significant amount of support from other meeting groups and lead individuals. 12/02/19- Director of Operations agreed to leave rec 5.7 open for now as this recommendation still needs to be completed and ties into Internal Audit Records Management recs. 18/03/19- Assurance officer emailed Director of Nursing, Quality and Patient Experience for confirmation she is happy to agree extension to September 2019 for rec 4.7 'Effective tracking system and mechanisms for triangulation of information ensuring lessons are learnt, developed, established and in place' as further work needs progressing including the development of an interactive quality dashboard. 09/04/19- Head of Assurance and Risk met with Director of Nursing, Quality and Patient Experience who agreed to extension of 4.7 to September 2019. 30/04/19- Rec 5.7 (records management)- Rec should be completed once paper goes to June BPPAC (and Executive Team prior to this) setting out the records management plan with realistic timescales. 17/07/19- Assurance officer requested to receive an update on rec 4.7 from the reporting officer by 29/07/19 for next PMAF review. 29/07/19- Update provided from reporting officer, currently still on track for September 2019 deadline. A rich source of data is now collected in the Data warehouse and is being used for performance management data and quality data. Assurance reports are being presented to QSEAC on a bi-monthly basis which considers a number of quality measures used within the HB .

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