Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	19 April 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Beare, Assistant Director of Assurance and Risk

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

All reports from audits, reviews and inspections carried out across the UHB are logged onto the UHB central tracker.

Oversight of the timely implementation of recommendations has become even more important following the introduction of HIW's Service of Concern process for NHS organisations. This will allow HIW to identify and highlight any service which requires significant improvement. Its purpose is to increase transparency around HIW discharges its role, and ensuring that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. The document can be found via the following link: 20211115NHSSoCProcessdocumentFinal-EN_0.pdf (hiw.org.uk)

HIW have defined three threshold points to determine whether a service ought to be designated as one of concern as follows:

- Have Immediate Assurance (IA) and/or Improvement plan recommendations been actioned to an acceptable standard and agreed timescales?
- Have the same issues been raised during previous inspection/review activity and insufficient improvements been made?
- Have we received reliable information or gathered evidence to identify a matter requiring urgent action?

If the Health Board is not delivering within timescales, this could contribute to its services potentially being monitored under the Service of Concern process. The guidance has been shared with services, and implementation of recommendations against the timescales will be monitored as part of the ongoing discussions between the Assurance and Risk team and services.

Asesiad / Assessment

The Audit Tracker utilises a traffic light system in relation to the timeframes to implement recommendations. The criteria for this system is as below:

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead
Amber	Recommendation is currently in progress, and within the agreed timeframe for implementation
Red	Recommendation is in progress, but has exceeded its agreed timeframe for implementation (i.e. overdue)

Since the previous meeting, the rolling programme to collate updates from services has reverted back to bi-monthly, to coincide with reporting to ARAC. HIW inspection activity and the corresponding follow up to determine progress of recommendations raised is now undertaken and managed by the patient safety and assurance Team. The patient safety and assurance Manager now provides progress reports to the assurance and risk team against the HIW recommendations included on the Audit and Inspection Tracker.

The assurance and risk team have also completed a review of the Strategic Log with relevant Executive Directors and Lead Officers to establish the current position. Following this review, recommendations deemed as outstanding have been placed back onto the main Audit and Inspection Tracker, and are now included as part of this report.

Since the previous report 13 reports have been closed or superseded. 10 new reports have now been received by the UHB, with an additional 8 reports re-opened following the review and closure of the Strategic Log. These are listed in Appendix 2.

As of 22nd March 2022, there has been an increase in open reports from 93 to 98. 55 of these reports have recommendations that have exceeded their original completion date, which has increased from the 49 reports previously reported in February 2022. Of these 55 reports, 8 have been re-opened following the review and closure of the Strategic Log. This detail can be found in the ‘Audit Tracker Summary Per Service / Directorate’ table later in the SBAR.

There is a slight decrease in recommendations where the original implementation date has passed from 126 to 122. Detail on this decrease can be found in the ‘Audit Tracker Summary Per Service / Directorate’ table. There is little change in the number of recommendations that have gone beyond six months of their original completion date which has increased to 45 from 41 reported in February 2022. The table overleaf provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC February 22	New reports since February 22	Closed reports since February 22	Open reports at ARAC April 22	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	7	1***	1	7	5	6	1
CHC	3	0	0	3	3	2	2
CHC / HIW Contractors	1	0	1^	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	1	4***	0	5	2	8	7
HEIW	0	0	0	0	0	0	0
HSE	3	0	3	0	0	0	0
HIW	15	5**	0	20	11	36	9
HTA	1	0	1	0	0	0	0
IA	27	3	6	24	14	27	14
Internal Review	1	0	0	1	0	3	0
MWWFRS	23	2	0	25	11	27	5
Peer Reviews	3	1***	0	4	3	6	4
PSOW - S23 (Public interest)	1	0	0	1	0	0	0
PSOW - S21	2	2	0	4	2	0	0
Royal Colleges	2	0	0	2	2	4	3
Other (External Consultant)	1	0	1	0	0	0	0
WLC	2	0	0	2	2	3	0
TOTAL	**93**	**18**	**13^**	**98**	**55**	**122**	**45**

**Reports which have passed their original implementation date*
***Original implementation date noted for the recommendation has passed, or will not be met*
****Reports re-opened on the Audit Tracker following review and closure of the Strategic Log*
^ One surgery not managed by the UHB has been closed for the purposes of this report, as the practice remains directly accountable for implementing their recommendations

Appendix 1 provides a full list of 293 open recommendations (increase from 278 reported in February 2022) on the audit tracker. In addition to the new recommendations issued since the previous report, Appendix 1 includes the 22 recommendations highlighted as an 'external recommendation' (recommendation is outside the gift of the UHB to currently implement, for example reliant on an external organisation to implement). These are marked as 'External' in the RAG status column. For completeness these recommendations are now included as part of the 'Total number of recs April 22' column in the 'Audit Tracker Summary Per Service / Directorate' table below.

Appendix 1 does not include recommendations from HIW and CHC reports relating to inspections of independent contractors (i.e. GP and dental practice not managed by the UHB). The practices remain directly accountable for implementing these recommendations.

There are 69 recommendations in Appendix 1 that do not have revised timescales (where the date has passed and not known (N/K) is reported), which has increased from the 32 previously reported. The Assurance and Risk team are working with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' section below.

The 69 recommendations are as follows:

Recommendations requiring clarification of current position or agreement to close:

- 1 recommendation from Medicines Management in Acute Hospitals clarification being sought from Executive Lead if recommendations should be classed as 'external'
- 4 recommendations from IA backlog maintenance report – 3 of the recommendations are future actions that cannot yet be evidenced as completed until the relevant business cases are produced. Conversations taking place with Internal Audit to confirm if 1 recommendation is in a position to be closed.
- 1 recommendations from IA Discharge Processes report – clarification being sought following updated management response reported to ARAC in February 2022.
- 1 recommendation from the IA Governance Arrangements during the COVID-19 Pandemic report regarding agile working arrangements. A Task and Finish Group has been established in order to develop a Health Board policy and supporting documentation. An action plan will be finalised in April 2022 which will include a timeframe around policy and support documentation development.
- 3 recommendations from the Welsh Language Commissioner (WLC) investigation – An update was received after 22nd March 2022 (date the tracker was run off for this report), to advise that the Welsh Language Commissioner has now closed these recommendations. This will be reflected in the next Audit Tracker paper to ARAC.
- 1 recommendation from the IA Welsh Language Standards report – A revised date was provided after 22nd March 2022 (date the tracker was run off for this report), and will be reflected in the next Audit Tracker paper to ARAC.
- 2 recommendations from the HIW Welsh Ambulance Service Trust (WAST) report. Whilst updates have been provided via the Patient Safety and Assurance team, clarification is required if these recommendations can now be noted as implemented.
- 2 recommendations from new Peer Review - Congenital Heart Disease provider - 1 recommendation from the Peer Review undertaken on Congenital Heart Defect, with clarification being sought on revised completion dates.
- 1 recommendation from the HIW Quality Check: Morlais Ward, GGH report - The recommendation relates to face-to-face fire training which has been suspended as a result of COVID-19. Compliance has increased for Fire training level 2 on Microsoft Teams. Clarification to be sought via the Patient Safety and Assurance Team if this recommendation can now be closed.
- 3 recommendations from the RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report – since 22nd March 2022 (date the tracker was run off for this report) a meeting has now taken place with the new BGH General Manager which will be reflected in the next ARAC paper.
- 1 recommendation from the AW Review of Quality Governance Arrangements – Hywel Dda University Health Board. Clarification being sought if recommendation can now be closed.
- 1 recommendation from IA Medical Staff Recruitment report - awaiting clarification from Director of Operations if recommendation can be closed.
- 14 recommendations from 3 separate MWWFRS Letter of Fire Safety Matters (LoFSM) at PPH – The UHB have agreed with the MWWFRS that a full action plan will be developed once all of the LoFSMs relating to PPH have been received by the UHB (circa end March 2022).

Recommendations re-opened following closure of the Strategic Log

- 1 recommendation from the DU Focus on Ophthalmology: Assurance Reviews report. This report has been re-opened on the audit tracker following the closure of the Strategic Log. Reporting officer confirmed an update on progress and revised timescale

will be provided following the review of the progress of glaucoma patients in March 2022.

- 1 recommendation from the HIW Unscheduled Care Directorate & Surgical Assessment Unit inspection, 2015. This report has been re-opened on the audit tracker following the closure of the Strategic Log. Discussion to take place with Deputy Director of Operations to confirm if this recommendation can now be closed.
- 1 recommendation from the Respiratory Cancer Peer Review, 2016. This report has been re-opened on the audit tracker following the closure of the Strategic Log. The new SDM confirmed she will review this recommendation with the Clinical Lead and provide clarification on progress for the next Audit Tracker paper to ARAC.

<u>New reports where management responses are being drafted by the service</u>

- 19 recommendations from the HIW National Review of Mental Health Crisis Prevention in the Community.
- 6 recommendations from the Delivery Unit report on All Wales Assurance Review of Crisis and Liaison Psychiatry Services (CAMHS).
- 6 recommendations from the Delivery Unit report on All Wales Assurance Review of Crisis and Liaison Psychiatry Services for adults.

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 22nd March 2022, including trends since the last report to ARAC in February 2022. A rolling programme to collate updates from services on a quarterly basis is in place in order to report progress to the Committee. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager.

The arrows included in the table below are as follows:

	Increase in number of recommendations / reports
	Decrease in number of recommendations / reports
	No change in number of recommendations / reports

The relevant icon below has been assigned to each service in the table below to display the current trend position:

	Concerning trend	Special cause concerning variation = a decline in performance that is unlikely to have happened by chance.
	Usual trend	Common cause variation = a change in performance that is within our usual limits.
	Improving trend	Special cause improving variation = an improvement in performance that is unlikely to have happened by chance.

Service	Open reports as at March 22	Overdue reports as at March 22	Total number open recs March 22*	Total overdue (red) recs March 22	Recs overdue by more than 6 months	Comments
Acute Services	1 (➔)	0 (➔)	13 (🡻)	2 (➔)	1 (➔)	• HIW National Review on WAST - 13 recommendations (recs) outstanding which has reduced from 19. Updates have been provided via the Patient Safety and Assurance team.
Cancer Services (*N/A- No open reports at ARAC April 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
CEO Office (Welsh Language)	3 (➔)	2 (➔)	8 (➔)	4 (➔)	0 (🡻)	• WLC investigation - 3 recs outstanding, however an update was received after 22nd March 2022 (date the tracker was run off for this report), to advise that the Welsh Language Commissioner has now closed these recommendations. This will be reflected in the next Audit Tracker paper to ARAC.2 IA reports - one report has 1 overdue rec, and the other report has an 'external' rec.
Community - Carmarthenshire (*N/A- No open reports at ARAC April 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Community - Ceredigion	2 (➔)	1 (➔)	16 (➔)	13 (🡹)	0 (➔)	• AW report - 1 'External' rec included. • HIW report – 13 recs now overdue however the Patient Safety and Assurance Team are awaiting updates from the service.
Community - Pembrokeshire (*N/A- No open reports at ARAC May 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Central Ops	3 (🡹)	2 (🡹)	6 (🡹)	5 (🡹)	5 (🡹)	• HIW report re-opened from the Strategic Log - 1 rec. Discussion to take place with Deputy Director of Operations to confirm if this recommendation can now be closed. • IA report on Field Hospital Decommissioning – 1 rec due for completion by June 22. • Peer Review – 4 recs (over 6 months overdue) previously delayed by Covid-19. Revised timescales of March 2023 have been provided by the service. Discussions with the Service Delivery Manager and Deputy Director of Operations have confirmed that the recommendations are relevant, and work has commenced to address them now that the pressures of Covid-19 have eased somewhat. Given the developments of new initiatives such as SDEC and 111 service since the original recommendations were raised, consideration is to be given as to whether the responses for the original peer review report should be revised.

Service	Open reports as at March 22	Overdue reports as at March 22	Total number of recs March 22*	Total overdue (red) recs March 22	Recs overdue by more than 6	Comments
Digital and Performance	3 (🡻)	2 (🡻)	9 (🡻)	6 (🡻)	6 (🡹)	• 1 new IA report on Follow Up: Deployment of WPAS into MH&LD. • IA IM&T Assurance – Follow Up -1 overdue recommendation regarding compliance with EWTD The first switchboard has been installed at GGH, with remaining switchboards expected to be operational by April 22 by which point the recommendation can be closed. • IA Records Management remains open following briefing paper to February 2022 ARAC meeting, reporting 5 recs outstanding (over 6 months overdue). Clarification to be sought if this report should remain with Digital & Performance or be moved to Central Operations as the lead service. • 3 IA reports closed following approval from the Director of Finance. • 1 AW report and 1 external consultant report - closed following approval from the Director of Finance
Estates	30 (🡹)	13 (🡹)	70 (🡻)	32 (🡻)	6 (🡹)	• Number of outstanding recs has decreased from 72 to 70, with the number of overdue recs decreased from 35 to 32. The majority of these recs are from the 7 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs). • MWWFRS continues to be kept fully up-to-date with any adjustments to the programme of phased works at GGH and WGH, and work undertaken at BGH. MWWFRS have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extensions required. • 2 further Letters of Fire Safety Matters has been received for PPH. The UHB have agreed with the MWWFRS that a full action plan will be developed once all of the LoFSMs relating to PPH have been received by the UHB (circa end March 2022). • All MWWFRS recs overseen by HSC via the Fire Safety Update Report provided to every meeting by the Director of Estates, Facilities and Capital Management. •3 IA reports (1 new report since last ARAC report) - 2 overdue recs. 1 rec currently being reviewed by Internal Audit for closure, and the other rec the Estates services are liaising with IT services to complete implementation of hardware by September 2022. •2 HIW reports re-opened from the Strategic Log - 3 overdue recs to be implemented by end March 2022.
Finance	2 (➔)	0 (➔)	5 (🡹)	0 (➔)	0 (➔)	• 3 recs relating to the IA on Financial Planning, Monitoring and Reporting report. • IA report Use of Consultancy has been superseded by the IA Follow –up: Use of Consultancy, issued in February 2022 with 2 recs.
Governance	2 (🡹)	0 (➔)	2 (➔)	1 (➔)	0 (🡻)	• IA advisory review remains open, with recs being supported by the Workforce & OD Directorate.
Medical (*N/A- No open reports at ARAC April 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	• N/A

Service	Open reports as at March 22	Overdue reports as at March 22	Total number of recs March 22*	Total overdue (red) recs March 22	Recs overdue by more than 6 months	Comments
MH&LD	10 (↑)	5 (↑)	52 (↑)	6 (↑)	1 (→)	• 5 HIW reports – 2 have recently been confirmed as closed by the service and awaiting formal approval of closure. Of the 3 remaining reports, awaiting updates from the Patient Safety and Assurance team for progress updates. 1 IA – 1 overdue rec (not by 6 months) • 1 CHC – 4 recs within date • 3 new reports have been added to the tracker with management responses currently being drafted by the service (2 DU reports – All Wales Assurance Reviews of Crisis Management for CAMHS and AMHS, and HIW National Review of Mental Health Crisis Prevention). Completion dates for these 31 recommendations are currently not known until management responses finalised.
NQPE	5 (↓)	4 (↓)	10 (↓)	3 (↓)	1 (↓)	• 3 material breaches and 1 IA report closed. • AW report - 2 overdue recs, clarification being sought if 1 of these recs can now be closed. • 1 IA report - 1 rec overdue by over 6 months, clarification being sought from service if this is implemented. • 3 PSOW reports (1 additional since the last ARAC report).
Pathology (*N/A- No open reports at ARAC April 2022*)	0 (↓)	0 (↓)	0 (→)	0 (→)	0 (→)	• Formal approval of closure of the Human Tissue Authority report received from the Head of Service since previous meeting.
Primary Care, Community and Long Term Care	2 (→)	2 (↑)	9 (↑)	4 (↑)	0 (→)	• IA report – 2 overdue recs, awaiting clarification of correct reporting officer to obtain updates. • AW report- re-opened from the Strategic Log. • HIW GP surgery closed as this is surgery is not managed by the UHB therefore will no longer be included as part of this report.
Public Health	1 (→)	1 (→)	2 (→)	2 (→)	2 (→)	• IA report - 2 outstanding recs over 6 months overdue. No update received from reporting officer.
Radiology	3 (→)	2 (→)	9 (↓)	5 (↓)	4 (↓)	• HIW IRMER (WGH) – 35 out of 39 recs have now been completed. 4 recs remain (1 overdue by more than six months) • HIW IRMER (PPH) - 3 red recs (overdue by more than six months), a decrease from 7 in the previous report • IA report - 1 rec overdue by more than six months, with a revised date of December 2022, reflecting the establishment and workforce review
Scheduled Care	4 (↑)	3 (↑)	10 (↑)	9 (↑)	8 (↑)	• CHC report – 1 'External' rec and 2 recs delayed by over 6 months. • 3 reports re-opened from the Strategic Log with a total of 7 overdue recs.
Strategic Development & Operational Planning	6 (→)	5 (↑)	17 (↓)	10 (→)	4 (↑)	• AW report - 1 overdue rec. • Internal review of Capital Governance - 3 recs overdue. Clarification being sought if these recs can now be closed. • 4 IA reports - total of 6 overdue recs. 3 overdue recs related to IMTP submission to WG. 1 rec to be implemented following reporting to Capital Sub Committee and other 2 recs evidence has been sent to Internal Audit to review if these can now be closed.

Service	Open reports as at March 22	Overdue reports as at March 22	Total number of recs March 22*	Total overdue (red) recs March 22	Recs overdue by more than 6	Comments
Therapies	1 (➔)	1 (🡅)	0 (🡇)	0 (🡇)	0 (➔)	• All recommendations raised in the IA Therapies Directorate Review have been addressed and completed, and awaiting formal approval of closure for the report on the tracker.
USC BGH	2 (🡅)	1 (➔)	7 (🡅)	3 (➔)	2 (🡇)	• RCP follow up report with 3 overdue recs – a meeting has been scheduled with the new BGH General Manager and these updates will be reflected in the next audit tracker paper to ARAC. • New PSOW report - updates to be obtained from the Ombudsman Case Manager
USC GGH	3 (➔)	2 (➔)	4 (🡇)	3 (➔)	3 (➔)	• DU report All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review- 2 recs overdue with revised completion dates of April 2022. • HIW report - 1 overdue rec which has surpassed the revised completion date of November 21. • Awaiting formal approval of closure of PSOW report as confirmation received from Ombudsman Liaison Manager that actions have been completed
USC PPH	3 (🡅)	2 (🡅)	7 (🡅)	7 (🡅)	0 (➔)	• 1 HIW report on Ward 7 – 5 overdue recs. The Patient Safety and Assurance Team are liaising with the service to provide a three month progress update in relation to this review. • 2016 Peer Review on Respiratory Cancer report - re-opened from the Strategic Log. The new SDM will be reviewing the Respiratory pathway with the clinical lead in order to address the recommendation (1 overdue rec) • 1 IA – 1 overdue rec
USC WGH	1 (➔)	1 (➔)	1 (🡇)	0 (🡇)	0 (➔)	• HIW report- 1 'External' rec
Women & Children	6 (➔)	4 (➔)	26 (🡇)	3 (➔)	2 (🡅)	• 1 Royal College report - 2 overdue recs • 2 HIW reports - 1 rec overdue by more than 6 months and 1 external rec. • 2 Peer Reviews – 1 rec overdue by more than 6 months and 1 external rec • Awaiting formal approval of closure for HIW report on Puffin/PACU Unit • 1 IA and 1 HIW report closed since the previous reports
Workforce & OD	4 (➔)	2 (➔)	8 (🡇)	3 (🡇)	0 (➔)	• WLC report - 1 'External' rec • IA report – 2 recs overdue • 2 AW report – 1 rec overdue. 1 report to be closed following approval from the Director of Workforce & OD
Unscheduled Care	1 (➔)	1 (➔)	1 (➔)	0 (➔)	0 (➔)	• CHC report - 1 'External' rec
Total	**98**	**55**	**293**	**122**	**45**	

**Total number of recs now includes 'external' recs for completeness.*

Services of Concern

Mental Health & Learning Disabilities
There has been consistency in the performance of existing recommendations assigned to MH&LD, and the closure of recommendations since the previous meeting. Three new reports have been assigned to the Directorate since the previous ARAC meeting, with management responses currently being formalised in response to the recommendations raised within these reports. A Learning Disability Unit remains an area of focus due to the immediate improvement plan as issued by HIW, containing 9 recommendations, and final report containing a further 5 recommendations. A three month progress update was submitted to HIW on these recommendations in February 2022. At the time of writing, 4 recommendations have been fully implemented, and 3 are partially completed. 3 recommendations are noted as being overdue.

There has been improvement noted in the following areas previously noted as potential areas of concern:

Central Operations
4 recommendations (over 6 months overdue) previously delayed by COVID-19. Timescales have now been amended to March 2023. Discussions with the Service Delivery Manager and Deputy Director of Operations have confirmed that the recommendations remain relevant, and work has commenced to address now that the pressures of Covid-19 have eased somewhat. Given the developments of new initiatives such as SDEC and 111 service since the original recommendations were raised, consideration is to be given as to whether the TOR for the original peer review report has now been superseded. The outstanding recommendations have been linked to corporate risk 129 (Ability to deliver an urgent Primary Care Out of hours Service for Hywel Dda Patients) on Datix.

Radiology
4 recommendations are overdue by more than 6 months, which has decreased by 4 since the previous paper. The Directorate is committed to addressing outstanding recommendations and reviewing associated risks on the Directorate risk register. The outstanding recommendation raised as part of the Internal Audit Radiology Directorate (October 2019) has a revised completion date of December 2022, reflective of the work being undertaken on the establishment and workforce review.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to take an assurance on the rolling programme to collate updates from services on a quarterly basis in order to report progress to the Committee.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.3 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 Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CHC – Community Health Council DCP – Discretionary Capital Programme DU – Delivery Unit EWTD – European Working Time Directive GGH – Glangwili General Hospital HEIW – Health Education and Improvement Wales HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IGSC – Information Governance Sub Committee IRMER – Ionising Radiation (Medical Exposure) Regulations Management & Technology Sub Committee MH&LD – Mental Health & Learning Disabilities MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience NWIS – NHS Wales Informatics Service PAMOVA – Prevention, Assessment & Management Of Violence & Aggression SDEC – Same Day Emergency Care

	PPE – Post Project Evaluation PPH – Prince Philip Hospital PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SIFT – Service Increment for Teaching SSU – Specialist Services Unit UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children
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

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Medicines Management	Jenny Pugh-Jones	Director of Primary, Community and Long Term Care	AW_MMAH_001b	Not stated	R1b: Refresh its Medicines Management Strategy to provide an integrated vision across primary and secondary care that is developed in full partnership between pharmacy, medical and nursing staff.	One of the key roles for the newly appointed Head of Medicines Management will be to update and refresh the strategy for the service. Employing the County Leads, who all have busy operational and managerial roles, as rotating interim Heads of Medicines Management has not allowed strategic aims to be tackled.	Apr-16	Sep-22	Red	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. Update provided 09/12/2021- The short term vision for pharmacy services are identified within the IMTP. Development of the strategic HB document is delayed due to the impact on Covid and the need for the Health Board to reassess its own Clinical Strategy. Work will be undertaken to develop a vision for the profession within the Health Board based on the National, WG endorsed, Pharmacy: Delivering a Healthier Wales. A draft document will be signed off through MMOG (Medicines Management Operational Group), through to QSEAC and Board. Revised timescale of September 2022
295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Jenny Pugh-Jones	Director of Primary, Community and Long Term Care	AW_MMAH_004a	Not stated	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	N/K	Red	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales.
603A2018-19	Jun-18	Audit Wales	District Nursing: Update on Progress	Open (external rec)	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans / Sharon Daniel	Director of Operations	WAO_DistrictNursing_001	Not stated	R6. Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the case mix between teams compared with team resources.	The Health Board said that it expects this issue to be definitively addressed through the publication of the All Wales dependency tool, currently expected in 2020.	Jan-19	~~Mar-20~~ ~~Nov-20~~ ~~Dec-21~~ N/K	External	24/11/2020- Community Head of Nursing confirmed the All Wales DN Workstream is progressing well with the development of a dependency and acuity tool and the first testing phase of the DN Welsh Levels of Care Acuity and Dependency tool is planned for March / April 2021. There is good representation on the national workstream from HDUHB and all DN teams will be engaging in the planned pilot phases of testing. Malinko scheduling system is also being rolled out across the community nursing teams in HDUHB which will further support the use of this tool. The plan is a 6 month pilot followed by review and then most likely a further 6 month testing phase. It is more likely that there will be a tool in use consistently in 2022 although we will have something to use from Spring 2021. Revised timescale December 2021. 19/08/2021- The Draft District Nursing (DN) Welsh Levels of Care Acuity and Dependency tool (WLoC Tool) underwent phase 1 of testing in July 2021
2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	Work is underway to review the capacity and capability of the Planning Team. A proposal will be taken to the Executive Team to recurrently increase the capacity of the service planning team and further develop the 'business partnering' approach.	Sep-21	~~Sept-21~~ ~~Dec-21~~ Jun-22	Red	19/08/2021- Management response reported to ARAC August 2021. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- proposal for potential new posts were reported to Exec Team in August 2021.Director of Strategic Development & Operational Planning deciding the longer term arrangements for the team. 18/11/2021- Revised management response being reported to ARAC December 2021 meeting, tracker will be updated following the meeting. 26/01/2022- Head of Planning was unable to provide update. Assurance and Risk Officer to contact Director of Strategic Development and Operational Planning for clarification of timescale. 03/02/2022- Director of Strategic Development & Operational Planning confirmed this recommendation is part of the IMTP discussions. An outline
2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all	With the increase in capacity, it is the intention that the members of the Planning team are exposed to a wider range of Planning activities to build their knowledge, understanding and capabilities in order to strengthen the overall Planning function (to include Operational Delivery Groups, ARCH etc)	Mar-22	~~Mar-22~~ Jun-22	Red	19/08/2021- Management response reported to ARAC August 2021, timescale noted as 'Quarter 4 (subject to recruitment timescales)'. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- proposal for potential new posts were reported to Exec Team in August 2021. Director of Strategic Development & Operational Planning deciding the longer term arrangements for the team. 18/11/2021- Revised management response being reported to ARAC December 2021 meeting, tracker will be updated following the meeting.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_001a	High	R1.a The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Subcommittee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: a) mandate the use of the recently issued generic	The EDONQPE to reissue templates and instruct utilisation at each quality governance meeting at service and directorate meetings.	Nov-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022, no response received. 22/02/2022- unclear from update reported to ARAC if this recommendation has been implemented, to be clarified with the service. 21/03/2022- requested clarification on 15/03/2022 if this recommendation has been implemented, no update received.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_001b	High	R1.b The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Subcommittee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: b) issue guidance on record taking at meetings; and	Guidance document to be developed and issued with (R1a)	Nov-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- unclear from update reported to ARAC if this recommendation has been implemented, to be clarified with the service. 21/03/2022- requested clarification from Head of Corporate & Partnership Governance if this recommendation is now implemented, awaiting response.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_001c	High	R1.c The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Subcommittee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: c) ensure that local records are stored in a standard location to facilitate access.	Include within guidance document (R1b) a reminder of the importance of storing of meeting papers in accordance with corporate records management policy.	Nov-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- unclear from update reported to ARAC if this recommendation has been implemented, to be clarified with the service. 21/03/2022- requested clarification from Head of Corporate & Partnership Governance if this recommendation is now implemented, awaiting response.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_002	High	R2. There are inconsistent leadership arrangements at an operational level for assurance, risk, and safety across the Health Board. The Health Board should either strengthen current arrangements where staff resources for assurance, risk and safety are managed by directorates to improve consistency, or move to a model where these staff are managed centrally, ensuring that support	There are consistent leadership arrangements in place at operational level (acute, community and primary care) for assurance, risk and safety, however responding to the pandemic has impacted on the capacity of the leadership teams to be able to discharge all their accountabilities effectively. There has been a daily focus on managing risks across the system, however this has not always been reflected in the risks on the Datix Risk System.	Dec-22	Dec-22	Amber	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error).
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_003b3	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	Dec-22	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- update to ARAC provides revised date of December 2022 for the implementation of the new risk management system. This is an All Wales system therefore the implementation date is outside the gift of the Health Board.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_003b4	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	Jul-22	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_004	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	Dec-22	Amber	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error).
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_001d	Not stated	R1. Retaining a strong focus on staff wellbeing. NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	The Staff Wellbeing Information Line was launched on 19.11.21 and will be evaluated at the end of May 2022.	May-22	May-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms May 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_002c	Not stated	R2. Considering workforce issues in recovery plans. NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	In addition, the Health Intervention Coordinator has been granted funding to develop over 100 peer support wellbeing champions from NHS Charities together budget. 55 have already been trained, with the intention of increasing this number to 100 by September 2022. The aim is to improve access to wellbeing support for all staff by promoting health and wellbeing within the workplace. Champions are ideally positioned to offer initial advice and signposting to appropriate support services.	Sep-22	Sep-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms Sept 2022 timescale.

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AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_002d	Not stated	R2. Considering workforce issues in recovery plans. NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	The Health Board will ensure that our recovery plans are aligned to any workforce planning implications that may impact on wellbeing.	Mar-22	Mar-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms March 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_003a	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer. NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	User satisfaction feedback and clinical outcomes monitoring is in place for all 121 psychological support services and trend analysis is conducted monthly. User satisfaction and clinical outcomes are monitored on an ongoing basis with monthly reporting to the Wellbeing Dashboard. Evaluation plans are in place for the new Staff Wellbeing Information Line as well as the Staff Ecotherapy Programme. A Well-Being Dashboard is produced monthly.	Apr-22	Apr-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting. 11/02/2022 - The Ecotherapy pilot will be evaluated on completion with a target date of April 2022. 22/02/2022- update to ARAC confirms April 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_003b	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer. NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Evaluation plans are in place for the new Staff Wellbeing Information Line as well as the Staff Ecotherapy Programme. A Well-Being Dashboard is produced monthly.	May-22	May-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms April 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_003c	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer. NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	The Ecotherapy pilot will be evaluated on completion with a target date of April 2022 to inform future cohorts of the programme.	Apr-22	Apr-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms April 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_003e	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer. NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Evaluation of the wellbeing champions initiative is planned to establish a better understanding of the wellbeing champion role as it develops and the overall impact on staff wellbeing and areas for development.	Sep-22	Sep-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms Sept 2022 timescale.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_006b	Not stated	R6. Building on local and national staff engagement arrangements. NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	'Working in confidence' platform to support the staff voice will launch in December 2021.	Dec-21	Apr-22	Red	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms revised completion date of April 2022.
What's your NHS like for you? Hearing from people with a learning disability	May-18	CHC	What's your NHS like for you? Hearing from people with a learning disability	Open (external rec)	N/A	Unscheduled Care	Unscheduled Care	Sian Passey	Director of Operations	NHSLikeForYou_001	N/A	R5. All Wales Working Group currently developing standards of practice for annual health checks including training programmes for GPs.	• Once finalised the standards of practice to be implemented across the GP practices • GPs to participate on All Wales Training Programme	Mar-19	~~Apr-20~~ ~~Aug-20~~ N/K	External	Educational Packs for GPs are ready to go and a launch at Welsh Government level is imminent – but no date has been received as yet. As soon as the pack is received the Community Learning Disabilities Team will participate in the delivery of the training to primary Care Teams. 19/07/2021- update provided by Professional Lead LD nursing on behalf of Assistant Director of Nursing, (Nursing Practice)- The 'delivering healthcare to people with a learning disability' has been launched by Welsh Government and Improvement Cymru. An E-Learning version is currently in development. Due to the pandemic a full launch has not been possible. However HDUHB now employ 3 Primary Liaison nurses and 3 Health Check Champions (individuals with a learning disability) who are working to improve the quality, quantity and outcome of the annual health check. They plan to launch the training as part of their ongoing work. The Health Check Champions have developed 2 posters which were circulated to all GP practices and Hospital out -patient and emergency departments during learning disability awareness week at the beginning of June, and will be circulated to day care services when they re-open.(see attached) The learning disability service is currently undergoing service review as part of this work a physical health pathway will be developed which will clarify processes for people with a learning disability their families/carers and all those who support their physical health. 22/11/2021- further progress update requested. No update provided as of 26/01/22, however Assistant Director of Nursing has suggested the Professional Lead LD nursing contact the Head of Patient Experience for any support required. 21/03/2022- email sent to report officer 07/03/2022 requesting update or confirmation if recommendation implemented. No update received.
Eye Care Services in Wales Follow Up	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	Director of Operations	EyeCareServices001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	~~Mar-21~~ ~~Sep-21~~ Mar-22	Red	,25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and set up plans is being led by the Primary Care Optometric Leads who need to update on this action.

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Eye Care Services in Wales Follow Up	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	Director of Operations	EyeCareServices002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ Mar-22	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and set up plans is being led by the Primary Care Optometric Leads who need to update on this action.
Eye Care Services in Wales Follow Up	Jan-20	CHC	Eye Care Services in Wales Follow Up	Open (external rec)	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	Director of Operations	EyeCareServices005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ Apr-22	External	WG have awarded the contract and implementation of EPR will be progressed on an All wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 25/08/2020 update- still awaiting national roll out as part of national work stream. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream.
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_003	N/A	Whilst people may not be able to have face-to-face support or therapy, some people may feel that phone calls are helpful in the interim and these may need to be part of an active offer by the Health Board.	This will be addressed through the MH/LD 'keeping in touch group'.	Mar-22	May-22	Amber	Progress update provided to CHC as part of the management response in August 2021: 'Keeping in touch' Task and Finish Group has been established, next meeting 27th September 2021. 12/10/2021 - some of these actions are dependent in implementation of WPAS, therefore any services with a waiting list is being prioritised in Phase 2. WPAS can prompt MHLD to keep in touch. 13/01/2022 - The implementation of WPAS into IPTS is in preliminary discussions but not confirmed roll out date yet. 01/03/2022 - Use of Third Party content via Informatics team has been used to send initial set of letters to individuals awaiting an appointment with
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_004	N/A	The Health Board needs to have clear ways of discussing discharge arrangements with people so that they do not feel decisions have been made without them having their views heard.	A discharge audit will be developed by the Quality Assurance Practice Development (QAPD) team in collaboration with operational services. Complete the audit and develop improvement plan based on the results.	Mar-22	Mar-22	Amber	Progress update provided to CHC as part of the management response in August 2021: A discharge audit has been designed for inpatient units and is on the HB annual audit plan. The inpatient audit tool has been developed based on the AIMS accreditation standards, the QAPD team will work with the CTP lead and nominated operational staff to adapt for use in community MH/LD services. Results of the audit will inform the development of a service wide improvement plan 12/10/2021 - audit proforma has been created and agreed, to confirm when audit will be undertaken in the CMHT. 07/12/2021 - Healthy Ward Checks currently underway, and to confirm progress of audits with Helen Thomas Bone.
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_005	N/A	Many people have expressed a need for easy and quick to access direct mental health support for all ages.	The MH/LD Directorate have been implementing a 111 Welsh Government pilot project. Trained Mental Health practitioners are embedded in the 111 service to guide and direct people to the appropriate service as required.	Mar-22	Mar-22	Amber	Progress update provided to CHC as part of the management response in August 2021: This single point of access will improve access to mental health services, this pilot will become a substantive 24hour, 7 day a week service, funded by WG. Substantive job descriptions are currently being developed to support the expansion of the service, which is currently being provided 7 days a week, Monday to Friday 6.30pm – 10.30pm, weekends 2pm until 10pm. It is expected that the 24/7 service will be implemented from December 2021 pending recruitment. There has been a rolling evaluation throughout the pilot. Ways of communicating the availability of the 111 service are currently being explored by the project team. The QR code for collating service user feedback is currently being developed and a question has been added asking about ease of access to service.
Focus on Ophthalmology: Assurance Reviews	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	Strat_ScheduledCare_007	N/A	R2.1. Lack of progress with ODTC in Ceredigion	05/09/19 update- Discussions are continuing as part of the Mid-Wales collaborative programme.	N/K	Apr-22	Red	22/02/2022- SDM, Scheduled Care commented that this action needs to be updated & owned by Head of Dental & Optometry Services & Optometric Advisor as the Diagnostic Treatment Centre (ODTC) funding and set up plans is being led by the Primary Care Optometric Leads. 23/02/2022- update from Head of Dental and Optometry- The first stage was to develop ODTs in Primary care to deliver The Glaucoma pathway and this has been delayed because of the appointment process for a lead consultant with a sub specialist interest in glaucoma and the installing of IT systems to support the pathway. Plans are in place to start the pathway providing there is a recurrent source of funding available from the 01/04/2022.
Focus on Ophthalmology: Assurance Reviews	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	Strat_ScheduledCare_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	05/09/19 update- As part of the eye care sustainability funds there are plans in place to transform the pathways for patients with stable Glaucoma to be monitored in Community Optometric Practices. All patients will be allocated a Health Risk Factor by the end of September 2019 which will allow for a review and baseline assessment to be undertaken.	N/K	N/K	Red	22/02/2022- SDM confirmed recommendation to remain open until we're in a position to review the progress of the Glaucoma patients in March 2022 - then we'll have an idea of when the work will be completed by. 21/03/2022- Recommendation added back to the main audit tracker.
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio002	N/A	R2:Ensure that all administrative record keeping – both electronic and within the medical records – are maintained to the highest of standards.	Monthly audits of outcome form to establish % compliance - feedback any non-compliances with Clinical lead to address non-compliance.	Aug-19	~~Oct-20~~ ~~Dec-20~~ ~~Aug-21~~ ~~Nov-21~~ Apr-22	Red	Unable to progress due to COVID priorities reviewed date for completion is now September 2020. 02/10/2020- reporting officer confirmed It has not been possible to complete the planned monthly audits of outcomes forms at Cardiology Clinics as face to face Clinics have been suspended over the summer months due to COVID. Currently in the process of re-starting clinics now and will look to achieve monthly audits of outcome forms over the next few months. This will then allow us to present a % compliance. New timescale of December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- reporting officer update- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. With increasing numbers of face to face clinics reinstated in coming months, plan to undertake this audit in August 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 10/08/2021 – new outcome form utilised from 09/08/21. Compliance audit to be undertaken w/c 06/09/21 which will report findings and remedial actions by end of September 2021. 16/03/2022 - new outcome form still being used. Compliance-audit currently in progress and completes at end of March 2022, which will report findings and remedial actions by end of April 2022.
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio003	N/A	R3b: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): b. clinical agreement that all referrals sent to tertiary service clearly include the clinically determined PSD and current adjusted PSD, including a standardised referral form which is consistent across HDUHB.	For 100% of referral letters to have a PSD identified by November 2019 - audit undertaken in February 2020 demonstrates a 31% compliance. SDM Cardiology and Cardiology Service Support Manager to reinforce need of PSDs to referring clinicians and re-audit in 3 months.	Dec-19	~~Dec-20~~ ~~May-21~~ Sep-21 Apr-22	Red	Unable to progress due to COVID priorities reviewed date for completion is now December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- Update from reporting officer- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. Plan to re-audit this compliance over the next few weeks. 24/05/2021- Requested update if this rec will be completed by end of May 2021, no response as of 28/05/2021. 11/06/2021 update -Audit currently being undertaken across all 4 HDUHB referring sites. Findings and recommendations will be collated and reported by the end of June 2021. Cardiology SDM and SSM will focus on any needed remedial actions from July 2021 and re-audit compliance in October 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 10/08/2021 – Compliance audit currently in progress and will report findings and remedial actions in September 2021. 16/03/2021 – Compliance audit undertaken in August 2021 demonstrated a 50% compliance, with the Community Heart Failure Service requiring most remedial actions to address. Workshop delivered to Community Heart Failure Service to facilitate improved compliance in October 2021. Compliance-audit currently in progress and completes at end of March 2022, which will report findings and remedial actions by end of April 2022.
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio003	N/A	R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.	HDUHB was in the process of working with IT to setup another SharePoint system to move towards the electronic referral of patients between Cardiology and Cardiac Surgery. However, this hasn't been progressed due to the All Wales Accelerating Cardiac Informatics work being progressed on Hospital to Hospital Referrals. Cardiology Service Delivery Manager currently in discussion with HDUHB Informatics and AWACI.	May-19	~~Dec-20~~ ~~Jun-21~~ Mar-22	Red	Unable to progress due to COVID review date December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- Update from reporting officer- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. Clinical Lead/SDM plan to review the possibility of developing a more reliable SharePoint system to support referrals and discuss this with SBUHB counterparts with respect to have we might progress this. 24/05/2021- Requested update if this rec will be completed by end of June 2021, no response as of 28/05/2021. 11/06/2021 update -The Cardiology Service is currently undertaking a Pathway Transformation Project which will review the tertiary care element and processes of all pathways – it is anticipated that this work will provide an updated perspective of the needed digital/electronic component of future cardiology pathways. This project runs to the end of March '22 at which point it will report its findings and recommendations relevant to this action. 10/08/2021 – Cardiology Pathway Transformation Project in progress and will report it's recommendation re development of an electronic referral system by March 2022. 16/03/2021 – Discussions continuing between HDUHB and SBUHB Cardiology Management Teams concerning need/feasibility of developing SharePoint system.

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All Wales Review of progress towards delivery of Eye Care Measures	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_002	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	Jun-20 Aug-20 Oct-20 Mar-26	Red	22/02/2022- Plans submitted as part of IMTP and ARCH plan for Glaucoma now in place. Meeting arranged with Shrewsbury & Telford in Feb 2022 to scope provisions for the North of the Health Board and the patients in Ceredigion. 21/03/2022- Recommendation re-opened on the audit tracker.
All Wales Review of progress towards delivery of Eye Care Measures	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_004	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	Jul-20 Aug-20 Oct-20 Mar-26	Red	22/02/2022- If this will be addressed via the IMTP, then once the IMTP is approved Andrew is happy for this to be closed. 21/03/2022- Recommendation re-opened on the audit tracker.
All Wales Review of progress towards delivery of Eye Care Measures	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_006	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	Jun-20 Aug-20 Oct-20 Mar-26	Red	22/10/22- update from SDM: Successful regional recruitment of Consultant Ophthalmologist with an interest in Glaucoma. Honorary Contract in place with Swansea Bay for Consultant. Interviews arranged for Feb 2022 for substantive Consultant Ophthalmologist - potential candidate able to commence March 2023. Meeting arranged with Shrewsbury & Telford in Feb 2022 to scope opportunities for the North of the HB and patients in Ceredigion. 21/03/2022- Recommendation re-opened on the audit tracker.
All Wales Review of progress towards delivery of Eye Care Measures	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	DelUnit-EyeCare_007	N/A	R7. As part of the medium-long term plan development, the cataract service options require appraisal prior to the commencement of the next planning cycle, supported by a clear, time-bound delivery plan.	Options included as part of the IMTP.	Mar-20	Jul-20 Sept-20 Mar-26	Red	27/01/22- Update from SDM- Plans for the North of the Health Board and the patients in Ceredigion will be discussed as part of the meeting with Shrewsbury & Telford in Feb 2022. No WG funding for continued outsourcing has been agreed after the end of March 2022. 21/03/2022- Recommendation re-opened on the audit tracker.
DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_001	N/A	The Health Board should ensure there is an equitable timely crisis response regardless of where a person lives or presents for a crisis assessment.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_002	N/A	The Health Board should ensure that the service engages with referrers to identify opportunities and escalation processes that support collaborative multiagency risk formulation through advice, liaison, or direct assessment, when young people present in a crisis or risk which is perceived to be exacerbated by adverse social circumstances.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_003	N/A	The Health Board should ensure that all referrers are clear on how to access crisis support, whether via their GP, Emergency Department or Single Point of Contact. The Health Board should also ensure that the use of fax to receive referrals does not cause any potential delay in response or issues regarding information governance.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_004	N/A	The Health Board should ensure that children and young people do not experience unduly long waiting times for a psychological intervention when transferred from CATT to S-CAMHS.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_005	N/A	The Health Board should ensure that mental capacity is assessed and clearly recorded in all assessment documentation.	Management response being prepared by the Directorate	N/K	N/K	Amber	

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DU_AWARCLPS0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPS0322_006	N/A	The Health Board should ensure that follow up information is clearly communicated to all referrers, children and young people and families.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_001	N/A	To map the current models of Psychiatric Liaison and their allied crisis services for all ages including the provision of services to Emergency Departments (EDs), Medical Assessment Units (MAUs) and General Hospital wards across NHS Wales. This will include gaining an understanding of the availability of 24/7 support and how models and responses differ across the age ranges.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_002	N/A	Drawing on the views of service users, family and informal carers on the responsiveness of mental health unscheduled care provision.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_003	N/A	To confirm the referral criteria and pathways used by Psychiatric Liaison and their allied crisis services. To test the compliance against these, from the perspective of referrers and crisis and liaison services. This will include understanding where there are different pathways for emergency and routine responses.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_004	N/A	To understand the current demand on Psychiatric Liaison and Crisis services and how the services link with the wider NHS mental health provision, social care and other agencies.	Management response being prepared by the Directorate	N/K	N/K	Amber	

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DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_005	N/A	To understand the current workforce of Psychiatric Liaison and Crisis services, including the capacity and skill mix.	Management response being prepared by the Directorate	N/K	N/K	Amber	
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	DU_AWARCLPSA0322_006	N/A	To understand the impact of Psychiatric Liaison teams on care within DGH services.	Management response being prepared by the Directorate	N/K	N/K	Amber	
Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Nov-14	HIW	Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Open	N/A	Estates	Unscheduled Care (GGH)	Paul Evans	Director of Operations	HIW_TWGGH_001	N/A	Corridors were also cluttered due to lack of adequate storage for large equipment.	Ward storage and clutter ongoing challenges due to nature of ward equipment needs and also size of ward areas. Plan in place with Estates for change of function of unused bathrooms into storage areas. Awaiting costs and plan of actions required. Further ward refurbishment needs being assessed by Estates and will be reviewed in line with refurbishment plans for site.	N/K	Mar-22	Red	15/03/2022- Recommendation placed back on the audit tracker from the Strategic Log. Estates confirmed recommendation to be implemented by end of March 2022 as part of Phase 2 programme. Lead directorate amended from GGH to Estates and reporting officer amended to Head of Estates Risk & Compliance.
Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Nov-14	HIW	Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Open	N/A	Estates	Unscheduled Care (GGH)	Paul Evans	Director of Operations	HIW_TWGGH_002	N/A	We found that the environment was old, tired and some areas required refurbishment.	Estates working with Senior Nurse and Ward Manager to devise plan for refurbishment identifying priorities and will be managed as part of the site refurbishment plans with Estates.	N/K	Mar-22	Red	15/03/2022- Recommendation placed back on the audit tracker from the Strategic Log. Estates confirmed recommendation to be implemented by end of March 2022 as part of Phase 2 programme. Lead directorate amended from GGH to Estates and reporting officer amended to Head of Estates Risk & Compliance.
Ward 6 - PPH - Unannounced DECI - 23Sep14 (Elective Orthopaedic)	Jan-15	HIW	Ward 6 - PPH - Unannounced DECI - 23Sep14 (Elective Orthopaedic)	Open	N/A	Estates	PPH	Paul Evans	Director of Operations	HIW_W6PPH_001	N/A	R5:Toilet and washroom facilities should have colour coded doors to assist people who are living with sensory impairment.	Estates have been informed 28/10/2014 of the specific requirement /recommendation re Ward 6 PPH. The painting and signage of the doors of hygiene facilities doors across all in-patient areas will be part of timetabled, HDUHB wide refurbishment programme which reflects the Kings Fund, evidence based principles for a dementia –friendly environment Senior Nurse forum and Estates Lead will timetable to implement and monitor completion of work.	N/K	Mar-22	Red	15/03/2022-One recommendation placed back on the audit tracker from the Strategic Log. Estates agreed to look into completing colour coded doors for Ward 6 by end of March 2022 to allow this recommendation to be closed. Lead directorate amended from Unscheduled Care to Estates and reporting officer amended to Head of Estates Risk & Compliance.
Unannounced Hospital Visit - Unscheduled Care Directorate & Surgical Assessment Unit - 11 & 12 Aug 2015	Mar-15	HIW	Unannounced Hospital Visit - Unscheduled Care Directorate & Surgical Assessment Unit - 11 & 12 Aug 2015	Open	N/A	Central Operations	Central Operations	Deputy Director of Operations	Deputy Director of Operations	Strat_HealthRecords_001	N/A	The health board should consider its progress towards electronic patient records which could assist with the current lack of storage for paper records.	Previous Health Board work undertaken on Digitalised patient records project to be reviewed and business case to be re-submitted for consideration as part of the capital bids programme	Jan-16	N/K	Red	10/03/2022- Deputy Director of Operations responded that there are a couple of complications to discuss before confirming if recommendation can be closed. Recommendation moved back to the main audit tracker from the Strategic Log and will be discussed with Deputy Director of Operations to establish if this recommendation can now be closed.
Thematic Review of Ophthalmology 2015/16	Jan-16	HIW	Thematic Review of Ophthalmology 2015/16	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	Director of Operations	Strat_ScheduledCare_001	N/A	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	N/K	Mar-22	Red	22/02/2022- SDM confirmed actions a & c completed. Action B will be addressed with the implementation of the Glaucoma clinics and the risk stratification work. 21/03/2022- Recommendation and action B re-opened on the main audit tracker.

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HIW_JTRCMHT	Feb-19	HIW	Joint Thematic Review of Community Mental Health Teams 2017-2018	Open (External Rec)	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	HIW_JTRCMHT_02 1	N/A	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection	The MH/LD Directorate continues its commitment to co-producing the implementation of its Transforming Mental Health Programme. A data and evaluation work stream has recently been established to review data gathering processes and develop means of continuous quality improvement. The UHB are being assisted by Swansea University. Ensure information systems are updated with a move to Welsh Patient Administration System (WPAS) anticipated this year, followed by migration to Welsh Community Care Information System (WCCIS) across health and social care services.	Dec-22	N/K	External	4/12/2020 update requested, response received: WPAS migration has been completed however some issues between the interfaces of the systems are being ironed out. 19/02/2021 This recommendation is partially completed by the HB. The HB has agreed with the Delivery Unit to deliver a presentation on any outstanding actions. Outlining the thematic actions that are considered unachievable. (Outside of gift of the HB). 12/10/2021 - CarePartner - integrated record system in place and being utilised. Have the facility to grant access to records to people should they need them. quality improvement is undertaken between operational services and QAPD. Ward Managers Forum (clinical) in place, and Community Management Forum being considered with relevant TORs to be updated to reflect this - forums where service improvements are being discussed. Standing agenda items such as PSOW reports, Level 1 incidents etc. Local Authority element of the recommendation remains outside of the gift of the HB. Phase 1 of WPAS has been completed, with CMHTs included in forthcoming Phase 2. 07/12/2021 - Local Authority attendance at twice daily meetings, and working collaboratively with the Health Board to ensure effective patient flow and managing patients in the community. The situation with regards CarePartner remains the same. 01/02/2022 - as per December update. WPAS and Care Partner in place, however confirmation needed from Digital re: the progress on WCCIS. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_014	N/A	R14:The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.	Clinical Directors to discuss the need for improved prescribing of oxygen with medical staffing. To provide training for ward staff on the use of oxygen therapy and prescribing.	Oct-19	~~Dec-20~~ ~~Jun-21~~ Nov-21	Red	Senior Nurse currently working alongside Senior Nurse for Medicines Management to devise training package. Will form part of wider HB approach to addressing training needs for all practitioners in relation to oxygen administration. Suspended due to Covid-19 pandemic. To rearrange for October 2020. 22/01/2021- Hospital HON confirmed she will check with clinical Directors that this was discussed with medical staff and will check training status. 19/02/2021- Hospital HON confirmed she will discuss with Dr. Ward to undertake audit of O2 prescribing. 26/03/2021- update from Consultant Respiratory -'the project should be complete within the next 2 months. Hopefully sooner. It may take a bit longer to organise an educational session, so a rough timescale of 2-3 months'. Revised timescale of June 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 11/08/2021- The doctors who were doing the oxygen QIP have completed the first cycle, they are handing over to the current team to complete. Hopefully within 2-3 months. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
19009	Sep-19	HIW	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019	Open (external rec)	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason / Kay Isaacs	Director of Operations	19009_007	N/A	The Health Board must ensure that their policy/s on the interface between DoLS and MHA is compliant in law to ensure it does not diverge from the principle in law	Following reviews of current legislation, interface guidance between DOL's and MHA will be developed and draft will be sent to HB legal department for review prior to ratification.	Jul-20	Apr-22	External	22/10/2020 response received Head of AMH to request information from Sarah Roberts Administration Manager, as whilst new legislation not due we can use what is current. Internal DOLS policy currently being used until new legislation in April 2022. 4/12/2020 Recommendation outside gift of Health Board until new legislation is in place. 12/10/2021 - review of the Mental Health Act, new legislation still being developed and will be looked at through the Mental Health Capacity Group. To send copy of the HIW report to Sarah Roberts for further review and discussion, and to possibly amend ownership and timescales for this recommendation as legislative changes will impact the whole Health Board and not specifically OAMHS. 07/12/2021 - Code of Practice consultation completed, however no new legislation in place. To set up meeting with Madeleine Peters to discuss the ownership of the recommendation. 01/02/2022 - as per December. RW to send on to Liz to discuss with Madeleine. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
19258	Jul-20	HIW	PACU and Cilgerran Wards, Glangwili General Hospital	Open	N/A	Women and Children's Services	Women and Children's Services	Paula Evans	Director of Operations	19258_015	N/A	R15: The health board must ensure that required staff are provided with up-to-date level two fire safety training.	Currently on hold for face to face training due to COVID, consideration for E learning or electronic platforms to deliver training	Aug-21	Aug-21 Dec-21 Jul-22	Red	18/09/2020 Request for update issued: Response: All fire training is completed via ELearning on ESR. 20/11/2020 issued for update: Service response: Due to Covid restrictions and social distancing the fire officer has agreed that fire safety training level 2 is to be completed via ELearning on ESR. 03/02/2021 DSN to check and establish any gaps in the training within the areas. 07/04/2021 escalated via DSN awaiting update. 27/05/2021 Face to face training reliant on relaxation of WG guidelines. 08/09/2021 Requested update on the number of outstanding staff in PACU and Cilgerran awaiting response. 23/09/2021 The acute paeds teams are at 82.61% for the fire e learning on ESR but this is lower than it should be as some of the face to face training done last month by Richard Jupp has not been imputed into the ESR records. Staff who attended to check their ESR records and contact Fire Trainer to
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open (external rec)	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	19097_026	N/A	R26: The Deprivation of Liberty Safeguards (DoLs) policy is updated to reflect the Liberty Protection Safeguards in line with the Mental Capacity (Amendment) Act 2019	Protocol drafted for managing the MHA/MCA interface. Currently out for consultation. Final version to be approved by the MCA and Consent Group	Aug-20	~~Aug-20~~ Apr-22	External	16/09/2020 Update received: SH advised A report on this is to be submit to the mental capacity and consent group next week for approval. It's been delayed as some of the key consultees in mental health haven't been available and the consent group hasn't met since February due to Covid response issues. If approved by the group next week it will still need to go for approval by the equivalent Mental Health scrutiny group, I'm not sure when they next meet. Further progress to be issued next week. 6/11/2020 update received from DOLS Co-ordinator. We have a DoLS policy that is within its review date. LPS will be completely new legislation and the DoLS policy will become obsolete on its introduction as it completely replaces DoLS. The work on the interface could be added to the current DoLS policy as an appendix detailing procedures to be followed, it can then be added to a future LPS policy as very similar issues will remain under the new legislation. Unable to provide a new date
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	Open	N/A	Women and Children's Services	Women and Children's Services	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_026	N/A	Consider the implementation of a live PSAG display feed, to enhance patient handover	Process for handover is in place – copied and scanned on a daily basis. Explore an All Wales approach. WG Directive	Mar-22	Mar-22	External	15/03/2021 - this recommendation while raised in the initial report has not been included in the required template for completion by HIW (see p43 of original report) 19/03/2021 Report included as part of normal scheduled request for updates. 19/03/2021 Process for handover is in place – records are copied and scanned on a daily basis. Explore an All Wales approach. WG Directive (outside gift of HB) 26/05/2021 Manual processes in place at HB, this recommendation is changed to external as PSAG is being led by WG. 12/07/2021 No change to recommendation awaiting WG solution. 30/11/2021 No change to recommendation awaiting WG solution. 02/02/2022 - no further update - awaiting WG solution. 22/02/22 Update received from ward area, Whiteboard installed to provide information in meantime.
20136	Apr-21	HIW	Quality Check: Morlais Ward, GGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	20136_001a	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Morlais is classified within C4C as significant. The most recent audit was undertaken on the 25th February 2021. A detailed action plan is being compiled to identify the extent of repairs required and to establish a target cost, funding source and an achievable timescale for completion. The initial analysis will be undertaken by May 2021 with subsequent action (subject to funding approval) phased in following the bid and approval process. In the event capital funding is unavailable to address these concerns then the service will escalate accordingly.	May-21	~~May- 21~~ ~~Nov- 21~~ Jan-22	Red	19/05/2021 Operations Manager Confirmed: We commenced the redecoration work in the area on the 11/04/21 , this work is due for completion on the 18/07/21 The bathroom refits required capital funding , which was approved last week 11/05/21 (Completed) Capital funding approved. We are in the process of completing a multi-quote to appoint a contractor for this element of the work. This type of sanitary wear tends to have a significant lead to delivery date , so we have allowed 8 weeks. Anticipated commencement on site 16th August 21 -completion 15th November 21. 31/05/2021 Recommendation revert back to Amber as not completed until Nov 2021. 4/06/2021 Recommendation is now Red. 07/09/2021 - confirmation from ward manager received that no bathroom refits/work had started in August. Recommendation to remain red. 29/11/2021 - confirmation received that redecoration work is now complete, however there has been a delay in receiving new toilet pans due to required specifications. Expected delivery date of end of November, with anticipated completion following delivery of January 2022. Update 23/02/22 Works currently underway to change broken toilets and sinks in en-suite bathrooms. Update required from Simon Chiffi for further information as lead for this action.
20136	Apr-21	HIW	Quality Check: Morlais Ward, GGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	20136_001b	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Outside of this specific challenge within Morlais, The Estates team are phasing in a new Synbiotix system (already in place in other Health Boards) that will allow real time data, reaction and improvements in efficiency in cleaning standards. This system is being phased in throughout the 2021/22 financial year.	Mar-22	Mar-22	Amber	19/05/2021 New system delayed, although the C4C work identified is being progressed and capital funding has been approved work is likely to be completed November 21. 29/11/2021 - update received that work is due to be complete by March 2022, in line with original completion date provided to HIW. Recommendation therefore to remain Amber. 23/02/2022 update Unaware of update regarding synbiotix system. I believe operations manager is leading on this action and will have further information to update.

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20136	Apr-21	HIW	Quality Check: Morlais Ward, GGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	20136_002a	High	The health board must review the training data and provide assurance that staff have up to date skills and knowledge to provide safe and effective care as well as reviewing the training data to ensure the reports provide an accurate and current compliance figure.	As a result of the Covid-19 pandemic, all face to face L2 fire safety training has been suspended until further notice. This position is being reviewed regularly as to when L2 face to face sessions can resume.	N/K	N/K	Amber	19/05/2021 Awaiting WG relaxation of current of social distancing rules to be approved prior to face to face training being recommenced. 07/09/2021 - Fire training has recently commenced via Microsoft Teams and members of staff are booking on and attending 29/11/2021 - 21 staff of the 30 on the ward have now undertaken the fire training and a further session has been agreed with the Ward Sister and Head of Fire Safety Management scheduled for the week of 29th November 2021 to complete the training for the remaining 9 members of staff. Update 23/02/22 Significant percentage increase of compliance since return of training via microsoft teams.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	Jun-22	Amber	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_001b	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Point of Ligature, Major works to be completed. Plans currently out to tender. Construction Phase 1 on target to be commenced 15/11/21. Phase 2+3 to be commenced 03/01/22, completion expected April 2022.	Apr-22	Apr-22	Amber	16/11/21 - MHLD PoL Capital Works Meeting - Edmunds & Webster have been assigned the contract, and waiting for Finance to approve. Construction Stage to start on the 22/11/21. 22/10/21 - Fire Stopping Meeting - Fire Stopping works are to start on the 08/11/21 and the PoL works to start on the 22/11/21 working parallel with each other, as majority of work is outside with minimal work on the ward. 09/11/21 - Pre-Contract Meeting with Contractors 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in April 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_002a	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	To comply with IPC and Fire Safety, all furniture on ward to be replaced, including waste bins and patient mattresses. Procurement process has commenced realistic timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ Dec-21	Red	17/09/21 - Supplier visited ward for list of required furniture for the ward. 20/09/21 - Quotation received from Supplier. 01/10/21 - Meeting with Senior Nurse and Ward Manager to verify everything was on the list. 04/10/21 - Contact with Procurement for placing order on Oracle. 14/10/21 - Chasing Procurement for the delay, checking on the Supplier with the NHS Framework which was verified that day. 25/10/21 - Gareth Rees Final Approver approved procurement order. 28/10/21 - Procurement send through that all had been approved and PO sent to supplier. Supplier contacted that furniture will be delivered end of
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ Jan-22	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_010b	High	During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	To note the current policy in relation to FoC is still in use and staff are working closely with WAST colleagues to minimise the risk of skin tissue damage when there are delays in line with current policy.	Mar-22	Mar-22	Amber	16/02/2022 Previous management response - This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Where appropriate the ED nursing staff will undertake intentional rounding paperwork on patients whilst on the ambulance. Patients are turned on the trolleys in the ambulance if they are delayed with offload for more than 1 – 2 hours. Additional suitable equipment is being sought by the Health Board for use during offload delays.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_011b	High	WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	To note the current policy in relation to FoC is still in use and staff work closely with WAST colleagues to ensure patients who are delayed in ambulances maintain adequate nutrition and hydration in line with current policy	Mar-22	Mar-22	Amber	16/02/2022 Previous management response - This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Where appropriate the ED nursing staff will undertake intentional rounding paperwork on patients whilst on the ambulance. Patients are turned on the trolleys in the ambulance if they are delayed with offload for more than 1 – 2 hours. Additional suitable equipment is being sought by the Health Board for use during offload delays. Ensure that food and drink is available to the patients if clinically appropriate.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	Mar-22	Amber	23/02/2022 (BGH) - The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. Doctors' rotas reviewed every day to ensure appropriate cover. The Executive Director of Patient Experience and Quality agreed that if ED have to surge into minors, then one additional RN to be put on duty for nights.

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20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_015	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_016	High	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_017	High	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_018	High	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_019	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_020	High	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03b	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	There has been a meeting with WAST colleagues in January representatives from each HB were in attendance. An agreement was reached that each HB shared their self – assessments with WAST and the ADN f or WAST would meet with HIW to discuss next steps	Dec-21	~~Dec-21~~ N/K	Red	16/02/2022 Previous management response - Audit tool to be introduced to support the evaluation. 23/02/2022 (BGH) - Beginning of February 2022, a digital system for handover is being used by doctors. EPCR team have been at BGH from 8th February 2022, providing training for the Terrapace portal web.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03c	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	There has been a meeting with WAST colleagues in January representatives from each HB were in attendance. An agreement was reached that each HB shared their self – assessments with WAST and the ADN f or WAST would meet with HIW to discuss next steps	Mar-21	~~Mar-21~~ Mar-22	Red	16/02/2022 Previous management response - • The family liaison officers (FLO's) Are present in ED across the HB, these have a role in ensuring that there is good communication being maintained between the patients, staff and relatives. The Health Board are reviewing these roles and consideration will be given to extending funding 23/02/2022 (BGH) - Designated Team Leaders on every shift, and Family Liaison Officers are present in ED to improve the process of handover. Frailty team at front door will undertake an assessment on the ambulance and determine whether admission is required or if community support is more appropriate. ENP's, see, treat, assess and discharge using the Manchester Triage Tool shared with WAST.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03d	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Health Board would look at other organisations practices and roles, which are not embedded into our current service delivery models and would welcome further discussion with WAST, other HB's and HIW in relation to this.	Dec-22	Dec-22	Amber	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	Mar-22	Amber	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been set up chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_07b	High	WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	There has been a meeting with WAST colleagues in January representatives from each HB were in attendance. An agreement was reached that each HB shared their self – assessments with WAST and the ADN f or WAST would meet with HIW to discuss next steps	Jan-22	~~Jan-22~~ N/K	Red	17/11/2021 - to confirm with Louise O'Connor what the process is on this for feedback from F&F 16/02/2022 Previous management response - There is a requirement to ensure that information received from these services are constantly reviewed to support identification of themes and trends. 23/02/2022 (BGH) - BGH continuing to share feedback to WAST colleagues. Staff are encouraged to report delays and concerns via the Datix risk management system. Patients are informed of the Health Board's PALS service, with leaflets being provided to patients on how to raise a concern/complaint.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	Mar-22	Amber	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_001a	High	R1a. The health board must ensure that in addition to being offered hand wipes, staff must ensure that patients clean their hands before and after meals and after using the toilets.	Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes of meeting will be circulated to all staff to evidence discussion.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.

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21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_001b	High	R1b. The health board must ensure that in addition to being offered hand wipes, staff must ensure that patients clean their hands before and after meals and after using the toilets.	Implement observational audits on the ward to monitor as part of monthly programme.	Dec-21	Dec-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_004	High	R4. The health board must ensure that a who's who board is installed on the ward.	The Health Board is in the process of implementing who's who boards in all areas. A Who's who board will be put in place on the ward as part of HB roll out.	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_005	High	R5. The health board must ensure patient documentation is fully completed including transfer of care and discharge planning.	Added to agenda for discussion at next Clinical Development meeting arranged for 10th November 2021. Notes of meeting will be circulated to all staff to evidence discussion. Documentation audits undertaken by senior staff, this will be added to the audit.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_007	High	R7. The health board must ensure that results of the feedback should be made known to patients, in a prominent position on the ward.	This information will be anonymised and displayed on a new ward noticeboard which has been ordered.	Dec-21	Dec-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_008	High	R8. The health board must ensure that staff are made aware of how the feedback process works in practice.	This will be a standing agenda item for staff meetings. Notes will be circulated after the meeting to all staff to evidence discussion and displayed on notice boards. Observational audits are also undertaken by the QAST team and spot checks from nursing teams will provide assurance this is taking place.	Dec-21	Dec-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_014	High	R14. The health board need to ensure that sepsis training is evidenced on the electronic staff record and all staff receive relevant sepsis training.	The e-learning element of Aseptic Anti-Touch Technique training is embedded in ESR but the sepsis training, ALERT, is not recorded there. Staff are now being rostered on to the ALERT training study days as they become available and staff released to attend.	Mar-22	Mar-22	Amber	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_016	High	R16. The health board need to ensure that all daily nursing checks are completed in full.	This will be audited as part of nursing checks to support assurance these are being completed. Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes will be circulated after the meeting to all staff to evidence discussion.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_017	High	R17. The health board must ensure that the use of red trays is made known to staff and the trays are used appropriately.	Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes will be circulated after the meeting to all staff to evidence discussion.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_019	High	R19. The health board must ensure that the patient nutrition charts are completed fully after each meal.	Add to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Implementation of observational audits and spot checks on the ward to monitor as part of monthly programme.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_021	High	R21. The health board must ensure that medication must be properly controlled when opened, included who has used the medication.	This will be added to monthly medicines management audit. Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November and notes made available for all staff.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_023	High	R23. The health board must ensure that processes are in place • To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to.	Health Board policies are communicated and followed on the ward by Nursing management. Datix system used to report all incidents and the Speaking up Safely Policy is also available to all staff should they need to raise any other concerns. All staff have been made aware of the values of the HB and that any instances of discrimination would be treated in line with HB policy. Added to agenda for discussion at next staff meeting on 24th November 2021 and notes of meeting will be released to evidence discussion.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_024	High	R24. The health board must ensure that processes are in place to ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken.	There are policies and procedures within the Health Board to support staff being treated equally and fairly. Speaking up safely policy has been introduced in the Health Board and this will be re-iterated to staff in meetings November 2021.	Nov-21	Nov-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_025	High	R25. The health board must ensure that appraisals are completed for all staff in a timely manner.	At a glance monthly Compliance sheet being devised for Ward Sisters' reference and audit and action accordingly. This will enable ease of monitoring to ensure 100%compliance is achieved. Staff are aware of requirement to complete mandatory training and supported to do so. Monthly compliance sheet will support monitoring this.	Dec-21	Dec-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.

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21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_026	High	R26. The health board must ensure that staff complete their mandatory training in a timely manner.	At a glance monthly Compliance sheet being devised for Ward Sisters' reference and audit and action accordingly. This will enable ease of monitoring to ensure 100% compliance is achieved. Staff are aware of requirement to complete mandatory training and supported to do so. Monthly compliance sheet will support monitoring this.	Dec-21	Dec-21	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_028	High	R28. The health board must ensure that measures are put in place to improve the wellbeing of staff, in light of some of the less positive responses to the questionnaire.	Staff support services clearly displayed in Staff area and is to be discussed in next staff meeting. Further wellbeing sessions currently being arranged within the ward area.	Sep-22	Sep-22	Amber	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_1	High	HIW requires details of how the health board will assess and address all risks to fire safety within the unit. HIW is not assured that all environmental risks within the service are managed appropriately.	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Mar-22	Mar-22	Amber	21/12/2021 - Awaiting confirmation from Richard Jupp, Head of LD sent chaser on 21st December. 20/01/2022 - Walk around took place on 19th January, good progress made, some final areas to be addressed once re-decoration is complete. Separate fire assessment completed, with decoration works currently on track 27/01/22 - Walk arounds have been undertaken in January 2022, and fire assessment completed, with noted actions to be addressed once redecoration has been completed. Decoration works are on track for completion by March 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_10	High	The health board must provide assurance that long term segregation or seclusion is appropriately managed within the confines of the Mental Health Act (1983) and in keeping with individual patient care plans, to ensure and allow opportunity for personal skills growth and development.	The unit is divided into 3 independent care areas each with it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired.	Jun-22	Jun-22	Amber	21/12/2021 - Factual accuracy completed to advise that this was incorrect: The unit is divided into 3 independent care areas each with it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired 20/01/2022 - noted that no response from HIW received relating to the comments raised in the factual accuracy form, which queried this recommendation. 26/01/2022 - noted that separate flats are all open access, with no locked doors. 27/01/2022 - The MHLD Seclusion Procedure is currently under review by the Consultant Nurse, Reducing Restricted Practice Lead and Senior Nurses. The procedure will include guidance on long term segregation or seclusion in line with the Mental Health Act. The first draft is expected to be reviewed at the Written Control Group in March 2022, with final ratification expected in May 2022. An implementation plan will also be presented alongside the procedure for ratification, demonstrating how this will be enacted and adopted going forward. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_11	High	The health board must ensure that staff wear appropriate health care uniforms for the role and care needs of the patient group and setting requirements.	Learning disability services do not wear uniforms, as uniforms are regarded as an additional barrier to supporting individuals with a learning disability and emphasise the 'them and us' culture which services are trying to move away from	Mar-22	Mar-22	Amber	21/12/2021 - Factual accuracy completed to advise that this was incorrect: Learning disability services do not wear uniforms, as uniforms are regarded as an additional barrier to supporting individuals with a learning disability and emphasise the 'them and us' culture which services are trying to move away from. 20/01/2022 - noted that no response from HIW received relating to the comments raised in the factual accuracy form, which queried this recommendation. 27/01/2022 - A service specification for Ty Bryn is currently being developed, and the issue and recommendation regarding work wear will be considered and captured within it. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_12a	High	HIW requires assurance from the health board that: • Every effort is made to gather patient voice data on their views of the service provided by the setting • Patients are able to provide feedback on their experiences of physical restraint.	Develop an Easy Read version of the Patient Experience Questionnaire, linked to the friends and family test	Apr-22	~~Apr-22~~ Jun-22	Amber	21/12/2021 - on track for completion by April 2022 20/01/2022 - On track for completion by April 2022. This pilot form was devised September 2021 and used once (prior to patient moving and subsequent closure of unit). We will continue to use once reopened, and review. The intention is that the form will be used on site and post-discharge. Feedback will be captured and presented to MHLD QSE on a bi-monthly basis. Dream Team (group of individuals with Learning Disabilities who help inform our service development) have agreed to support gathering patient experience data post discharge. With regards to providing feedback on their experiences of physical restraint, MHLD is in communication with the Reducing Restricted Practice Lead to consider what would be the most effective method of capturing this detail for those with a learning disability. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_2	High	HIW requires details of how the health board will ensure that the environment is adjusted and maintained to ensure that environmental triggers to challenging behaviours are reduced and to allow patients access to suitable outdoor space.	A capital bid was submitted to Welsh Government, this was successful, works have been approved and will commence in January. This includes a secure boundary fence to facilitate access to outside space.	Mar-22	Mar-22	Amber	21/12/2021 - Capital bid agreed, work to commence on new fencing and internal works in the New year 26/01/2022 - start date has been delayed due to contractor requiring isolation due to covid in staff team. Due to recommence early February, and expected to meet the March 22 deadline. 27/01/2022 - Work is due to commence early February 2022, with a view for works being completed by March 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_4a	High	HIW requires details of how the health board will ensure the risk to patients from ligature within the setting will be managed and avoided to prevent harm to patients at the setting.	A capital bid was submitted to Welsh Government, this was successful, works have been approved and will commence in January. This includes a ligature free secure boundary fence to facilitate access to outside space.	Mar-22	Mar-22	Amber	27/01/2022 - Work is due to commence early February 2022, with a view for works being completed by March 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_5	High	HIW requires details of how the health board will ensure the building is property maintained in order to prevent the risk of harm to patients and staff.	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Mar-22	Mar-22	Amber	21/12/2021 - A detailed action log has been developed: remaining works: Replacement doors, delivery est 8-10 weeks, completion date end Feb 22 Emergency lighting has been reviewed and minor works costed to be completed end Feb 22 Assessment of Trees – new fence will come inside of the tree line, so preventing access by patients. Additional works: New sink and cladding to shower in bathroom Guttering has been repaired/replaced as required. 26/01/2022 - updated fire assessment completed. 27/01/2022 - Works are ongoing, with completion expected by March 2022 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_6a	High	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	A full training needs analysis will be completed once the inpatient model has been developed and approved. This work is currently ongoing.	Feb-22	Feb-22	Red	21/12/2021 - Workshop held to scope new service model, further work ongoing to develop a service specification, workforce plan and training needs analysis. 20/01/2022 - Draft service specification for approval at written control group 25th January 2022 (approved). 26/01/2022 - All staff in work completed fire training and dedicated time to be secured for returning staff. Staff training plan in place currently booking speakers will commence mid February. 27/01/2022 - Training needs analysis has been drafted and currently out for consultation with staff. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.

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21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_6b	High	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	All staff will update their mandatory training and be given experience of other services to inform future practice.	Mar-22	Mar-22	Amber	21/12/2021 - Temporary deployment of staff commenced, training given in PBM and other training needs will also be met. Some staff now also deployed to support vaccination programme 26/01/2022 - Staff meeting fortnightly to update on progress still working to March date but dependent on works. 27/01/2022 - All staff currently in work have completed fire training, and dedicated time is to be secured for returning staff. Staff meet fortnightly to update on progress being made on training. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_8	High	The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients at the setting.	Once the purpose and function of the unit is established, staffing levels will be assessed, reviewed and implemented as part of the workforce review.	Feb-22	~~Feb-22~~ Mar-22	Red	21/12/2021 - no update provided. 20/01/2022 - Draft service specification completed for approval at written control group and consultation will commence, with the aim of finalising by end March 2022. 27/01/2022 - A draft service specification has been completed and submitted to Written Control Group, and approved in January 2022. The specification is now within a consultation period, with the aim of finalising by March 2022
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_9b	High	The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.	Staff wellbeing are developing a structured programme of support for the staff ongoing, these will be in the form of reflect and act sessions. These are opportunities to listen to staff and learn from their experiences be able to understand what underlying needs there are, and look at how best to support.	Feb-22	~~Feb-22~~ Jun-22	Red	21/12/2021 - Planned, commencing in January 2022 Relationships Manager supporting HoS to look at other ways to improve support for staff. 26/01/2022 - Workforce and Organisational Development are conducting 1:1 meeting with staff, and this will be a continual process so as to allow staff to air concerns. In addition, fortnightly staff meetings are being held with good attendance, and staff are also being asked to comment and shape the future service model. Workforce modelling has commenced, with draft job roles and descriptions being defined. Once finalised, these will be required to go through the formal health board processes for approval. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_01a	High	The Health Board must ensure that cleaning schedules include a brief comment to explain any exceptions or omissions	Ward cleaning schedules have been amended to include comments and will be operationalised from January 2022	Jan-22	Jan-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_02c	High	The Health Board must: • Update their standard operating procedure to formalise and standardise the process for the movement of staff from ward to other areas of the hospital site. This should include a risk assessed approach towards staff's personal circumstances • Update the COVID-19 symptom reminder signage to better reflect the breadth of COVID-19 symptoms.	Ward sister and Senior nurse will place staff movement as an item on the next ward team meeting	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_03b	High	The Health Board must ensure: • The reason why medication is not administered is recorded appropriately • That oxygen is prescribed and recorded • That controlled drugs are countersigned at all times.	Oxygen to be prescribed to be addressed in the next scrutiny assurance meeting 21st December 2021 and Hospital Governance meeting 8th February 2022	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_04b	High	The Health Board must recommence senior nurse manager (matron) audits at the earliest opportunity. The Health Board must ensure that there are processes in place to ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated.	The Deputy Head of Nursing for PPH and the Hospital Clinical Director will remind staff of the support services available to them at the next (Feb 2022) Professional Nurse Forum meeting and the via Medical Staffing.	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_04c	High	The Health Board must recommence senior nurse manager (matron) audits at the earliest opportunity. The Health Board must ensure that there are processes in place to ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated.	The Deputy Head of Nursing for PPH and the Hospital Clinical Director to bring to the attention of staff the availability of Equality training, BAME network meetings, and Speak up Safely as a mechanism for raising concerns at the next (Feb 2022) Hospital Governance meeting, the next (Feb 2022) Professional Nurse Forum meeting and via Medical Staffing.	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.

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21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_05b	High	The Health Board must provide a written narrative or policy for the risk assessment and / or redeployment decisions regarding registered nurses across the site. The Health Board must capture any additional or refresher training needs.	Ward sister and Senior nurse will place staff movement as an item on the next ward team meeting	Feb-22	Feb-22	Red	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Workforce & OD	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_05c	High	The Health Board must provide a written narrative or policy for the risk assessment and / or redeployment decisions regarding registered nurses across the site. The Health Board must capture any additional or refresher training needs.	Head of Education & Training to review the TNA process with the aim of capturing refresher training needs. This will be done as part of the review of the Clinical Education Framework currently underway and the implementation of the wider review of TNA processes.	Mar-22	Mar-22	Amber	31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_001	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_002	N/A	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_003	N/A	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_004	N/A	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_005	N/A	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_006	N/A	Health boards need to consider how they can strengthen links between services to improve access and provision for individuals needing support for their mental health and well-being.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_007	N/A	Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	Management response being prepared by the Directorate	N/K	N/K	Amber	

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HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_008	N/A	Health boards need to consider how they can strengthen the role and involvement of the third sector to improve the range of provision for individuals needing support for their mental health and well-being.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_009	N/A	To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_010	N/A	Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_011	N/A	Health boards and Welsh Government should consider benchmarking mental health services across Wales to identify good practice and positive initiatives and to share learning.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_012	N/A	All health boards should consider how mental health crisis teams can be more accessible to emergency services, to help provide advice and/or timely care and support to people with urgent mental health needs.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_013	N/A	Health boards, emergency services and primary care services should consider how mental health staff can be incorporated within emergency call handling teams across Wales, to enable early advice and support to people who need urgent care or support for their mental health.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_014	N/A	Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_015	N/A	Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_016	N/A	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	Management response being prepared by the Directorate	N/K	N/K	Amber	

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HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_017	N/A	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_018	N/A	Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.	Management response being prepared by the Directorate	N/K	N/K	Amber	
HIW_20220303_NR MHCP	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	N/K	Director of Mental Health	HIW_20220303_NR MHCP_019	N/A	Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.	Management response being prepared by the Directorate	N/K	N/K	Amber	
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_002	High	The health board is required to inform HIW of the action taken to provide information to patients of their replies to surveys, with actions taken on feedback	As above. Information board to include a 'you said .. we did' section updated monthly. This will be rolled out in radiology departments across all four acute sites	Jun-21	~~Jun-21~~ Sep-21	Red	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021. 23/09/2021 - A notice board has been ordered and is due to arrive by the end of September. This will display patient and staff feedback. We are also working with the Head of Culture and Workforce experience team to align staff experiences with patient experiences. 10/02/2022 - confirmation received that "You said, we did" boards in place at PPH, with other sites awaiting receipt of theirs. To confirm progress in February 2022 Radiology service update 09/03/2022 - update received the link to patient experience has been added to the shared drive for staff members to use and have widely distributed this information across all modalities. We are in the process of making the 'you said we did' notice board in the waiting area to display feedback to patients and to provide information for patients on how to give feedback. The service has nominated a radiology assistant to take this up. It has been very difficult to get this done within the initial specified timeline due to the critical service needs/staffing.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_005	High	The employer must ensure that the audit programme and associated documentation includes timeframes and frequency for the audits, how the findings were shared and how recommendations were actioned. In addition, there must be reference to when re-audit was required following the implementation of change.	To be discussed and updated at the RPG in April 2021 All findings will be shared at the RPG and Radiology Quality Safety and patient Experience group	May-21	~~May-21~~ Nov-21	Red	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021. 23/09/2021 - RPG did not take place due to managerial changes. This will now take place in Nov. A Radiology health board wide programme will be implemented - this will be pulled together by new RSM when in post. 10/02/2022 - Audit programme for PPH has been compiled, with confirmation required from other sited. To confirm progress in February 2022 Radiology service update 09/03/2022 update received Audit pathway has been included in the recent updated employers procedure (Dec 21) The work on this is ongoing. Discussed at RPG and site leads are formulating a plan of action going forward. A meeting is to be arranged to discuss and implement the action. *This needs wider discussion with Site Leads and Head of Radiology
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_010a	High	The employer must ensure that a detailed analysis is completed, including themes and trends of accidental or unintended exposures including near misses. This should include what actions had been taken to enable shared learning and identify what changes were implemented in practice to improve patient safety	Annual review and analysis of all relevant incident submissions to be undertaken and presented to the RPG (the new Once for Wales Concerns Management System (OfWCMS) has improved concerns codes which will allow for capturing of radiology related incidents and theming of the learning).	Apr-22	Apr-22	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021. 23/09/2021 - To be reviewed and agreed at RPG Nov 2021 10/02/2022 - all site leads tasked to analyse Datix themes, trends and learnings identified and to feedback to RPG. To request further progress as part of the February 2022 Radiology service update 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in April 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_012	High	The employer must ensure that the employers procedures for theatres are updated to include how benefit and risk information is communicated to patients prior to the exposure.	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	May-21	~~May-21~~ ~~Nov-21~~ Jun-22	Red	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021. 23/09/2021 - To be reviewed and agreed at RPG Nov 2021
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_004	High	Quality of the patient experience - The health board should ensure that arrangements are in place to provide staff and patients with regular updates on the patient experience feedback received by the service, as well as any subsequent actions taken.	Arrange and display information of the patient feedback service on the waiting room notice board. 'you said, we did' section in response to comments/feedback. To communicate with staff at regular staff meetings	Dec-21	Dec-21	Red	16/11/2021 - Still updating the display within the waiting room, now have access to patient feedback service where staff can electronically upload feedback including cards. On target for December completion 09/02/2022 - no further progress to note at this stage, confirming with the service for a revised completion date 09/03/2022 - In the process of making the 'you said we did' notice board in the waiting area to display feedback to patients and to provide information for patients on how to give feedback. Radiology assistant nominated to take this up. It has been very difficult to get this done within the initial specified timeline due to the critical service needs/staffing.

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21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_012	High	Delivery of safe and effective care - The employer must ensure that training and competency records are maintained for all duty holders working within the department, including practitioners, non-medical referrers and those staff providing medical physics support.	Ensure that practitioner and non-medical referrer and medical physics training records meet competency requirements and undergo regular review. Work to develop an electronic version which can be both read, updated and signed by users	Oct-22	Oct-22	Amber	16/11/2021 - Risk raised on Datix in relation to electronic document management (1269). In lieu of a central electronic document management system, the service is uploading items to Teams as a file, with the same approach expected to be taken for EPs. 09/02/2022 - completed, and creating a folder on the Radiology shared drive as well for electronic version. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_026	High	Delivery of safe and effective care - The employer should ensure that information is available setting out the capacity requirements and scope of practice for MPEs that provide advice and support to the department.	This is currently in progress, with completion of the recommendation expected by March 2022.	Mar-22	Mar-22	Amber	16/11/2021 - New Head of Radiology to determine the role of the MPE within the Health Board 09/03/2022 A new service level agreement between Swansea Bay UHB and Hywel Dda UHB for radiation physics services from 1 April 2022 is about to be issued for HDUHB approval. This agreement covers HDUHB services for X-rays and radioactive materials and includes scope of MPE support. A separate agreement for MRI physics services is about to be issued for HDUHB consideration. Hywel Dda has been receiving a limited service from radiology since November and the new agreement (starting from 1 April 2022) will offer the full range physics services including patient, staff and environmental risk assessment, scanner QA programme and support for complex sequences.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_036	High	Quality of management and leadership - The health board must ensure that all staff working within the department receive regular appraisal discussions with their line manager, which cover their training and development requirements.	This statement has been challenged within the factual accuracy. New site lead in post who is attending PDR training 14.10.21, after which a programme will be rolled out to update all outstanding PDRs within Radiology WGH	Mar-22	Mar-22	Amber	16/11/2021 - Site Lead has received PADR training, and therefore able to undertake PADR training for staff on site. 09/02/2022 - PADRs are currently being undertaken 09/03/2022 - New site lead has worked hard to engage with staff and has completed PDRs with all modality leads. We are working hard recruiting agency staff in order to get up to date with mandatory training, governance and audit alongside the extreme service and clinical pressures. We have made excellent progress with this.
HDUHB-1718-34	Feb-18	Internal Audit	National Standards for Cleaning in NHS Wales	Open	Reasonable	Estates	Digital and Performance	Rob Elliott	Director of Operations	HDUHB-1718-34_001	High	R4 • C4C audit methods and practices should be actioned by all Domestic Supervisors to ensure C4C are consistently thorough across all sites. • Audits should be planned ahead and noted on schedules and rotas to ensure audits are completed and do not get overlooked if a member of staff is away or on secondment. • If a member of staff is absent during the 48 hours following an audit, an alternative Domestic Supervisor should be deployed to check that the action plan arising from the cleaning audit has been completed in the functional area. • PMS should be asked to remap the rooms on the software and make amendments to the system so it accurately reflects the functional areas being audited. This will mean that the C4C system will be more user friendly and	inspecting C4C Audits across the Health Board in order to ensure that consistency is appropriately applied. Due to the imminent release of the new MICAD System and C4C upgrade along with the revised National Cleaning Standards for Wales 2009, planned for April 2018, all domestic supervisors will be retrained which will present an opportunity to address any non-consistency in audits and reduce any subjectivity. It is also planned to implement rotation audits across sites and comparison made to further assure consistency by the Soft FM Compliance Manager. Careful planning will ensure Nursing and Estates staff are advised in advance of the audit times and dates to ensure they are able to attend. Supervisory cover will be allocated in the period following the audit, to ensure all relevant action plans are	Jun-18	~~Mar-22~~ Sep-22	Red	04/03/2021-Director of Estates, Facilities and Capital Management confirmed that in the last couple of weeks that new software SYNBIOTIX to replace current C4C system has been agreed. Implementation is planned to take place Q3/4 of 2021/22. 10/05/2021- There are concerns with a possible delay in IT implementing the new software, Assistant Head of Operational Facilities Management to check with IT for update. This recommendation was previously noted as an external recommendation and has since reverted back to Red (behind schedule) as it is now within the gift of the Health Board to implement. 10/06/2021-Regular dialogue taking place with Head of Digital Operations and Assistant Director of Digital Services. 27/08/2021- Full rollout on soft FM for 2 acute sites will hopefully be achievable by March 2022, but all 4 sites is likely to take longer (including all the clinical staff being up to speed on accessing the help desk function to access portering services etc.). A"Synbiotix Project Group" is to be established, and involvement of key catering / soft FM personnel as the UHB build the delivery of this project. Revised timescale of September 2022 included on the tracker, If progress is quicker than estimated the completion date will be brought forward. 15/09/2021- this recommendation has been dependent on implementing hardware, etc which has been outside the gift of the Estates team.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Digital and Performance	Digital and Performance	Patrycja Duszynska	Director of Finance	HDUHB1819-33_001	Medium	R1. Management should ensure the Corporate Records Management Strategy and Policy are submitted to the Business Planning & Performance Assurance Committee for approval.	Following internal discussions, the Corporate Office is leading the review and updating of the Corporate Records Management Strategy and Policy. This will require contributions and input from a number of teams across the UHB. Once reviewed, these will be submitted to the Business Planning & Performance Assurance Committee at the earliest opportunity.	Sep-19	~~Sept-20~~ ~~Jan-21~~ ~~Mar-21~~ ~~Apr-21~~ ~~Jun-21~~ ~~Aug-21~~ ~~Oct-21~~ Dec-21	Red	04/02/2021- Structured review of Records Management to be included in 2021/22 IA plan. 15/03/2021- Head of Information Governance confirmed this policy will be taken to IGSC in April 2021. 13/05/2021- Digital Business Manager obtained update from Head of Information Governance - the policy is in draft at the moment and will be reported to the next IGSC in June 2021. 30/06/2021- Policy now being reported to IGSC in August 2021. 28/07/2021 - This work has been undertaken by Information Governance in collaboration with the Corporate team and the paper is ready to be submitted to the August Information Governance Sub-Committee (IGSC). To be closed once report received at IGSC. 28/09/2021 - An updated Policy will be presented to the October meeting of IGSC 22/10/2021 - A draft policy has been circulated to the Chair of IGSC however a final revision policy will be presented to December 2021 IGSC 04/11/2021 - Policy is currently under final review and scrutiny by Digital Director (4th review of the document) and on schedule to be presented to IGSC at its December meeting. 11/01/2022 - formally received at December IGSC, and while awaiting final approval at February SRC, the recommendation has been implemented.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Central Operations (Records Management) / Digital & Performance	Steven Bennett	Director of Operations	HDUHB1819-33_003	High	R3. We would recommend that management review current storage arrangements to establish whether they continue to be fit for purpose, whilst consideration should be given in the progression of other solutions for example, scanning of documents, to reduce the amount of manual health records retained by the Health Board.	In November 2018 a records management brief was presented to the Executive Team highlighting a number of issues in various services across the Health Board. In addition to the issues a number of potential solutions were identified which could significantly improve current storage arrangements, increase efficiencies and also provide some potential savings. A follow up paper is being presented to the Executive Team on the 19th December 2019 and within the paper it clearly identifies future arrangements to deliver the solutions. The proposal is to have one overall project group with Executive leadership, with working sub group responsible for carrying out the work. As part of this process all services involved will be completing a detailed review of their current records management arrangements, storage arrangements and storage capacity. The project proposal should be finalised early in the new year.	Mar-19	Jul-21	Red	22/10/2020 - update as per follow up report issued to ARAC in October 2020: In October 2019, a Health Records Management Report was submitted to the Business Planning & Performance Assurance Committee providing an update on the progress made with the health records modernisation programme. The programme established a Health Records Management Group and five key workstreams. The Health Records Management Report also provided an updated of the work being/to be undertaken with the key theme of storage capacity (and the reduction of manual records) running through the workstreams. An update paper was submitted to the Executive Team meeting in March 2020 providing an update of the health record modernisation programme and also a request for additional resource to create a dedicated Programme Management Office Support to aid in the development of the workstreams. However, since February 2020 the progress of the workstreams to address storage capacity within the organisation has been paused due to the impact of Covid-19. Timescale unknown. 08/12/2020- Health Records Manager update-The Health Records Manager sent a global reminder to all Health Board staff, however currently due to
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Central Operations (Records Management) / Digital & Performance	Steven Bennett	Director of Operations	HDUHB1819-33_004	Medium	R4. Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.	As identified in the recommendation above following a report reviewed by the non pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of the scoping working the groups will be required to identify any records outside of retention guidance and the relevant	Mar-19	Jul-21	Red	22/10/2020 - update as per follow up report issued to ARAC in October 2020: The previous report identified a disparity between department and services on the compliance of record retention and destruction. We can confirm that the Health Records Manager issued a reminder to all staff of their responsibilities to adhere to the Retention and Destruction of Records Policy in February 2019 via the global email system. In addition, the retention and destruction of records was identified as a key theme within the workstreams established by the Health Record Modernisation Programme. However, as noted above, due to the impact of Covid-19 the progress of the Health Record Modernisation Programme was temporarily paused in February 2020. Timescale unknown. 08/12/2020- Health Records Manager update- There is a possibility that we may be able to provide some joint IG/Health Records training in 2021. The training possibility is currently under review and will be assessed in line with current covid protocols, guidance and hospital rates. Further meetings are
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Central Operations (Records Management) / Digital & Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs	Mar-19	N/K	Red	22/10/2020 - update as per follow up report issued to ARAC in October 2020: The previous report identified two recommendations for the finding of third party storage providers: *To review the current storage arrangement with third party providers; and *To establish what information is stored with third party storage providers and that retention and destruction of information is done within guidelines The storage of Health Board documents and records by third party providers was another key driver of the Health Record Modernisation Programme. Whilst we noted the formation of the Health Record Modernisation Programme and workstreams to address this issue, since February 2020 this work has been paused due to the impact of Covid-19 on the organisation. Timescale unknown. 08/12/2020- Health Records Manager unable to provide revised timescale at this time- discussions taking place with Internal Audit team around suggestion to audit specific areas and make those service leads and identified Information Asset Owners responsible for taking forward the actions. 04/02/2021- Structured review of Records Management to be included in 2021/22 IA plan.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Central Operations (Records Management) / Digital & Performance	Steven Bennett	Director of Operations	HDUHB1819-33_007	Medium	R7: Management should establish refresher sessions to ensure existing staff receive records management training.	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.	Feb-19	Jun-21	Red	22/10/2020 - update as per follow up report issued to ARAC in October 2020: The Health Records Manager confirmed that following a departmental review it was decided that Health Records employees did not require additional refresher training due to department induction and on job training. The Welsh Health Records Management Group have had initial conversations on the production of an 'All Wales' training programme but it is still very much in its infancy with little progress made to date. In addition, there is no resource at present in the Health Board to deliver refresher/update training locally. Timescale unknown. 08/12/2020- Health Records Manager update- we are going to change track slightly following a meeting with the IG team. It has been agreed refresher training in records is not required but the IG team may now have capacity to support joint training with us and we are going to undertake and assessment in February with a view to implementation middle of next year. I will be adding this as an action on my risk register. 04/02/2021- Structured review of Records Management to be included in 2021/22 IA plan. 12/03/2021- Head of IA confirmed that the recommendations from the Records Management IA report could be closed following agreement that there will be an in-depth review of records management in the 2021/22 IA Audit Plan. 28/02/2022 - Briefing paper noted and states management action not addressed - Current findings - The situation on training has not progressed due
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Central Operations (Records Management) / Digital & Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section2. Management should establish what information is stored with the third party storage providers and that the retention and destruction of information is being undertaken in line with the Welsh Government arrangements.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year)	Mar-19	N/K	Red	22/10/2020 - update as per follow up report issued to ARAC in October 2020: The previous report identified two recommendations for the finding of third party storage providers: *To review the current storage arrangement with third party providers; and *To establish what information is stored with third party storage providers and that retention and destruction of information is done within guidelines The storage of Health Board documents and records by third party providers was another key driver of the Health Record Modernisation Programme. Whilst we noted the formation of the Health Record Modernisation Programme and workstreams to address this issue, since February 2020 this work has been paused due to the impact of Covid-19 on the organisation. Timescale unknown. 08/12/2020- Health Records Manager unable to provide revised timescale at this time- discussions taking place with Internal Audit team around suggestion to audit specific areas and make those service leads and identified Information Asset Owners responsible for taking forward the actions.
HDUHB 1819-32	Oct-19	Internal Audit	Radiology Directorate	Open	Reasonable	Radiology	Radiology	Head of Radiology	Director of Operations	HDUHB1819-32-002	High	R8: It should be ensured that staff work on call or overtime hours in addition to their basic hours and not instead of. The full number of basic hours should be worked prior to receiving any payments for additional hours.	As per previous response, the on call arrangements are historic with the reasoning for this being the need to sustain out of hours services with the levels of staff available. However it is noted key staff are often away from the department on rest days and this is acknowledged as a significant issue with efficiency. Compensatory rest days count towards the basic hours with the current on call arrangements and as per previous response the system is to be reviewed with the task and finish group and staff consultation. Please note any staff member that works less than full time hours does not receive overtime payments until they reach normal working hours.	Apr-19	~~Aug-20~~ ~~Dec-21~~ Dec-22	Red	Further meetings have been held with leads from the programme management office in an effort to maintain momentum Another is scheduled to happen in August . In addition discussions in July have been held with Workforce and Organisational Development regarding the bespoke leadership training for the radiology site leads. Any changes to current staging rotas have taken into consideration new ways of working There however has been no opportunity to present developments to date or the revised staffing models to the executive team due to the response to Covid-19 . 24/08/2020- revised date of December 2021 date as this relies on a new system, substantial more staff and a whole radiology transformation. Update to be provided to ARAC in February 2021. 04/02/2021- Head of IA to check the detail of the recommendation to see if the original recommendation has been addressed. 26/02/2021- Update to ARAC Feb2021 meeting reports recommendation 8 as outstanding. This recommendation is connected to the historic arrangements for the radiography out of hours provision.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber- on schedule, Green-complete)	Progress update/Reason overdue
HDUHB-1920-05	Oct-19	Internal Audit	Welsh Language Standards Implementation	Open (external rec)	Reasonable	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	CEO	HDUHB-1920-05_001	Low	R1. Management should consider introducing a Welsh Language Standards e-learning module as part of the ESR training programme to ensure staff and managers understand their roles and responsibilities in line with the Standards.	The Welsh Language Services Team has contributed to a national piece of work being co-ordinated by Betsi Cadwaladr UHB and Shared Services, in the Once for Wales spirit of partnership, and the outcome is an e-learning resource. Timescale for this is currently unknown, but we plan to roll out once launched. In the meantime, we are targeting focused training and awareness and cascading through key teams.	Oct-19	~~Oct-20~~ ~~Apr-21~~ ~~Oct-21~~ ~~Dec-21~~ N/K	External	21/10/2020 update-Work is on-going at an All-Wales level to produce an e-learning module for all Health Boards. This has been delayed due to Covid-19, but the group plans to launch the new e-learning model in April 2021.It is anticipated that face-to-face corporate induction sessions will recommence within the next month (November 2020). Revised date of April 2021 provided. 28/01/2021 update-Work is progressing at an All-Wales level, with Hywel Dda UHB input, to produce an e-learning module for all Health Boards in Wales. This has been delayed due to Covid-19, but the group is on track to launch the new e-learning model in April 2021 by the amended deadline. Recommendation is currently outside the gift of the UHB to implement. 26/05/2021- Reporting officer confirmed no update provided at this moment but the UHB has inputted into the process. Welsh Language standards meeting due in June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 18/08/2021- At a recent All Wales Welsh Language Officers meeting (July 2021), Betsi Cadwaladr informed the meeting that the expected date for completion is October 2021.
HDUHB_1920_40	Mar-20	Internal Audit	IM&T Assurance – Follow Up	Open	Reasonable	Digital and Performance	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB_1920_40_003	Medium	R3. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	The business manager was able to supply a paper which was produced for the Executive Team in June 2019, this paper evidences that work is underway to address the noncompliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence that this recommendation, to seek advice on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to is in train.	May-19	~~May-21~~ ~~Aug-21~~ ~~Oct-21~~ ~~Nov-21~~ ~~Feb-22~~ Apr-22	Red	28/07/2021 - The Digital Team have encountered a number of issues, outside of their control, which has affected the implementation of the new Switchboard solution. Therefore there has been a delay in the ability for lone workers (nights and weekends) to be able to have a compulsory break from the switchboard. The work is due to be completed by September/October 2021, in line with the wider network improvements within the Health Board. This will allow staff to switch over between sites to allow them to have a break. The system will installed on sites shortly to allow for training and testing and for the staff to become familiar with the new system before the full switch over. Work is also being carried out with the switchboard supervisors to look at streamlining processes and making information available across sites. 27/09/2021 - The completion of this recommendation is linked to the improvements on the network which has been delayed due to BT. The Health Board has been held up by the remedial work required to unblock a duct under the main road outside PPH, which required the council to dig up the road. This work has now been completed and we anticipate finalisation of the network upgrade by mid-October. Once the work outlined above has been completed, the Team will be able to release the required bandwidth for the Switchboard infrastructure to go live.
HDUHB-1920-10	Jun-20	Internal Audit	Business Continuity	Open	Reasonable	Public Health	Public Health	Sam Hussell	Director of Public Health	HDUHB-1920-10_001	Medium	R1. The Director of Public Health should review training processes currently in operation within the Health Board and ensure this is accurately reflected in the Business Continuity Planning Policy.	The Policy will be amended to reflect that training for BCM and associated TNA and record keeping has been replaced with hands-on-support, guidance and instruction by the Emergency Planning Team to individual(s) responsible for creating the BC Plan for each department.	Nov-20	~~Nov-20~~ ~~Jun-21~~ Dec-21	Red	Final version received at August 2020 ARAC. 27/11/2020 emailed requesting update 10/12/2020 Business Continuity Officer updated: The delay is due to Covid19, unable to give a predicted date as to when this will be completed. 05/02/2021 issued for update- Requested to check with Audit to see if the recommendation can be closed. Response received from audit all recommendations still require completion. Emailed CC - no response. 22/03/2021 Response received. Business Continuity Planning Policy reviewed and has been discussed the recommendations, added to, and updated the Policy. Policy to go to the People, Planning & Performance Assurance Committee. 23/03/2021 Head of Health Emergency Planning new date June 21.
HDUHB-1920-10	Jun-20	Internal Audit	Business Continuity	Open	Reasonable	Public Health	Public Health	Sam Hussell	Director of Public Health	HDUHB-1920-10_002	Medium	R2: Management should ensure the Business Continuity Planning Policy is reviewed and updated to reflect current processes and procedures before being submitted for approval at the People, Planning & Performance Assurance Committee	A review of the Health Board's Business Continuity Planning Policy was postponed earlier this year due to the Coronavirus outbreak. As we are still in response mode to this crisis, we agree to review the policy as it stands as an interim measure. The reviewing of this Policy was intentionally paused in the New Year following learning taken from the extreme pressures and sustained periods of escalation of the urgent care system, particularly during December 2019. It was proposed that we would develop a Business Continuity Framework to aid escalation and de-escalation during periods of high demand or pressure in the system. This work was taken over by events at the end of January / beginning of February 2020.	Nov-20	~~Jun-21~~ Dec-21	Red	Final version received at August 2020 ARAC. 27/11/2020 emailed requesting update 10/12/2020 Business Continuity Officer updated: The delay is due to Covid19, unable to give a predicted date as to when this will be completed. 05/02/2021 issued for update- Requested to check with Audit to see if the recommendation can be closed. Response received from audit all recommendations still require completion. Emailed CC - no response. 22/03/2021 Response received. Business Continuity Planning Policy reviewed and has been discussed the recommendations, added to, and updated the Policy. Policy to go to the People, Planning & Performance Assurance Committee. 23/03/2021 Head of Health Emergency Planning new date June 21. 21/05/2021 Requested update of outstanding recommendations, no response. Escalated to Director of PH with request for update by 11 June 2021. Awaiting response. 08/07/2021 EP Officer emailed Policy Co-ordination Officer to advise this policy should be approved at PPPAC.
SSU-HDU-1920-02	Jun-20	Internal Audit	Glangwili Hospital Women & Children's Development Phase 2	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_006	High	R6: In accordance with the NEC contract, the external advisers should provide a detailed assessment report of the delays to date (to include contributing factors, programme and cost implications, acceptance / rejection etc.)	The Project Manager will produce a detailed retrospective assessment of the delays to date in accordance with the requirements of the NEC contract (to include cause, time/cost impact and determination of acceptance / rejection of delay etc.) (Update to Management Response June 2021- PM will produce a detailed retrospective assessment once the work on Section 1 and 2 of the scheme is complete. Completion date for Section 2 has been delayed.)	Jul-20	~~Aug-21~~ ~~Oct-21~~ ~~Feb-22~~ Mar-22	Red	28/05/2021- Head of Capital Planning confirmed PM will produce a detailed retrospective assessment once the work on Section 1 and 2 of the scheme is complete. Completion date for Section 2 has been delayed. No revised timescale received. 09/06/2021 & 09/07/2021- Meeting with Internal Audit, the report will be prepared at the end of Section 2., which is currently scheduled for the end of July 2021. 22/07/2021- Internal Auditor confirmed recommendations 6 & 8 are linked to one another and are unlikely to be concluded until the end of August 2021 and the end of the current stage of the project. 11/08/2021 & 08/09/2021 update- Section 2 completion has been delayed to September 2021. 06/10/2021- end of Section 2 is further delayed, quantum of latest delay needs to be assessed prior to completion of report. Revised date of November 2022 provided. 29/10/2021 It is estimated that Section 2 will not be complete until December 2021 at the earliest the report completion will be undertaken at this point.
HDUHB2021-11	Sep-20	Internal Audit	Governance Arrangement during the Covid-19 Pandemic	Open	Advisory	Governance	Workforce & OD	N/A	Board Secretary	HDUHB2021-11_010	N/A	Ensure there is a fully updated record of staff movement / redeployments.	Not included in report, following update provided in TOA from December 2020 Audit Committee:	N/K	Dec-21	Red	25/05/2021- Audit tracker will be updated once update has been reported to ARAC. 10/08/2021 - update received as follows: This will require further discussion/consideration as there is no straightforward solution that could easily be implemented. The Workforce team attempted to log all staff temporary movements during Covid (deployments) although Directorates tended to deploy in real time and sometimes on a shift by shift basis. The Workforce team were therefore unaware of numerous movements which had already been effected by local Line Managers. Managers did not utilise ESR to log changes due to the regularity and volume of staff movements which would have made it a cumbersome exercise. We will undertake to establish how other HB's handles this issue. 14/09/21 update received the Operational Workforce team will now establish how many staff remain on deployment from their substantive roles, the reason and the location of temporary role. Discussions will then take place with substantive ad interim Line Managers in order to determine likely duration. It is proposed that staff change forms will be completed for all current and future deployments of over 8 weeks duration in order to help track movements and to enable substantive Line Managers to backfill. Discussions need to take place with Directorate service teams and Trade Unions and therefore it is estimated that this process will be complete by end of Dec 21.
HDUHB2021-11	Sep-20	Internal Audit	Governance Arrangement during the Covid-19 Pandemic	Open	Advisory	Governance	Workforce & OD	N/A	Board Secretary	HDUHB2021-11_012	N/A	Additional specific guidance in relation to staff working at home including, the need to maintain privacy when using video conferencing and the storage of any hard copy documents.	Not included in report, following update provided in TOA from December 2020 Audit Committee:	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC. 10/08/2021 - update received as follows: The Agile working agenda is not being led from W&OD. Facilities are about to tender re some project management in order to build an infrastructure within the Health Board. The Home Working Policy does come under the remit of Workforce although will be reviewed as part of the HB wide initiative referred to above. 14/09/21 update received Facilities management are leading this initiative. Key design assumptions for the project will shortly be discussed with Execs and then submitted to Board at end of Sept. The T&F group met 13/09.21 – Workforce are part of this group and will ensure that any policy change is addressed as part of the actions.
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Strategic Development and Operational Planning	Rob Elliott	Director of Operations	SSU-HDU-2021-08_001	High	R1. PBC's should include appropriate funding strategies and plans to manage maintenance and backlog maintenance which will arise over the life cycle of the new (or repurposed) assets.	Agreed	Sep-21	~~Sep-21~~ Jan-22 N/K	Red	01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 02/07/2021- Recommendation owner changed to Assistant Director of Strategic Planning following discussion with Internal Audit. 31/08/2021- email from Internal Audit confirmed the recommendation should sit with Assistant Director of Strategic Planning as it relates to the PBCs for the new and repurposed buildings. 08/09/2021- Head of Capital Planning in discussion with internal audit on ownership of recommendation. 08/11/2021- Meeting arranged to discuss ownership of recommendation. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog) and Assistant Director of Strategy & Planning is responsible for everything which is within the AHMMW programme. The PBC for AHMMW is being drafted for Board. The PBC for the Major Infrastructure (keeping existing Estates safe) are to be drafted. Once PBCs confirmed this recommendation can be closed. 06/01/022- Revised date of February 2022, hopeful information to be reported to Board in January 2022 on the PBC for AHMMW will allow this to be closed. This recommendation will be reviewed with Internal Audit following the Board meeting.
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_002	Medium	R2. The PBCs and as they progress to Outline and Full business case stages will need to determine the in-house Estates staff requirements, and how these will be satisfied given current pressures.	Agreed. The Health Board will need to determine how the necessary Estate in-house staff resources is established in order to successfully deliver the AHMWW and Business Continuity/Major Infrastructure PBCs.	Feb-21	~~Feb-21~~ N/K	Amber	06/05/2021- Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses, which is dependent on WG decision. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 08/11/2021- Meeting arranged to discuss ownership of recommendation. Action to be changed from external to amber as this is a future action that cannot yet be evidence as completed, but is within the gift of the HB to implement. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_003	Medium	R3. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Urgent but un-related works arising subsequently in the same time frame.	Agreed. It is recognised that such works will arise and will additionally need funding in the same time horizon as the discretely funded works of each business case. This will be taken into account at detailed design stages of BJCs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC.	Sep-21	~~Sep-21~~ N/K	Amber	06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). 15/09/2021- This recommendation is for future action and can only be demonstrated once the BJCs or OBCs are produced therefore will remain amber. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_004	Low	R4. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Co-located issues (known, or discovered following invasive works).	Agreed. It is recognised that such works will arise and will additionally need funding in the same time horizon as the discretely funded works of each business case. This will be taken into account at detailed design stages of BJCs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC.	Sep-21	~~Sep-21~~ N/K	Amber	06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). These recommendations can only be demonstrated once the BJCs or OBCs are produced.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU_HDA_1920_01.1	Feb-21	Internal Audit	Capital Assurance- Follow Up	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Paul Williams / Rob Elliott / Anthony Tracey / Julian Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_001	Medium	R1. Cardigan Integrated Care Centre (original R1): Clarification should be provided to differentiate between the Project Group quorum, members and attendees.	Superseded: Noting that the Cardigan project is now complete and handed over, a Post Project Evaluation (PPE) should be undertaken to identify lessons learnt (including an assessment of Internal Audit recommendations and their application at future projects). Specifically issues identified at the Cardigan project i.e. • Inclusion of quoracy arrangements in approved Project Group terms of reference; • Development of full activity based resource plans for all stages of the project which should be subject to regular review; • The regular review and update of the Project Governance Framework throughout a project's duration; and • Preparation of management control plans at the outset of projects.	May-19	~~Jul-21~~ ~~Oct-21~~ ~~Nov-21~~ Mar-22	Red	14/04/21, 09/06/21 & 09/07/2021- Planning Project Manager update- Post project Evaluation for Cardigan ICC has been delayed due to COVID-19. It has been agreed with WG that the Cardigan PPE/Gateway 5 Review will now be undertaken in October 2021. 11/08/2021- Initial meeting with WG has been held, outcome WG will now contact Assurance Hub to arrange the Gateway 5 review, now likely to be in Nov 21. Internal PPE will be concluded in advance of the Gateway 5 review. 08/09/2021- Work on the internal PPE has commenced. 29/10/2021- Internal PPE report will be presented to CEIM&T in November 2021. 05/01/2022 & 02/03/2022- Report presented to CEIM&T in November 2021. Gateway 5 PPE evaluation to be carried out in March 2022. Internal Audit confirmed this recommendation remains open until evidence can be provided following the evaluation. 07/03/2022- Head of Capital Planning sent qoracy actioned on existing project to Internal Audit, awaiting confirmation if Internal Audit now happy for this recommendation to be closed.
SSU_HDA_1920_01.1	Feb-21	Internal Audit	Capital Assurance- Follow Up	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Paul Williams / Rob Elliott / Anthony Tracey / Julian Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_002	Medium	R4: Bronglais Front of House: The planned post project evaluation (PPE) exercise for the Bronglais Front of House development will consider the issues raised in the prior Bronglais audit reports as follows: • An evaluation of the adequacy of design solution for the development; • Confirmation (or otherwise) that the original business case assumptions remain valid, or implications will be assessed; and • performance against the targets of the business case will be assessed.	Outstanding At the time of issuing this report, the completion of the Front of House scheme was scheduled for June 2020. This is the end of the defects period for the final phase [Theatre Evacuation lift]. The Project Director will lead the completion of the PPE by March 2021.	Sep-19	~~Mar-21~~ ~~Sept-21~~ ~~Jan-22~~ Mar-22	Red	23/02/2021 - as per this new follow up report follow up of SSU_HDA_1920_01.2), recommendation outstanding as follows: The Project Director will lead the completion of the PPE by March 2021. The recommendation was previously considered to be outstanding from the previous follow up report. 04/03/2021- more realistic date of September 2021 provided, this work has been delayed due to other work prioritised due to Covid-19. 14/04/21, 09/06/21 & 09/07/2021- Planning Project Manager update- Post project Evaluation for BGH Front of House has been delayed due to COVID-19. It has been agreed with WG that the FOH will be an internal PPE and a date needs to be agreed with the County Team. 11/08/2021 and 08/09/2021 update- The conclusion of this review will be reported to CEIM&T in January 2022. 05/01/2022- this is the initial stages with an update being provided to CEIM&T in January 2022. Approx. completion date of March 2022 (date of
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP-SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ Jul-23	Amber	26/05/2021 no update. 09/06/2021 in progress. Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract.
HDUHB-2021-01	Apr-21	Internal Audit	Health & Safety	Open	Reasonable	Nursing	Nursing (Health and Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality and Patient Experience	HDUHB-2021-01_003	Medium	R3. The Health and Safety Team should submit their annual audit programme and approach taken to the Health & Safety Assurance Committee for discussion.	A formal audit programme shall be devised and presented to the Health and Safety Assurance Committee for discussion.	Jul-21	Apr-22	Red	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021. 06/07/2021- Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. 27/09/2021- lead officer confirmed this has not been submitted yet but he will double check. 21/11/2021- progress update requested 08/11/2021, no update received as yet. 29/11/2021- Head of Health, Safety & Security doesn't recall that this has been implemented. Will check if this has been completed at the next agenda setting meeting in March/April 2022. Head of Health, Safety & Security to write formal plan to be reported to next HSC. 09/02/2022- Head of Health, Safety & Security to write formal plan to be reported to next HSC meeting. Once reported this recommendation can be closed. 15/03/2022- emailed Head of Health, Safety & Security to confirm if this recommendation can now be closed following the HSC meeting. Awaiting
HDUHB-2122-07	Aug-21	Internal Audit	Field Hospital Decommissioning	Open	Advisory	Central Operations	Central Operations	N/K	Operations Director	HDUHB-2122-07_001	N/A	Management should undertake a 'lessons learned' exercise with key individuals across the field hospital commissioning, operation and decommissioning phases in order to identify what went well and what could be done differently, not only for similar projects but potentially also in the operation of acute hospital settings.	The Executive Director of Operations, the Field Hospital management team and other Health Board senior managers welcome this Internal Audit advisory report into the decommissioning processes relating to the field hospital portfolio. The opportunity to embed the learning recorded in this report into future practice in whatever form that might take is an opportunity not to be missed if the Health Board is to improve on similar processes in the future.	Jun-22	Jun-22	Amber	13/09/2021- Agreed at ARAC August 2021 that the management lead and timescale for the 'lessons learnt' exercise to be undertaken would be provided in the Table of Actions. Tracker to be updated once Table of Actions are shared. 19/10/2021 - Update for October 2021 ARAC meeting: The Deputy Director of Operations was party to an initial planning meeting, on 6th October 2021, where the approach to a follow-up workshop involving a broader representation of colleagues involved in the Field Hospital campaign was determined. The workshop is expected to take place in October 2021; the output will be a short report on lessons learned. A recap will follow after the
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_001	High	R1. The WLS Team should support directorates and services that have engaged with them to ensure the requirements of the Standards are embedded within their individual plans.	The Welsh Language Team to contact all directorates to offer support directorates to ensure that the Standards are embedded within their individual plans. The Health Board IMTP for 2022/23 – 2024/25 will include planning objectives in relation to compliance with the standards and are currently exploring through the transformation steering group where we want to go further to embrace Welsh Language and Culture.	Oct-21	~~Oct-21~~ ~~Dec-21~~ N/K	Red	25/09/2021- update requested from lead officer to confirm if this recommendation is on track to be implemented by October 2021. 02/11/2021- email has been sent to services and support has been offered but nothing forthcoming. CEO has requested an overarching strategic objective which is to be agreed. Update to People, Organisational Development and Culture Committee (PODCC) on 13/10/2021 confirmed work has commenced with regard to the strategic approach and ambition in terms of the Welsh language and would be incorporated within the next iteration of the HDdUHB Annual Plan as a planning objective which can be measured. 21/03/2022- Progress update requested 07/03/2022, no update received.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_002	High	R2. Management should assess the financial and reputational risk of non-compliance with the Welsh Language Standards on the risk register.	An assessment will be undertaken to establish whether the financial and reputational risk of non-compliance with the Welsh Language Standards have been captured on Health Board risk registers.	Mar-22	Mar-22	Amber	02/11/2021- A risk has been added to the Welsh Language risk register regarding compliance with the Welsh Language Standards. The UHB is not aware if all Directorates are complying with the standards, as not all Directorates have responded to the self assessment due to Covid-19 and other operational pressures. 21/03/2022- Progress update requested 07/03/2022, no update received.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_003a	High	R3.1 The WLS Team should chase up the outstanding directorates and service for their self assessment tool and escalate areas of non-engagement to the appropriate Executive Director	The WLS Team to chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director, and support directorates and services, who request it, in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	Sep-22	Amber	02/11/2021- it was advised by the CEO to stand down anything not absolutely critical to support the front-line teams. The Planning day for strategic objectives was called off.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_003b	High	R3.2 The WLS Team should support directorates and services in their development of action plans to address areas of non-compliance with the Standards.	The WLS Team will support directorates and services that engage with them in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	Sep-22	Amber	02/11/2021- The Welsh language team are supporting those teams who are engaging, in the development of their action plans.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_004	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	Mar-22	Amber	02/11/2021- Welsh Language Steering Group to be established once new Director is in post, who is due to join the UHB January 2022. 21/03/2022- Progress update requested 07/03/2022, no update received.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit	Open	Reasonable	Strategic Development and Operational	Strategic Development and	Daniel Warm	Director of Strategic Development and	HDUHB-2122-06_001	Low	R1. Management should ensure all planning objectives are referenced in future annual plans for completeness.	The planning process for the 2022/25 Integrated Medium Term Plan has begun. This includes a review of all Planning Objectives, and these will form the key deliverables for the Plan. The Health Board will ensure that all Planning Objectives are included in future iterations of the Plan.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- Paper going to Public Board 27/01/2022 for Planning Objectives 2022-25 for approval, which is the first part of the process. All of these planning objectives will feature in the IMTP, for onward submission to WG by end of March 2022.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	HDUHB-2122-06_002	Medium	R2. Management should ensure the structure and contents of submitted technical documents are consistent to enable key information to be aligned to the current year's strategic and planning objectives.	As part of the development of the technical documents to support the Integrated Medium Term plan, the Health Board will ensure that there is greater alignment to the strategic and planning objectives. To support this, guidance will be provided to all authors of the technical documents to ensure better alignment with the strategic and planning objectives.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- Guidance has been provided for the Technical docs supporting the IMTP, which will be clearly linked to the planning objectives, for onward submission to WG by end of March 2022.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	HDUHB-2122-06_003	Medium	R3. Management should ensure that 'Plans on a Page' for every planning objective is promptly developed and fully completed with key information before their submission.	The plans on a page for the 2021/22 Annual Plan will be reviewed to ensure all key information is completed. All new or revised Planning Objectives for the 2022/25 Integrated Medium Term Plan, will be supported by 'plans on a page'. The Health Board will ensure that all key information is completed prior to submission.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- 'Plans on a Page' being drafted for each planning objective, which will be completed by end of March 2022 for submission with the IMTP.
HDUHB-2122-20	Oct-21	Internal Audit	Mental Health and Learning Disabilities Directorate Governance Review Final Internal Audit Report	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll / Sara Rees / Warren Lloyd	Director of Operations	HDUHB-2122-20_001	Medium	Management should ensure complete and accurate terms of reference for the BPPAG and QS&EG meetings and supporting sub-groups are maintained and approved.	Agreed – The BPPAG will be reviewed and ratified, whilst the QS&EG TOR will be amended to reflect bi-monthly meeting in the coming weeks. In addition, a sub□group TOR tracker will be developed.	Oct-21	~~Jan-22~~ Apr-22	Red	11/11/2021 - The Terms of reference have been reviewed and updated and will be signed off at BPPAG meeting on the 25th November. QSEG TOR to be ratified at the next meeting. Work to be undertaken on sub group TOR 25/11/2021 - TOR agreed at signed off at BPPAG meeting today, with a review of TOR scheduled for the April BPPAG meeting, and on an annual basis thereafter 04/03/2022 - Draft TOR submitted for April meeting

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2122-20	Oct-21	Internal Audit	Mental Health and Learning Disabilities Directorate Governance Review Final Internal Audit Report	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll / Sara Rees / Warren Lloyd	Director of Operations	HDUHB-2122-20_003	Medium	Management should ensure a review and identification of potential saving schemes is undertaken to contribute to addressing the Directorate's financial deficit.	Whilst the directorate is currently underspent against budget, work is ongoing with Finance colleagues to scope and identify savings opportunities during 2021/22 and beyond.	Mar-22	Mar-22	Amber	07/12/2021 - IMTP process has been undertaken, to confirm progress with Liz C and Leon P.
HDUHB-2122-33	Oct-21	Internal Audit	Prince Philip Hospital Directorate Governance Review	Open	Reasonable	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Sarah Perry/ Melanie Long	Director of Operations	HDUHB-2122-33_003	Low	Management must ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.	Accepted – We will continue to ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.	Dec-21	~~Dec-22~~ Apr-22	Red	15/03/2022 - Staff have been reminded of their responsibility in relation to the Standards of Behaviour Policy, with all staff being reminded and notified via e-mail, and nursing staff to be updated at a forthcoming PNF meeting scheduled for April 2022
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001a	N/A	R1a. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page.	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	Mar-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms March 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001b	N/A	R1b. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page.	Task and Finish group to be established as part of the UEC programme under policy goal 6, to set consistent principles and standards, with staff reps from across HB community and acute and work through the recommendations together – appreciating that localities may have differing processes this group could share best practice and consideration given as to whether these practices can be taken forward across HB. This approach may also aid identifying training required.	Mar-22	Mar-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms March 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002a	N/A	R2a. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. Providing we are able to demonstrate delivery of those standards how the services are constructed should not matter. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	N/K	N/K	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC does not provide a timescale, to be confirmed with the service.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002b	N/A	R2b. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with	A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002c	N/A	R2c. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with	As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PG5 & 6 workstream.	Jan-22	N/K	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC does not clarify if action has been implemented, to be confirmed with the service.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003a	N/A	R3a. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised.	Following a recent staff survey one of the key recommendations is to develop better, very practical and locally delivered discharge planning training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003b	N/A	R3b. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process.	Important to note that there is still work to be done on data quality. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_006	N/A	R6. Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient	Apr-22	May-22	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms revised timescale of May 2022 in a phased approach. The audit tracker has been amended with the revised management response reported to ARAC.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_008	N/A	R8. Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_009	N/A	A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001a	High	R1a. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Continue to deliver formal training at the New Consultant Development Programme and any other relevant leadership/management development programmes for those responsible for staff in the Medical & Dental staff group to ensure recruiting managers are aware of their responsibilities and key performance indicators.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- Reporting officer confirmed this recommendation is on track- Training session is scheduled be delivered to the Medical Leadership Development programme (the next available session) in May 22. Training content will include an overview of the responsibilities of Recruiting Managers and an update on key performance indicators in order to deliver improvements. It has also been requested that a link to training animations which are already available on the L&D platform be published in the Medical Directors Newsletter ensuring easy access. These links will feature in the next issue of the Medical Directors newsletter which is due to be distributed in March 22.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001b	High	R1b. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	In addition to formal delivery of training, continue to promote access to virtual training which is already available on the intranet in '10 top tips' which covers preparing to recruit.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- Reporting officer confirmed this recommendation is on track- Lnks to virtual and information relating to any other available recruitment training are shared on the L&D platform as well as via global messaging, internal Facebook pages and the staff bulletin board. In addition wef March 2022, a link to recruitment training is added to the monthly KPI performance reports as a gentle reminder of the availability and access of training to those with a responsibility to recruitment New recruitment training is continuously being developed. Finally, a link to the recruitment training will feature in the Medical Director newsletter. The next edition will be distributed in March (and will feature the link).
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001c	High	R1c. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Develop further training including virtual Trac training which will reinforce the need to place vacancies on Trac at the earliest opportunity.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- Reporting officer confirmed this recommendation is on track-In addition to animations available to all staff, the recruitment team have training available which can be booked on via the L&D platform which includes Trac Training. This is further promoted via Global messaging, internal Facebook page and staff bulletin board. A link is also to be included in the Medical Directors Newsletter (next edition March 22) to ensure promotion is directly targeted. We are also including links to the training in the monthly KPI reporting as a gentle reminder of it's availability to those responsible for recruitment.

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HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001d	High	R1d. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Share Medical Recruitment KPI performance with other officers in the W&OD Directorate e.g. OD Relationship Managers, Medical Workforce Team, Workforce Efficiency team, Workforce Planning Team etc to encourage them to support the importance of timely recruitment when they liaise with managers	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- Reporting officer confirmed this recommendation is on track- Med Rec Monthly KPIs are sent to Director of Operations, Medical Workforce Team, OD Relationship Managers and Workforce Planning. This includes information relating to outliers (breaches). A direct link to recruitment training is also included within this monthly report as a gentle reminder of it's availability to those responsible for recruitment.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001e	High	R1e. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Explore the option of electronic leaver forms to trigger prompt actions to recruit in a more timely manner.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- Reporting officer has requested an urgent response from Deputy Digital Director.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001g	High	R1g. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Director of Operations to routinely address monthly KPI performance on Medical Recruitment at the Operational Leads Delivery meeting highlighting areas of improvement or deterioration and service areas where performance requires improvement.	Dec-21	N/K	Red	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- reporting officer confirmed Medical Recruitment monthly KPIs shared with Director of Operations. However only Director of Operations can comment as to whether he has routinely addressed monthly KPI performance on Medical Recruitment at the Operational Leads Delivery. 10/03/2022- advice requested from Director of Operations on implementation of this recommendation, awaiting response.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_002	Medium	R2. Management should undertake a targeted review of consistent bottleneck areas within the recruitment process and develop actions in order to promptly address medical staff vacancies.	Medical Recruitment Team to review consistent 'bottleneck' areas and develop an action plan to address them. Example areas will include a) starting salary process b) occupational health process c) notice periods d) immigration process. This list is not exhaustive as the review may identify other bottleneck areas which need to be addressed.	Jan-22	May-22	Red	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- reporting officer confirmed reviews underway for various bottle neck areas including: Starting salary process, vacancy approval process (electronic starter forms), CoS. Revised timescale of May 2022 provided.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_003	Low	R3. Management should undertake a review of the onboarding process and engage with key stakeholders to establish whether enhancements can be made to the current system.	As part of the recruitment pathway strategic objective the recruitment team are reviewing information shared with key stakeholders in a bid to improve the recruitment journey including onboarding/pastoral care. The medical recruitment team are also supporting the Medical Directorate in a piece of work to further explore candidate connections pre Day 1 and on/around Day 1 for the M&D staff group. The findings of this audit and the outcomes of the discovery stages of the above workstreams will be consolidated to develop an action plan which focusses on improvement to the onboarding process.	May-22	May-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this. 25/02/2022- reporting officer confirmed this is ongoing. A new welcome booklet is being created by Med Ed with support of Med Rec. A new working for us internet page is being developed (launch autumn 22), and onboarding correspondence under review.
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_001	Medium	The Health Board should ensure that all budget holders sign the Accountability Agreement letters, as evidence of accepting ownership of their individual budgets, in order that they can be held to account for the financial performance.	Through the annual financial planning process, all Accountability Agreement Letters should be signed no later than the end of two months into the new financial year.	Jun-22	Jun-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_002	Medium	Budget holders should be reminded of their responsibility to monitor and manage their budgets, and make use of the available tools to do this. Management should consider monitoring budget holder use of the BI Dashboards and QlikView systems.	Recognising the need for familiarisation with the reports and systems across budget holders, there are different methods employed by Finance Business Partnering teams to support their budget holders with how to access and review their financial information. Each FBP team should review the financial position monthly with their budget holders, in an appropriate manner, and ongoing training provided to ensure budget holders move towards a self-service approach.	Jul-22	Jul-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_003	Medium	All virements should be appropriately authorised in line with the stipulations of the Budgetary Control procedure, subject to a review of the current criteria within the procedure. Management should ensure that Section 3 of the Virement form is fully completed in line with the requirements of the Budgetary Control procedure.	All virements transacted across directorates, excluding funding allocations from reserves, should be accompanied by a fully completed and approved virement form, in line with Budgetary Control procedures, which will be managed by the Financial Officer within the Corporate Reporting and Planning team, who will store the forms at the same time as approving the budget adjusted in the budget system.	Apr-22	Apr-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
HDUHB-2122-42	Feb-22	Internal Audit	Follow-up: Deployment of WPAS into MH&LD	Open	Reasonable	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-42_001	Medium	2.1 Once a decision has been reached to progress the remaining service areas, the Project Group should undertake a detailed risk analysis of those areas and document any identified risks, and also develop a training plan as per the assigned action.	2.1 Agreed. The Project Team have been requested to consider the development of a risk analysis approach for future service areas, following the implementation within Integrated Psychological Therapies Service (due to go live during February 2022)	Mar-22	Mar-22	Amber	28/02/2022 - This report now supersedes HDUHB-2122-16. 17/03/2022 - On track for completion by March 2022
HDUHB-2122-42	Feb-22	Internal Audit	Follow-up: Deployment of WPAS into MH&LD	Open	Reasonable	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-42_002	High	4.1 Management should ensure that appropriately skilled and dedicated resources are assigned to the third phase of the project to ensure accurate system mapping and effective implementation.	4.1 The Mental Health and Learning Disabilities Team have assigned funding to recruit a Band 5 – Application Specialist, and a Band 6 – Business Analyst to assist with the third phase of the project.	May-22	May-22	Amber	28/02/2022 - This report now supersedes HDUHB-2122-16. 17/03/2022 - On track for completion by March 2022

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HDUHB-2122-42	Feb-22	Internal Audit	Follow-up: Deployment of WPAS into MH&LD	Open	Reasonable	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-42_003	Medium	5.1 Management should ensure that lessons learned are formalised.	5.1 Agreed. A lesson learned document will be completed during March 2022, which will incorporate the original phases of work, and the upcoming implementation within Integrated Psychological Therapies Service.	Mar-22	Mar-22	Amber	28/02/2022 - This report now supersedes HDUHB-2122-16. 17/03/2022 - On track for completion by March 2022
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001a	Low	1.1.a The Operational Waste Management Sub-Groups' terms of reference should be updated to reflect current governance arrangements.	1.1.a Update, circulate and obtain sign off from the Waste Management Group that amendment reflects current TOR.	Apr-22	Apr-22	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001b	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	Oct-23	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_002	Medium	2.1 Management should engage with appropriate departments / forums to present the benefits of wider awareness/recycling training across the UHB.	2.1 This action requires input from the Corporate Training team as cannot be delivered by the Environmental Team alone as outlined during the audit process, although the Environment team will provide full support to developing the modules specific to this training. We will bring this to the attention of the Health Board's Corporate Training Team and seek support for this to be added to the mandatory training modules operating within the Health Board. We will need to update as a future action on how this is delivered in future by the Corporate Training Team.	Mar-22	Mar-22	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_003a.1	Medium	3.1.a Relevant staff should be reminded that bin labels should correctly reflect the bin liner in use.	3.1.a Contact Ward Sister of Cadog ward at GGH referenced in the audit report, to highlight the importance of correct bin labelling to avoid over or under treatment of Waste. Provide bin and magnetic label codes.	Mar-22	Mar-22	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_003a.2	Medium	3.1.a Relevant staff should be reminded that bin labels should correctly reflect the bin liner in use.	3.1.a We will deliver required training with Clinical teams to address this action by Sept 2022.	Sep-22	Sep-22	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_003a.2	Medium	3.1.c Management should liaise with Hotel Services (locally / centrally) to promote consistent compliance with WHTM 07-01 in the approach to clinical waste segregation across the UHB.	3.1.c Carry out face to face training for Senior domestic staff on all Acute sites to ensure consistent application of WHTM 07-01 requirements across all sites.	Sep-22	Sep-22	Amber	
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_003b	Medium	3.1.b Offensive (tiger-stripe) waste bins should be provided in appropriate public areas to support compliance with the WHTM 07-01 in the disposal of face coverings worn by patients, visitors and non-clinical staff.	3.1.b Contact GGH Hotel Services Manger to review the number of bins at entrances and exits for disposal of PPE to ensure there are sufficient numbers to support compliance with WHTM 07-01 and WG guidance. Documented outcome will be completed by June 2022.	Jun-22	Jun-22	Amber	
HDUHB-2122-43	Feb-22	Internal Audit	Follow-up: Use of Consultancy	Open	Reasonable	Finance	Finance	Jennifer Thomas / Alan Binks	Finance Director	HDUHB-2122-43_001	Medium	1.1 Management should maintain a central register of consultancy engagements to inform the financial coding exercise undertaken by Finance and facilitate monitoring and reporting of consultancy spend. This would also assist the Health Board in ensuring that engagements are subject to the appropriate approval process in line with the Scheme of Delegation.	1.1 Management will maintain a register of consultancy contracts that will facilitate the reporting of consultancy spend in the annual accounts.	Apr-22	Apr-22	Amber	28/02/2022 - This report supersedes HDUHB-2122-10.
HDUHB-2122-43	Feb-22	Internal Audit	Follow-up: Use of Consultancy	Open	Reasonable	Finance	Finance	Jennifer Thomas / Alan Binks	Finance Director	HDUHB-2122-43_002	Medium	2.1 Consultancy usage and spend should be collectively reported to and monitored by the Sustainable Resources Committee.	2.1 Consultancy spend will be reported to the Sustainable resources committee.	Apr-22	Apr-22	Amber	28/02/2022 - This report supersedes HDUHB-2122-10.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_001	N/A	R1. Develop a Capital Project Management Framework	Work in progress	Feb-22	~~Feb-22~~ Mar-22	Red	07/01/2022- Completion date moved to align with appropriate CEIM&T date in March 2022.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0010	N/A	R10. For future complex schemes the UHB might want to consider the resourcing the additional scrutiny of the SCP	The Health Board will assess the risk at the commencement of the project FBC stage. The availability of funding from WG would also need to be tested and approved as part of the resource schedule for FBC development. This approach will be incorporated into the Capital Project Management Framework (see action 1) which will be used for all future complex schemes.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0011	N/A	R11. Consideration of Project Director role	Given the significant step up in the UHB's aspiration to deliver capital projects over the next few years Project Director roles for specific projects will be full or part time roles. On their appointment specific agreement for time allocation and resourcing and backfill will be agreed. The operational impact on costs will be reflected in the appropriate Appointment Certificates and the Executive Director signature whose portfolio the Project Director sits will confirm that they are satisfied with these arrangements if they are not the Senior Responsible Owner. The above steps will be incorporated into the Standardised Project Governance Documentation (see action 2).	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 2 (Standardised Project Governance Documentation).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012a	N/A	R12. Training for Project Director	For the Project Directors that will be appointed for the specific AHMWW projects specific training sessions will be organised and facilitated to include the WG Assurance Hub, NWSSP Audit and Assurance input. This approach will be incorporated into the Capital Project Management Framework.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012b	N/A	R12. Training for Project Director	For smaller Projects specific SRO/PD facilitated sessions with NWSSP Audit and Assurance will be organised. This approach will be incorporated into the Capital Project Management Framework.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012c	N/A	R12. Training for Project Director	Develop a PD Pocket Guide	May-22	May-22	Amber	07/01/2022- in progress.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0013	N/A	R13. Review the resourcing of capital projects for Project Director	As point 11 above- This will be incorporated into the Standardised Project Governance Documentation (see action 2).	Mar-22	Mar-22	Amber	07/01/2022- Timescale aligned with completion of recommendation 2 (Standardised Project Governance Documentation).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0014	N/A	R14. The process for the prioritisation of schemes for the Infrastructure Investment Enabling Plan	Work has already been undertaken on the development of a prioritisation matrix for the allocation of part of the UHB's discretionary programme. WG Planning Framework call out the need to prioritise the bids for All Wales Capital. The prioritisation framework will need to link with the • UHB Strategic objectives • UHB's Planning Objectives • Implementation of AHMWW Strategy	Jan-22	~~Jan-22~~ ~~Feb-22~~ Mar-22	Red	07/01/2022- Completion date moved to align with sign off as part of IMTP. 02/03/2022- A Report is being prepared for Executive Team to consider in March 2022 prior to a WG submission by 31/03/2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_002	N/A	R2. Develop Standardised Project Governance Documentation including a checklist for sign off and assurance	Work in progress	Feb-22	~~Feb-22~~ Mar-22	Red	07/01/2022- Completion date moved to align with appropriate CEIM&T date in March 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_007	N/A	R7. Setting up of an internal scrutiny process for business cases prior to them being finalised and presented to CEIM&T for approval	Develop a proposal and draft terms of reference for Executive Team discussion. This will cover how the process will be resourced and ensure upfront scrutiny and approval prior to CEIM&T submission	Mar-22	Mar-22	Amber	07/01/2022- In progress for discussion by Executive Team by March 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_008	N/A	R8. Consideration be given if CEIM&T and the Groups that sit underneath it should have delegated approval limit	Review the current capital approval framework documentation and delegated capital approval limits with the Governance Team. SBAR to May CEIM&T	May-22	May-22	Amber	07/01/2022- in progress.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber- on schedule, Green-complete)	Progress update/Reason overdue
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to
BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Haverfordwest, SA61 2BG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_003	High	R3. Compartmentation / Dampers Reinstate the fire resistance in the following location: • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devices are functioning in line with its design specifications and manufacturer's instructions. According to the action plan dated 02 December 2019 V2 these ongoing works are to be completed in the timescale of this Enforcement Notice	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	03/02/2021- MWWFRS confirmed that this enforcement notice now runs in line with the agreed completion dates of: Stage 1 Jan 2021 & Stage 2 April 2022. Recommendation turned back to amber. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated
BFS/KS/SJM/00114719- KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level	Full action plan held by Estates.	~~Apr-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 04/03/2021-on track as per agreed programme of work. 06/05/2021-still on track, UHB meeting with WG 07/05/2021 to establish when to start the work on ward areas. 18/11/2021- update to Health & Safety Committee 15/11/2021- At the current time, HDdUHB remains confident that the April 2025 date can be
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023. 02/03/2022- The current forecasted completion date is April 2023, however this will need to be closely monitored and reviewed as the project progresses. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. MWWFRS is fully
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_02	High	R2.Compartmentation – All Vertical Breaches and / or Penetrations. To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 2nd Oct 2020). Fire resisting structures are to continue to slab/ upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023. 02/03/2022- The current forecasted completion date is April 2023, however this will need to be closely monitored and reviewed as the project
KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/09_01	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 05/01/2022- update being reported to Health & Safety Committee January 2022- At this point, confidence remains that the April 2024 completion date is achievable, however this will be confirmed upon completion of the detailed Business Case work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme should the nature of the works dictate that an additional period becomes necessary. 02/03/2022- Phase 2 remains on programme to be completed by April 2024 (subject to the full due diligence work needed as part of the Business Case development).
BFS/KS/SJM/00107739-02	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_001	High	1.1 The areas visited in this inspection should be included into the current Compartmentation survey (areas listed at end of schedule)	Full action plan held by Estates.	Aug-24	Aug-24	Amber	01/07/2021- Letter dated 08/06/2021 from MWWFRS states 'To be completed in line with the agreed advanced, first and second phase works as mentioned within the document: Fire Precaution Upgrade Works Glangwili General Hospital, presented to us on the 6th Jan 2021'. Timescale of August 2024 added to tracker as this aligns with Phase 2 works completion date. 18/11/2021- Assistant Head of Operational Facilities Management confirmed residents have been written to and contractor has been confirmed to carry out work from end of November 2021 to March 2022. 10/01/2022- Survey work to be completed by March 2022.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Article 8, Item 1.1 Fire Doors- A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Item 1.2 Fire Doors- Self-closing devices on all fire resisting doors are to be checked and, if necessary, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Item 1.3 Fire Doors- All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Item 1.4 Fire Doors- All Fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance

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Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _001	High	Item 1.5 Fire Doors-. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _0011	High	Article 17, Item 1 Maintenance - Records must be kept of events, tests, or maintenance of the following equipment / installations. Records must be made available to an inspector during an audit: •Fire alarm system (and the link to maglocks) •Dry risers •Dampers •Suppression system	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. 15/11/2021- Revised action plan dated 09/11/2021 confirms work has been completed and estates now liaising with MWWFRS to sign off this work as complete, at which point this recommendation will turn to green. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _003	High	3.1. Item 3 Compartmentation. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout green block. This should include: - • All the vents above the fire doors	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee states further clarity needed from MWWFRS. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _003	High	3.3 Item 3 Compartmentation. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout green block. This should include: - • Fire stopping within the plant room level 1 and the dry risers	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee states further clarity needed from MWWFRS. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022-remains on programme for a January 2022 completion date. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _005	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure there is a suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ ~~Nov-21~~ Feb-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of end August 2021. 15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore chaser to be sent, assuming if no response received plan will be agreed by February 2022. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501 _007	High	Item 2 Emergency Lighting - An assessment should be undertaken to ensure that escape routes within the Green block escape routes and external staircase is illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Sep-21	~~Nov21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of mid November 2021. 23/09/2021- Revised action plan states 8/12 weeks required completion date, February 2022. 15/11/2021- Revised action plan dated 09/11/2021 confirms tender process is taking place with work to be undertaken by end of March 2022. Report to Health & Safety Committee 15/11/2021 confirm this is due to linkage of work to a wider HDdUHB programme to introduce energy efficient lighting within the estate. An action plan has been submitted to MWWFRS. 05/01/2022- update being reported to Health & Safety Committee January 2022- This remains on programme to be delivered by March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169 _001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edges and frames are to be no more than 3 mm	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169 _001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169 _001	High	1.3. Fire doors should only be kept open by magnetic devices that releases when the fire alarm operate.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169 _001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required.

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			Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER														Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169 _002	High	2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is
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Admin - General/00113168	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Hafren block of flats, Bronglais General Hospital,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113168 _001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work
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Admin - General/00113168	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Hafren block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113168 _001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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Admin - General/00113166	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113166 _001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3mm	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 15/11/2021- Action plan provided shows completion of work by June 2022.Report to Health & Safety Committee 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April
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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_001	High	Item number 1 Alternative Escape Route (Distances). Provide an alternative means of escape as the overall travel distance from Lizzy's and Norma's Rooms is excessive. This new exit would need to be constructed within one of the rooms mentioned, the LABC and Planning department need to be contacted prior to any works undertaken (follow the recommendations within items 2 & 3 and this item will then no longer be required to be undertaken as we will accept item 2 and 3 as a compensatory feature for this situation).	Full action plan held by Estates.	Mar-22	Mar-22	External	24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed.
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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_004	High	4.3 Item number 4 Doors Difficult to Open Change the key lock to a thumb turn type lock on the following doors: 2. Final doors within the conservatory	Full action plan held by Estates.	Mar-22	~~Nov-21~~ Mar-22	External	24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed.
BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_006	High	Item number 6 Alternative Escape Route (Distance) Continue the path from the conservatory to the other side of the premises as if residents and staff are forced to evacuate in this direction it would be difficult meaning they may become trapped.	Full action plan held by Estates.	Mar-22	~~Nov-21~~ Mar-22	External	24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed.
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Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work
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Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_002	High	2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes.	Full action plan held by Estates.	Mar-22	~~Mar-22~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work
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Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_003	High	3.1 The electrical fuse board within the cupboards should be boxed in by 30 minutes fire resistant OR All combustible materials should be removed from the cupboard.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ ~~Nov-21~~ Jun-22	Red	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan shared by Head of Operations provides target date of October 2021. 15/11/2021- Revised timescale of November 2021 provided. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is
Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500_001	High	Article 8, Item 1.1 Fire Doors - A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 07/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 07/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this
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Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500 _001	High	Article 8, Item 1.5 Fire Doors - All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance and Risk has requested update following this meeting.
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Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500 _008	High	Article 14, Item 1 Storage of Combustibles and Obstructions - All combustible materials and obstructions should be removed from the means of escape routes, internally and externally.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ ~~Jan-22~~ N/K	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of end August 2021. 15/11/2021- Revised action plan dated 09/11/2021 shows completion date of January 2022- RCD been installed as mitigation until further works completed. 10/01/2022- final checks being undertaken to close this recommendation. 07/03/2022- requested confirmation if this recommendation has now been implemented, awaiting response.
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _001	High	Article 8, Item 1.1 Fire Doors - A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _001	High	Item 1.2 Fire Doors - Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so that the doors close completely into their rebates.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _001	High	Item 1.3 Fire Doors - All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _001	High	Item 1.4 Fire Doors - All Fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _001	High	Item 1.5 Fire Doors - All fire door vents should be designed in accordance with the require British Standard.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance and Risk has requested update following this meeting.
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _003	High	Item 3 Compartmentation - An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Purple block. This should include: -	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Mar-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _004	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure there is a suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Oct-21	~~Sep-21~~ ~~Nov-21~~ ~~Feb-22~~ N/K	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498 _007	High	Item 2 Emergency Lighting - An assessment should be undertaken to ensure all external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Mar-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 23/09/2021- Action plan states target completion date 11/03/2022. 15/11/2021- Revised action plan dated 09/11/2021 confirms tender process is taking place with work to be undertaken by end of March 2022.
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499 _001	High	Article 8, Item 1.1 Fire Doors - A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance and Risk has requested update following this meeting.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499 _001	High	Item 1.2 Fire Doors - Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so that the doors close completely into their rebates.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process. 07/03/2022- UHB meeting with MWWFRS on 10/03/2022 to set out a full programme of delivery for remaining elements of work. Head of Assurance and Risk has requested update following this meeting.
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499 _001	High	Item 1.3 Fire Doors - All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process.
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499 _001	High	Item 1.4 Fire Doors - All Fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499 _005	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure that there is suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Oct-21	~~Sep-21~~ ~~Nov-21~~ ~~Feb-22~~ N/K	Red	15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore chaser to be sent, assuming if no response received plan will be agreed by February 2022. 07/03/2022- requested confirmation if this recommendation has now been implemented/ awaiting response.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_001	High	Item number 1 Doors: Ensure that all doors on exit routes are available and can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency. Door from stairwell to EBME requires to have a locking device linked into the fire alarm system	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year. 02/03/2022- An action plan have been developed to address the small number of items identified in this LOFSM. We have already secured funds in
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_002	High	Item number 2 Fire Resisting Corridors and Stairs: Ensure that all escape routes are kept free from fire and smoke at all material times by Moving the server unit from the staircase between the EBME and the access to hospital care and coordination (as mentioned in the previous FSM letter).	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year. 02/03/2022- An action plan have been developed to address the small number of items identified in this LOFSM. We have already secured funds in
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_003	High	Item number 3 Compartment: Reinstate the fire resistance in the following location(s) insert details so that fire and smoke cannot pass. • Electrical room within the plant rooms for both A+E and Theatres. • All under stairs cupboards (witnessed in Post grad to wd1 stairs, this includes the transom light and door to the cupboard (ADV Work??) and the cupboard	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year. 02/03/2022- An action plan have been developed to address the small number of items identified in this LOFSM. We have already secured funds in
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_004	High	Item number 4 Combustibles near Heat Source: General housekeeping within the room LGF049 was to a poor standard due to combustible items stored close to a source of ignition.	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year. 02/03/2022- An action plan have been developed to address the small number of items identified in this LOFSM. We have already secured funds in the 2022/23 financial year to complete this work by circa June 2022.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_005	High	Item number 5 Add Device to Alarm: Provide detection complying with BS 5839 part 1 – L1 linked to the existing fire alarm system in all under stair store cupboards. The changes should be carried out and commissioned by a	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small
RJD/KLJ/00106219	Jan-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	RJD/KLJ/00106219_ 001	High	Breaches in Compartmentation During the inspection breaches in compartmentation were identified above cross corridor doors and from services riser cupboard to protected means of escape. The breaches in compartmentation would not appear to support the	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
RJD/KLJ/00106219	Jan-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Prince Philip	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	RJD/KLJ/00106219_ 002	High	Fire resisting doors The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. Main Kitchen trolley doors	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00335079	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0033 5079_001	High	Electromagnetic locking devices on a fire escape door may be acceptable on the proviso that the door will be released on actuation of the fire warning and/or detection system of the premises and is backed up by the provision of a manually operated break glass point (typically coloured green) guaranteed	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00335079	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Prince Philip Hospital Diabetic Unit	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0033 5079_002	High	Drapes and curtains should not be provided across escape routes or exits.	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00335079	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0033 5079_003	High	Ensure Gardening teams are clearing final exits of leaves and gardening waste.	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00094205	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0009 4205_001	High	During the inspection breaches in compartmentation were identified from the following areas •Corridors to attic area	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00094205	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Ty Bryn Template 25 Prince Philip Hospital Dafen	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0009 4205_002	High	Emergency routes and exits must lead as directly as possible to a place of safety. The routes from patient bedrooms to the garden area does not support the safe evacuation of persons due to the pathway not allowing being wide enough to allow free travel of hospital beds. The evacuation strategy for the premises is to be immediately reviewed and	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00094205	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0009 4205_003	High	The findings of the premises fire door survey are to be implemented. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B volume 2 Buildings other than	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00094205	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0009 4205_004	High	Where it is necessary to use dangerous substances , such as, gas cylinders, they must be stored in a secure and safe location, for example, a properly ventilated fire-resisting storeroom. The CO2 and propane storage areas are to be included within the premises fire assessment (A3.4)	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
459/VEM/BFS/00094205	Feb-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety)Order 2005 Letter of Fire Safety Matters	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	459/VEM/BFS/0009 4205_005	High	An immediate inspection of the external parts of the premises is to be undertaken by a competent person to ensure the external areas are adequately lit in an emergency situation.	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	02/03/2022- A different approach from MWWFRS from elsewhere in the HDdUHB. On this site, the inspector is issuing individual notices on each area of the hospital visited. This is likely to involve 15 or more individual LoFSM. No indication of any escalation above LoFSM on this site. HDdUHB have met with the inspector to agree a pragmatic approach to the development of an action plan given that it is unlikely to receive all of the letters until circa end March 2022. MWWFRS are in agreement with this approach and a full action plan will be submitted following the receipt of all the LoFSM.
Peer Review: Respiratory Cancer Review 16/06/2016	Jun-16	Peer Review	Peer Review: Respiratory Cancer Review 16/06/2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	PeerReview_Resp_ 001	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	Ongoing	N/K	Red	10/02/2022 - Recommendation owner amended to reflect recent changes in SDM role. 21/03/2022- Report re-opened and rec 6 placed back on the audit tracker from the Strategic Log. New SDM in post has confirmed she will be reviewing this with the Clinical lead to review respiratory as a whole pathway, and a risk will be raised on Datix regarding the service. This will take place once SDM returns from annual leave.
Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Nov-16	Peer Review	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Open (external rec)	N/A	Women and Children's Services	Women and Children's Services	Margaret Devonald-Morris	Director of Operations	PeerReview-CYPDiabetes001	N/A	R1. Absence of a 24 hour on-call advice system	Discuss development of a regional / All Wales 24/7 helpline with other UHBs as a more cost effective alternative to UHB specific arrangements.	Mar-16	Dec-22	External	The new 24/7 system is to be developed and implemented at an All Wales Level. 5/10/2020 Response received. There is currently no progress on this recommendation as it is being taken forward at an All Wales level by the All Wales Network. 04/12/2020 No progress awaiting All Wales response. 27/01/2021 No progress requires an All Wales solution. 07/04/2021 SDM to establish who the links are. 12/07/2021 No progress awaiting an All Wales Network response. 14/12/2021 Awaiting All Wales solution

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PeerReview-OOH001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director.	Dec-19	Dec-21	Red	09/02/2021- update from new SDM- We have improved boarder free working amongst the clinicians and this has reduced the need to have an enhanced clinical leadership on shift in the short to medium term. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Meetings have begun with the clinicians from across Hywel Dda. These meetings cover multiple topics including OOH working practices such as border free working. These meetings will continue over the next 2-3 months. Further updates will be available following the meetings and
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Physician Associates to also be considered as part of the longer term strategy.	This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign.	Mar-20	Dec-21	Red	09/02/2021- update from new SDM- After assessment physician associates are not for immediate deployment in Out of Hours but will be considered as part of the longer term Multi-disciplinary team. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- A multi-disciplinary team continues to be a high priority of the OOH workforce plan. Recently the new SDM and OOH management team with the Workforce Development team have reconvened to continue with work that began pre Covid-19. This evaluation of the OOH workforce and development of future workforce models is underway with plans and actions set. The use of Physicians Associates will be considered within this work. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PeerReview-OOH006	N/A	R6. Wider Workforce Planning The clinical competencies framework need to be considered for supporting ACP's, UCP, HCSW etc. and should now drive the future workforce planning	Initial meetings with Assistant Directors of Nursing have taken place. Senior Workforce Development Manager is assisting in mapping out workforce requirements.	Dec-19	Dec-21	Red	Initial meetings with Assistant Directors of Nursing have taken place and frameworks will be assessed within the nursing directorate. Senior Workforce Development Manager is assisting in mapping out workforce requirements as a part of TCS agenda, delayed significantly by COVID. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- New SDM now in place to drive this work forward. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Similar to the multi-disciplinary team action the wider workforce plan will form part of the work recently reconvened between OOHs and the Workforce Development team. Stakeholders are being identified and will be invited to participate in the evaluation and design of the OOH
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PeerReview-OOH014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical /operational staff In hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	~~Mar-20~~ ~~Oct-20~~ Dec-21	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- recommendation still delayed due to Covid, however in the meantime any significant issues are reported to the Director of Operations. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- The Clinical Lead and Service Delivery Manager are planning to meet all the OOH workforce to discuss issues and seek a team approach
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_001b	N/A	Each Local Children's Cardiology Centre will provide appropriate managerial and administrative support for the effective operation of the network.	IT system development under way.	Mar-22	Mar-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_002	N/A	e. address how paediatric cardiologists and paediatricians with expertise in cardiology (PECs) will work across the network, including at the Specialised Children's Surgical Centre, the Specialist Children's Cardiology Centres and Local Children's Cardiology Centres, according to local circumstances;	Review of job plans - EMBED IN PROCESS	Mar-22	Mar-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_003	N/A	There will be specific protocols within each Congenital Heart Network for the transfer of children and young people requiring interventional treatment.	Revise protocols and ensure right people aware	Jan-22	Jan-22	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_004	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_005	N/A	d. allow a timely and reliable transfer and receipt of images (including echo, CT, MRI) across the various ACHD services.	Action from Cardiff in terms of individual access. National imaging strategy may help overall problem? Service to make sure paediatrics included in upgrade discussions with adult service	Jun-22	Jun-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_007	N/A	Each designated paediatrician with expertise in cardiology will attend (in person or by VC link) the weekly network MDT meeting at least six times per year, and must also attend the annual network meeting. This requirement will be reflected in job plans.	Job plan review	Mar-22	Mar-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.

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Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_008	N/A	Each Local Children's Cardiology Centre must have identified registered children's nurses with an interest and training in children's and young people's cardiology.	Ensure link nurse business case includes time needed to meet these standards. ODN can provide letter of support.	Jun-22	Jun-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_009	N/A	Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director).	Job plan review	Mar-22	Mar-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_010	N/A	Local Children's Cardiology Centres must have locally designated registered children's nurses with a specialist interest in paediatric cardiology, trained and educated in the assessment, treatment and care of cardiac children and young people.	[ND to discuss with nurse leads]	Mar-22	Mar-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_011	N/A	Each Local Children's Cardiology Centre must have a locally designated 0.25 WTE registered children's nurse with a specialist interest to participate in cardiology clinics, provide support to inpatients and deal with requests for telephone advice.	Ensure link nurse business case includes time needed to meet these standards. ODN can provide letter of support.	Jun-22	Jun-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received.

Reports closed on the Audit Tracker since ARAC February 2022

Report name	Lead Executive/Director
Audit Wales: Follow-up on Information Backup, Disaster Recovery and Business Continuity	Director of Finance
Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Bronglais Hospital MB3	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Prince Phillip Hospital MIU / AMAU MB4	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Glangwili Hospital A&E (inc. reception) MB7	Director of Nursing, Quality and Patient Experience
Internal Audit: Deployment of WPAS into MH&LD	Director of Finance
Internal Audit: Digital Modelling (EDAPT)	Director of Finance
Internal Audit: IM&T Control and Risk Assessment	Director of Finance
Internal Audit: Local Deployment of the Welsh Immunisation Scheme (WIS)	Director of Finance
Internal Audit: Health & Safety	Director of Nursing, Quality and Patient Experience
Internal Audit: Use of Consultancy	Director of Finance
Human Tissue Authority: Glangwili General Hospital - 12136 – Follow up 19/10/21 (On –site inspection)	Director of Operations
Stratia Consulting: NHS Wales External Security Assessment	Director of Finance

Reports opened on the Audit Tracker since ARAC February 2022

Report name	Lead Executive/Director	Final report received at
Delivery Unit: All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS)	Director of Operations	To be confirmed
Delivery Unit: All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Director of Operations	To be confirmed
Health Inspectorate Wales: National Review of Mental Health Crisis Prevention in the Community	Director of Operations	To be confirmed
Internal Audit: Waste Management	Director of Operations	Audit and Risk Assurance Committee, February 2022
Internal Audit: Follow-up: Use of Consultancy	Director of Finance	Audit and Risk Assurance Committee, February 2022

Internal Audit: Follow-up: Deployment of WPAS into MH&LD	Director of Finance	Audit and Risk Assurance Committee, February 2022
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Ty Bryn Template 25 Prince Philip Hospital 459/VEM/BFS/00094205	Director of Operations	Health & Safety Committee, March 2022
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Prince Philip Hospital Diabetic Unit Template 459/VEM/BFS/00335079	Director of Operations	Health & Safety Committee, March 2022
Public Service Ombudsman (Wales): 202005624	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 202006285	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee

Reports re-opened on the Audit Tracker since ARAC February 2022 following review and closure of the Strategic Log

Report name	**Lead Executive/Director**
Audit Wales: Medicines Management in Acute Hospitals	Director of Primary, Community and Long Term Care
Delivery Unit: All Wales Review of progress towards delivery of Eye Care Measures	Director of Operations
Delivery Unit: Focus on Ophthalmology: Assurance Reviews	Director of Operations
HIW: Ward 6 - PPH - Unannounced DECI - 23Sep14 (Elective Orthopaedic)	Director of Operations
HIW: Teifi Ward - GGH - Unannounced DECI - 28Aug2014 (Trauma and Orthopaedic Ward)	Director of Operations
HIW: Thematic Review of Ophthalmology 2015/16	Director of Operations
HIW: Unannounced Hospital Visit - Unscheduled Care Directorate & Surgical Assessment Unit - 11 & 12 Aug 2015	Director of Operations
Peer Review: Respiratory Cancer Review 16/06/2016	Director of Operations