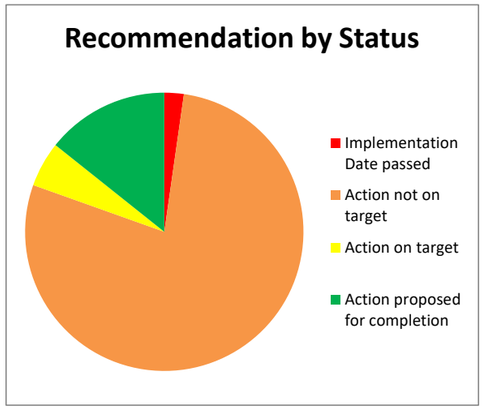
Appendix 1

Cwm Taf Morgannwg

Internal Audit Recommendations / Action Log - [h] 2019



Recommendations by Priority & Status					
Priority	TOTAL	Implementation Date passed	Action not on target	Action on target	Actions Completed
High	**43**	1	34	4	4
Medium	**74**	0	61	0	13
Low	**16**	2	9	3	2

Progress	
Total Recommendations	
New Recommendations	
Improving	19
No Change	4
Declining	

Recommendations by Executive Lead & Status					
Executive Lead	Total	Implementation Date passed	Action not on target	Action on target	Actions Completed
Director of Corporate Governance	**2**	0	1	0	1
Director of Finance	**2**	0	2	0	0
Director of Operations	**65**	0	51	4	10
Director of Nursing	**5**	0	3	0	2
Director of Planning & Performance	**16**	0	16	0	0
Director of Workforce & OD	**34**	2	24	2	6
Director of Public Health	**3**	1	2	0	0
Medical Director	**6**	0	5	1	0

Red -
Orange -
Yellow - Action
Green - Action
Blue - Action

Ref	Date added	Assurance rating	Recommendation	Priority	Management Action Agreed	Responsible Executive Lead/Management Lead	Responsible Management Lead	Original Agreed Implementation Date	Revised Implementation Date	Revised Implementation date	Status	Progress	Actions completed	Issues Arising This Period	Next Steps & Expected Milestones
MED POW 01	Febraury 2020	Reasonable	1. Management should ensure the draft Medical Devices policy covers all the relevant aspects as required by the MHRA guidance, is appropriately approved by the relevant Health Board Committee and made available to all relevant staff. 2. Management should ensure that a work plan with time-frames is put in place for the development of a single set of Medical Devices procedures.	Medium	1. This a reflection of Finding 4 in the broader CTM Clinical Engineering audit report. The Medical Devices Policy has been reviewed since the CTM Transition, and is currently in draft form but expected to be verified by the Medical Device Governance Board in early 2020. 2. We migrated to the CTM QMS Medical Device management procedures before the BSI audit in December 2019. Work has also begun on aligning equipment technical information and service procedures, although due to there being over 2,400 active models on the database, with sometimes different models of equipment on each site, this will be an ongoing process, with joint procedures agreed for new models as they are introduced (we're currently replacing most infusion pumps and Philips patient monitors), and selected common items reviewed via senior tem meetings (currently reviewing the	Director of Operations	Assistant Director of Facilities	Early 2020	Sep-20	Apr-21		Completed	1. April 2020 Update - Medical Devices Policy approved by Medical Devices Group. Clinical POlicies Working Group and Quality & Safety Committee, published on sharepoint 07/02/2020. Completed 2. January 2021 Update - There have been recurring safety issues with batteries used in the T34, which have now been resolved, with T34's now in use in POWH. Complete (PJ 22/01/2021).		2. April 2020 Update - T34 syringe pumps still currently being reviewed by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - T34 syringe pumps still currently being reviewed as an ongoing process by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team (DW 17/07/2020). 2. September 2020 Update - T34 syringe pump replacement project still an ongoing rollout process by Medical Electronics Engineering Manager & Head of Clinical Engineering and Clinical Engineering Team. WG advised that target date has been amended to reflect this update to 31/03/2021 (DW 28/08/2020).
MED POW 02	Feb-20	Reasonable	1. At the current time, wards and departments should be reminded of the importance of retaining detailed training records in relation to new equipment purchases, including information on who has attended the training. The Engineering Manager should be informed when training has taken place in order for equipment to be released for use. 2. Consideration should be given to the future method of retaining training records so that there is consistency across the PoW and former Cwm Taf sites. Any system used should facilitate the ability to demonstrate the applicability of training, what training has taken place, the dates training was provided, who attended the training and method of training (in house or manufacturer). 3. Training Needs Analysis forms should be consistently completed across all sites.	Medium	1 & 2) Work has already begun with the medical device trainer Robert Mathews to implement these recommendations on the POWH site asap, and we are liaising with Rob regarding training requirements for equipment currently being installed. Rob is also now in attendance on the POWH site several days a week, with additional training staff being recruited to assist in implementing training requirements expected to be in post shortly. 3) TNA process currently being reviewed with Robert Mathews, with a view to integrating into the installation process at POWH.	Director of Operations	Assistant Director of Facilities	Early 2020	Sep-20	Jan-21		Completed	1 & 2. July 2020 Update - B4 Medical Device training co-ordinator in post, now advised of all new medical equipment installions, and overseeing user training prior to issue. Complete (PJ 17/07/2020). 3. January 2021 Update - New B6 medical device trainer now in post, with all new equipment purchases being referred to Rob Matthews prior to installation. Complete (PJ 06/11/2020).		1 & 2 April 2020 Update - B4 training co-ordinator – in post as of 1/04/2020 and currently being allocated duties in relation to implementing recommendations and adding information to TNA plans and ESR. Head of Clinical Engineering has stated that medical device training is not recorded on ESR – it cannot be done at present in a way to be able to get the information back out that would be needed – we have only just had a B4 training co-ordinator start with us yesterday to start to deal with the backlog of recorded manufacturer training on forms and start recording any new manufacturer training on the medical device training database. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. April 2020 Update - TNA process still currently being reviewed with Robert Matthews, still with the view to integrate this into the POWH installation process. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 3. July 2020 Update - TNA process still currently being reviewed with Robert Matthews to integrate POWH training requirements (DW 17/07/2020). 2. September 2020 Update - TNA process still currently being reviewed with Robert Matthews to integrate POWH training requirements. WG advised that target date has been amended to reflect this update to 31/12/2020 (DW 28/08/2020).
MED FUP 01	Feb-20	Reasonable	The Health Board must be able to ensure that it can demonstrate that staff have been appropriately trained on Medical Equipment and Devices prior to them being used on patients. Prior to new equipment purchases being brought into use in a ward or department, a Training Needs Analysis (TNA) should be completed and where deemed necessary relevant training carried out. Records should be retained of the TNAs and the training provided.	Medium	1. Band 4 Training co-ordinator job advertised and in shortlisting for interview, will appoint as soon as is practicable. Backlog of manufacturer training data will then be updated to training system and new training data will be uploaded immediately when in post. The post holder will also assist with TNA processes. 2. Band 6 Medical Device Trainer post in process on TRAC and will be appointed as soon as is practicable to support the TNA plans for the HB.	Director of Operations	Assistant Director of Facilities	Apr-20	Sep-20	Jan-21		Completed	2. September 2020 Update - B6 role now in place. Complete (WG 28/08/2020) 1. January 2021 Update - Backlog to database has now been completed and database will now be maintained as an ongoing process in line with training requirements. Completed (WG 25/01/2021).		1. April 2020 Update - B4 training co-ordinator – in post as of 1/04/2020 and currently being allocated duties in relation to implementing recommendations and adding information to TNA plans and ESR. Head of Clinical Engineering has stated that medical device training is not recorded on ESR – it cannot be done at present in a way to be able to get the information back out that would be needed – we have only just had a B4 training co-ordinator start with us yesterday to start to deal with the backlog of recorded manufacturer training on forms and start recording any new manufacturer training on the medical device training database. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). 2. April 2020 Update - Robert Matthews continuing to implement recommendations and identifying training requirements for equipment currently being installed with Medical Electronics Engineering Manager. B6 trainer advertised – no suitable candidates – to be re-advertised ASAP. Target Date amended to reflect current circumstances regarding Covid-19 (DW 02/04/2020). July 2020 Update - 1. July 2020 Update - Substantial quantity of backlog training records have been updated on to database since staff member in post and is an on going process, started gathering information relevant for Bridgend training requirements but hampered by Covid-19. (WG 09/06/2020). Process still on-going (WG 16/07/2020). 2. July 2020 Update - Following re-advert, interview date set for 18th June 2020. (WG 09/06/2020). Recruitment checks in progress, start date to be agreed once all checks finalised, hopeful of start date of late August or early September (WG 16/07/2020). 1. September 2020 Update - Process still on-going with number of staff per ward per area and their training requirements currently still being collated by the B4 role. Pediatrics, District Nursing and Maternity staff lists have been completed, however due to ward movements during covid this has been delayed for other departments but continues to be collated. WG advised that target date has been amended to reflect this update and the amount of work involved to 31/12/2020 (DW
DRAM 15	Aug-20	Reasonable	1. Staff identified as requiring scheme of delegation training as part of their role should complete the on-line training module within ESR as soon as practically possible. 2. Consideration should be given as to whether any other staff within the directorate would benefit from Scheme of Delegation training to ensure there is consistency in training	Medium	This action will need to be picked up once the supporting staffing structures are in place on each of the acute sites and budgetary responsibilities have been clarified.	Executive Director of Operations	General Manager	Sep-20	Jan-21			In progress	RTE ILG January 2021 Update - action completed for CSG manager.		

CTM
Internal
[date]

Red -
Orange -
Yellow - Action
Green - Action
Blue - Action

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HNMA 01	Aug-20	Limited	1. The Health Board Executive Team should review the contents of the current draft version of the CBM terms of reference with a view to updating content particularly around business and membership and to ensure the format of the meetings will work with the new operating model. The revised Terms of Reference should then undergo a formal approval process for use in all CBMs as soon as possible. 2. In the mean-time, Clinical Business Meetings should be held monthly wherever possible. Officers who form the core membership of the CBM should be in attendance or send a representative where appropriate. 3. Officers who form the core membership of the Directorate Integrated Governance Business Meeting should attend each meeting or send a representative where appropriate. This ensures that key messages can be cascaded to all relevant teams within the	High	The Directorate does not have the final word on the cancellation of CBMs and does not organise them. The new ILG arrangements will over-ride the current CBM system. Performance review meetings and Quality Patient Safety meetings are established in the new ILG format approved by the Executive team in the inaugural performance review with the CEO in June 2020.	Executive Director of Operations	ILG Leads	Jul-20				Completed	January 2021 Update - Following a follow up review undertaken by Internal Audit the following update was provided: The draft ToR for the SGPR meetings addresses the concern we raised about attendees. The ToR still need to be finalised and adopted by each ILG. We will confirm that monthly meetings are taking place through our planned reviews of the Clinical Service Groups. Original recommendation has been **superseded**.		
HNMA 03	Aug-20	Limited	Monitoring of risks recorded in DATIX should be undertaken and appropriately reported to ensure action is taken in a timely manner within the Clinical Business Meeting or the Directorate Integrated Governance Business Meeting.	High	The UHB is undertaking a full review of risk registers across the Board and it is anticipated that this will improve the position significantly. There has been a significant piece of work undertaken on the risks in Ophthalmology, clinically lead and supported by the internal Patient Quality and Safety team. This work has also been shared with Welsh Government as part of the "no surprises" process. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. The new TOR for the MC ILG patient safety meeting receives a report to include the current risk register high level risks and	Executive Director of Operations	ILG's	No Date Indentified				Completed	January 2021 Update - Following a follow up review undertaken by Internal Audit the following was recommended: Responsibility for risk monitoring has been defined. We will confirm if risks are being monitored in these groups through our planned audits of the Clinical Service Groups and at an ILG level through our corporate risk management audit. Original recommendation has been **superseded**.		
HNMA 04	Aug-20	Limited	The Directorate should review all risks currently recorded on DATIX to ensure that all information is accurate and up to date. The Directorate should also ensure that appropriate processes are implemented to ensure that risks are regularly reviewed, including when risk handlers are absent from work for extended periods of time.	Medium	The UHB is undertaking a full review of risk registers across the Board and it is anticipated that this will improve the position significantly. Further, this issue will be highlighted to the Bridgend ILG when it takes over management responsibility for this service. The Directorate Management team responsible for the risk register have ensured any outstanding work has been completed and through the weekly meetings with Patient care and safety business partners will also ensure there is action undertaken on new risks in	Executive Director of Operations	Management Team	Sep-20				Completed	January 2021 Update - Following a follow up review undertaken by Internal Audit - the following was noted: The revised risk management arrangements will ensure more effective capturing and monitoring of risks. The work we undertake as part of our corporate review will help to confirm if these revised processes are starting to embed and operate effectively in the Health Board. Original recommendation has been **superseded.**		
HNMA 05	Aug-20	Limited	Management should ensure that all outstanding staff that have yet to complete a Declaration of Interest do so.	Medium	The Service Group Manager will seek the names of these individuals from colleagues at YMH and ensure that they return the appropriate information asap.	Executive Director of Operations	Service Group Manager	Sep-20				Completed	January 2021 Update - Following a follow up review undertaken by Internal Audit the following was noted: The new process means controls should have now strengthened. We will be able to confirm this through our future audits of the Clinical Service Groups. Original recommendation has been **superseded.**		
PDFU 01	Oct-20	Reasonable	**Updated Recommendation** 1. The Rhondda and Taf Ely ILG Quality, Safety, Risk and Experience (QSRE) Group's ToR should be approved as soon as possible. A ToR should be drafted and approved for the Service Group Performance Review as soon as practicably possible. 2. The Pathology Quality Manual should continue to be brought up to date following the review of the ToRs of the various groups/ committees within the directorate. The manual should also refer to the Service Group Performance Review meeting both within the ToR section and the	Medium	1. Quality, Safety, Risk and Experience Group's ToR to be finalised at ILG level once the structure is finalised. ToR for the Service Group Performance Review meetings to be drafted and finalised once the structure is finalised. 2. Pathology Quality Manual to be updated to included CSG performance review.	Director of Operations	Locality Nurse Director/Locality Director of Operations/Pathology Quality Manager	October 2020/November 2020/December 2020				Completed	January 2021 Update - QSRE Meetings in place at ILG level and attending		
PDFU 03	Oct-20	Reasonable	**Updated Recommendation** - The directorate should continue to monitor and review the risk register to ensure all risks are reviewed and updated by the set review date.	Medium	**Updated Management Response** - Pathology Risk Register will be reviewed as part of the RTE ILG risk review process. A peer review group is going to be established to look at risk scoring, and guidance to be provided on frequency of review.	Director of Operations	Pathology Quality Manager	Dec-20				Completed	January 2021 - Risk register review ongoing and a number of risks closed or downgraded appropriately as per CGSM		