Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 December 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, 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.

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)

There is a bi-monthly rolling programme to collate updates from services to coincide with reporting to ARAC. HIW inspection activity and the corresponding follow up to determine progress of recommendations raised is undertaken and managed by the Quality Assurance and Safety Team with progress provided to the Assurance and Risk team for the Audit and Inspection Tracker.

Since the previous report, 9 reports have been closed or superseded on the Audit Tracker and 9 new reports have been received by the UHB.

As of 15 November 2022, the number of open reports has remained the same as reported in October 2022 at 91. 52 of these reports have recommendations that have exceeded their original completion date, which has increased from the 47 reports previously reported in October 2022. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is a slight increase in recommendations where the original implementation date has passed from 124 to 133. Detail on this increase can be found in the 'Audit Tracker Summary Per Service / Directorate' table. The number of recommendations that have gone beyond six months of their original completion date has increased to 74 from 55 reported in October 2022. The table below provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC October 22	New reports since October 22	Closed reports since October 22	Open reports at ARAC December 22	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	5	0	0	5	5	5	4
CHC	2	0	0	2	2	3	3
CHC / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	4	0	0	4	2	7	7
HEIW	0	0	0	0	0	0	0
HSE	0	0	0	0	0	0	0
HIW	16	1	5	12	8	26	22
HTA	0	0	0	0	0	0	0
IA	20	5	1	24	20	47	16
Internal Review	1	0	0	1	1	1	1
MHRA	1	0	0	1	1	1	0
MWWFRS	24	1	2	23	6	14	0
NHS Wales Cyber Resilience Unit	1	0	0	1	0	1	0
Peer Reviews	5	0	1	4	3	22	16
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	9	2	0	11	1	1	0
Royal Colleges	2	0	0	2	2	4	4
Other (External Consultant)	0	0	0	0	0	0	0
WLC	1	0	0	1	1	0	0
TOTAL	**91**	**9**	**9**	**91**	**52**	**132**	**73**

**Reports which have passed their original implementation date*
***Original implementation date noted for the recommendation has passed, or will not be met*

Appendix 1 details all open recommendations on the audit tracker, with the exception of the Cyber Security Assessment Framework as issued by NHS Wales Cyber Resilience Unit due to the sensitive nature of the information. Progress will be monitored by the Sustainable Resources (SRC) In-Committee. There are currently 267 open recommendations (decrease

from 277 reported in October 2022) on the audit tracker. In addition to the new recommendations issued since the previous report, Appendix 1 includes the 17 recommendations that are considered to be outside the gift of the UHB to currently implement, for example reliant on an external organisation to implement). These recommendations are marked as 'External' in the RAG status column.

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

There are 63 recommendations (see Appendix 3) that do not have revised timescales (where the original date has passed and not known (N/K) is reported), which has increased from the 36 previously reported. Since the previous report, 38 recommendations have become classified as N/K. It is noted that of these, 23 recommendations have been noted as N/K in December 2022 which are currently being reviewed as part of follow-up work being undertaken by IA. Once follow up reports have been presented to ARAC, progress for these recommendations will be updated as required. An additional 15 N/Ks have also been noted either due to completion dates being surpassed in the last month, and also due to timing issues in the service update process undertaken by the Assurance and Risk Team. It is also noted that 11 recommendations have also either been confirmed as completed, or revised timescales obtained since the previous report. The Assurance and Risk team continue to work with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented. Appendix 3 details those N/K recommendations which are new for December 2022. Detailed analysis will be undertaken in advance of the next ARAC report in order to ascertain any recommendations that have been classified as N/K for a significant period of time.

An annual review of the Audit Tracker with Executive Leads to review the current relevancy of audit recommendations given the age of some the recommendations and the context the University Health Board (UHB) is currently working within has been completed. Whilst recommendations were closed during this process, they would have been closed anyway. It is proposed that this process is undertaken tri-annually going forward, or if the UHB's operating circumstances significantly change.

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate at 15 November 2022, including trends since the last report to ARAC in October 2022. A rolling programme to collate updates from services on a bi-monthly 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 November 22	Overdue reports As at November 22	Total number open recs November 22*	Total overdue (red) recs November 22	Recs overdue by more than 6 months	Comments
Acute Services	1 ➔	1 ↑	6 ➔	6 ➔	6 ➔	• HIW National Review on WAST - 6 overdue recommendations, which are now overdue by more than 6 months. The Patient Safety and Assurance Team have received revised dates from the service ranging from December 2022 to January 2023.
Cancer Services	1 ➔	1 ➔	3 ➔	3 ➔	3 ➔	• Peer Review on Colorectal Cancer - 3 recommendations which are overdue by more than 6 months. Since the last ARAC report revised completion received of March 2023.
CEO Office (Welsh Language)	1 ➔	1 ➔	3 ➔	3 ↑	2 ➔	• 1 IA reports - Welsh Language Standards has 3 overdue recommendations, 2 of which are overdue by more than 6 months. A follow-up review of these outstanding recommendations by IA is currently underway with a report planned to be presented at ARAC December 2022.
Community - Carmarthenshire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Community - Ceredigion	2 ➔	2 ➔	2 ➔	2 ↑	1 ➔	• 1 HIW report – 2 recommendations overdue, 1 of which is overdue by more than 6 months. Completion dates provided for both recommendations of January 2023.
Community - Pembrokeshire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Central Ops	2 ➔	2 ➔	7 ➔	7 ➔	7 ➔	• 1 IA report on Records Management – 3 recommendations overdue by more than 6 months with revised timescales ranging from November 2022 to March 2023. A further IA review is due to take place for records management in Q1 2023/24. • 1 Peer Review – 4 recommendations (over 6 months overdue) previously delayed by COVID-19. A new peer review on OOH was undertaken in July 2022, and the service is currently drafting their responses to the report. Findings from the new report will supersede the existing recommendations on the tracker.

Service	Open reports as at November 22	Overdue reports As at November 22	Total number open recs November 22*	Total overdue (red) recs November 22	Recs overdue by more than 6 months	Comments
Digital and Performance	4 →	3 ↑	27 →	3 →	1 →	• 1 report by NHS Wales Cyber Resilience Unit on Cyber Assessment Framework - 24 recommendations (1 of which is overdue), with a report completion date currently estimated as March 2024. • 1 IA report on Network and Information Systems (NIS) Directive – 1 recommendation with a revised completion date of November 2022. This recommendation will be closed once Board seminar has been undertaken. • 1 IA report on Follow Up: Deployment of Welsh Patient Administration System (WPAS) into MH&LD – 1 recommendation relating to the roll out of WPAS to other services within MHLD, with a completion date noted of November 2022. • 1 IA IM&T Assurance (Follow Up) - 1 recommendation overdue by more than 6 months regarding compliance with European Working Time Directive, with a revised completion date of March 2023 provided.
Director of Operations	1 →	1 →	1 ↓	0 ↓	0 ↓	• 1 AW Review of Quality Governance Arrangements – This has been reassigned to Director of Operations due to nature of outstanding recommendations and their ownership - 3 recommendations remain outstanding, with 1 over 6 months overdue.
Estates	27 ↓	8 ↑	78 ↓	19 ↑	0 →	• The number of recommendations has decreased from 97 to 78 (the majority of these recommendations are from the 5 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)). • Following confirmation from MWWFRS, 1 EN and 1 LOFSM have been closed. Since the previous report, a LOFSM for South Pembrokeshire Hospital has been received. • All MWWFRS recs overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting. • The number of overdue recommendations has increased from 15 to 19. 14 overdue recommendations relate to a number of LOFSMs. A meeting is planned for mid November 2022 with MWWFRS to discuss all investment programmes across the UHB Estate which may result in revised timescales agreed by MWWFRS. The remaining 5 overdue recommendations are from the Internal Audit WGH Fire Precautions Works: Phase 1 report, Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. • A further 3 IA reports with a total of 5 recommendations within original agreed timescales.
Finance	1 →	1 →	2 →	2 →	0 →	• IA report on Financial Planning, Monitoring and Reporting report - 2 overdue recommendations with no revised timescales. IA to review outstanding recommendations as part of the Financial Management Review report with fieldwork to commence once the scope of the review has been determined.

Service	Open reports as at November 22	Overdue reports As at November 22	Total number open recs November 22*	Total overdue (red) recs November 22	Recs overdue by more than 6 months	Comments
Governance	1 →	0 →	1 →	0 →	0 →	• IA report on Risk Management and Board Assurance Framework – 1 recommendation with current completion date of December 2022, however currently awaiting formal approval from IA that the recommendation can be closed pending on latest progress update.
Medical (N/A)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Medicines Management	1 →	1 →	1 →	1 →	1 →	• 1 AW report on Medicines Management in Acute Hospitals - 1 recommendation more than 6 months overdue with revised date of November 2022.
MH&LD	10 ↑	7 ↑	42 ↑	20 ↑	13 ↑	• 1 new HIW report - 10 recommendations with varying completion dates up to March 2023. • 1 DU report – All Wales Assurance Review of Crisis and Liaison Psychiatry Services for Adults – 3 recommendations with completion date of December 2022. • The number of overdue recommendations has increased from 19 to 20, and of those overdue by 6 months increased from 10 to 13. The detail of these overdue are below: ○ IA on Prevention of Self Harm – 4 recommendations overdue, of which 1 by more than 6 months, with revised completion dates of December 2022. IA will be undertaking a follow up in Q4 2022/23. ○ PSOW report – 1 recommendation overdue. This is due to be discussed in mid-November at a multi-disciplinary scrutiny meeting. ○ HIW Quality check: Morlais Ward - 2 recommendations overdue by more 6 months. Support from Estates is required to implement recommendations. ○ HIW National Review of Mental Health Crisis Prevention in the Community - 2 recommendations overdue with revised timescales to January 2023. ○ HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months. ○ HIW Learning Disability Unit - 9 overdue recommendations, 8 of which by more than 6 months. Recommendations are unable to be implemented due to the unit being closed, and some are dependent on approval and finalisation of a service specification.
NQPE	6 ↑	1 ↑	13 ↑	0 →	0 →	• 2 new IA reports received since previous ARAC report on Falls Management with 8 recommendations, and Quality Governance with 3 recommendations. • 4 PSOW reports - compliance evidence submitted to PSOW, awaiting confirmation to close 3 reports. 2 recommendations with completions dates of December 2022 and March 2023 noted on the remaining PSOW report.
Pathology	1 (→)	1 (→)	1 (↓)	1 (↓)	0 (→)	• 1 MHRA report for WGH - 1 outstanding recommendation, with a revised completion of February 2023.

Service	Open reports as at November 22	Overdue reports As at November 22	Total number open recs November 22*	Total overdue (red) recs November 22	Recs overdue by more than 6 months	Comments
Primary Care, Community and Long Term Care	4 ↑	3 ↑	10 ↓	7 ↓	6 ↑	• 2 IA reports – A total of 7 overdue recommendations (6 overdue by more than 6 months), which has reduced from the 9 as last reported. 6 of the overdue recommendations are from the Discharge Processes report. Progress updates have been obtained and recommendations are to be incorporated into the Unscheduled Emergency Care (UEC) programme workstreams. • 1 WLC report has moved from Workforce & OD to Primary Care, Community and Long-Term Care. • 1 PSOW report – 3 recommendations on schedule for implementation by January 2023
Public Health (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Radiology (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Scheduled Care	6 →	2 ↓	9 ↓	9 →	9 →	• 1 CHC report – 2 recommendations overdue by more than 6 months. One of these recommendations has a revised timescale of the end of March 2023 and the other has an unknown timescale. • 2 DU reports – 6 recommendations overdue by more than 6 months. • HIW report - 1 recommendation which is overdue by more than 6 months with a revised completion date of March 2023. • 2 PSOW reports - compliance evidence submitted to PSOW, awaiting confirmation to close report.
Strategic Development & Operational Planning	3 →	3 →	3 →	2 →	2 →	• 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangements - 2 overdue recommendations of which 1 is overdue by more than 6 months, confirmation is being requested from the Director of Strategic Development and Operational Planning to close these outstanding recommendations. • Internal review of Capital Governance - 1 overdue recommendation by more than 6 months, timescale not known as UHB is awaiting feedback from Welsh Government. • 1 IA report on Glangwili Hospital Women & Children's Development - 1 recommendation with July 2023 timescale (IA has confirmed recommendation stays open until the project is completed as it is related to the ongoing monitoring of contractor performance).
Therapies	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
USC BGH	1 →	1 →	4 →	3 →	3 →	• RCP follow up report on Visit to Ysbyty Bronglais – 1 recommendation with a completion date of March 2023 and 3 recommendations overdue by more than 6 months, 2 of which do not have a revised completion date. The General Manager (BGH) to discuss recommendations with County Director of Ceredigion, following which an update will be provided to the Assurance and Risk Team.

Service	Open reports as at November 22	Overdue reports As at November 22	Total number open recs November 22*	Total overdue (red) recs November 22	Recs overdue by more than 6 months	Comments
USC GGH	3 (↑)	2 (↑)	7 (↑)	6 (↑)	1 (→)	• 1 DU report on All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review – 1 recommendation overdue by more than 6 months, with a revised completion date of March 2023. • 1 PSOW report – compliance evidence submitted to PSOW, awaiting confirmation to close report. • New IA report on GGH Directorate Governance review with 5 recommendations overdue however IA have contacted directorate for evidence to close recommendations.
USC PPH	3 (↑)	0 (→)	2 (→)	2 (→)	2 (↑)	• 1 HIW report – 1 recommendation overdue by more than 6 months, with a revised completion date of January 2023. • Peer Review on Respiratory Cancer report - 1 recommendation which is overdue by more than 6 months however clarification is being sought with SDM as recommendation may be in a position to be closed. If not, the management response is to be clarified and strengthened with a revised date of completion, as requested by the Director of Operations. • New PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report.
USC WGH	1 (→)	1 (→)	6 (↑)	6 (↑)	0 (→)	• 1 IA report on Directorate Governance with 6 overdue recommendations, all of which have passed their original completion date. IA contacting directorate for evidence to close recommendations. • 1 HIW report has been closed since the previous report.
Women & Children	6 (↓)	5 (→)	28 (↑)	19 (↓)	11 (↑)	• 1 CHC report – 1 recommendation overdue by more than 6 months. • 1 HIW report - 1 recommendation overdue by more than 6 months (revised completion date of December 2022 provided by the Quality Assurance and Safety Team (QAST)) • 1 IA report – 2 recommendations with revised completion dates of March 2023. • 1 Peer Review – 1 'External' recommendation, and 14 recommendations overdue, 8 of which by more than 6 months. Head of Assurance and Risk to meet with SDM for Acute Paediatrics in early December to obtain progress updates against these recommendations. • 1 Royal College report - 1 recommendation overdue by more than 6 months, with a revised completion date of September 2022. • 1 new PSOW report - Timescales range from November to December 2022.
Workforce & OD	4 (↓)	4 (↓)	11 (↓)	11 (↑)	5 (↑)	• 3 IA reports on Medical Staff Recruitment, Non-Clinical Temporary Staffing and Overpayment of Salaries– 8 recommendations overdue, 3 of which by more than by 6 months. Follow up reviews on all 3 IA reports are currently underway, and expected to be presented at ARAC in February 2023. • 1 AW report on Taking Care of the Carers – 3 recommendations overdue (with 2 by more than 6 months) and one with the revised completion date to be provided.
Total	**91**	**52**	**267**	**132**	**73**	

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

Potential Services of Concern

The services below are being monitored based on current trend and performance.

Mental Health & Learning Disabilities
Following the improving picture reported to ARAC in October 2022, the overdue recommendations have increased slightly from 19 to 20, and of those overdue by 6 months has increased from 10 to 13. Of the 19 overdue recommendations, 4 are related to the Internal Audit Prevention of Self Harm report. These recommendations have December 2022 revised timescales and Internal Audit will be undertaking a follow up in Q4 2022/23. 9 overdue recommendations, of which 8 are overdue by 6 months, are from a HIW Learning Disability unit report, which are unable to be confirmed as implemented whilst the unit is closed to admission, and are dependent on approval and finalisation of a service specification. For 4 of the overdue recommendations the Patient Safety and Assurance team have received no updates.

Women and Children
The number of recommendations overdue by more than 6 months have increased by 6 since the previous paper, with recommendations recently lapsing into this category. It is also noted that there are 10 recommendations relating to the Peer Review on Congenital Heart Defects as listed in Appendix 3 which currently have no revised completion dates and therefore listed as N/K. This is due to the timings of the bi-monthly service update correspondence, and also as a result of the officer lead prioritising the work on the paediatrics review. A meeting between the Head of Assurance and Risk and the SDM for Acute Paediatrics is scheduled for early December, with progress updates and revised dates for any outstanding recommendations to be obtained.

Workforce and OD
The service was highlighted as a potential service of concern in the paper as presented in October 2022. It is noted that Internal Audit are currently undertaking follow up reviews on 3 reports (Medical Staff Recruitment, Non-Clinical Temporary Staffing, and Overpayment of Salaries) which will ascertain progress made against existing recommendations. The reports are due to be presented to ARAC in February 2023.

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 bi-monthly 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 BPPAG – Business Planning and Performance Assurance Group 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 MHRA – Medicines and Healthcare Products Regulatory Agency 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 UEC- Urgent and Emergency Care 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
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Medicines Management	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_001	High	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~~ Nov-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. 13/04/2022- Director of Primary Care, Community and Long Term Care informed of red RAG status for this recommendation. Assistant Director of Assurance and Risk offered to discuss further with Director of Primary Care, Community and Long Term Care. 13/07/2022: A draft version of the strategy will be considered at the Medicines Management Operational Group (MMOG) on 27th September. Following feedback and further consultation a final draft will be submitted to MMOG in November. If there is extensive feedback this may be delayed until the Jan 2023 meeting.
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_002	High	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	External	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. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales.
AW_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	AW_603A2018-19_001	N/A	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~~ ~~Sep-22~~ Jan-23	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. Evaluation and analysis of this pilot is currently underway with a report due to be shared with the All Wales Nurse Staffing Programme in December. The next phase of testing/rollout is likely to commence in January 2022. 20/10/2021- Work remains ongoing with this and no further updates currently. The review for this is January 2022. 21/03/2022- requested update from lead officer 21/02/2022, no update received. 04/05/2022- requested update from lead officer, no update received. 07/07/22-Work is progressing on an all Wales basis with the development of a dependency tool with the roll out planned for September 2022. 29/09/22- The Draft DN WLoC tool is now being piloted for use with the CIVICA Scheduling system, 6 teams across Wales including a team from HDUHB are participating in a month long pilot in Sept/Oct 2022. Once the pilot is completed and evaluated, recommendations and timescales for the formal roll out of the draft tool will be issued. It is likely that this time frame will now be January 2023. Delays have been due to the CIVICA Scheduling system building the additionality the app requires to capture the WLoC.
AW_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	AW_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	~~Mar-22~~ ~~Jun-22~~ ~~Sep-22~~ ~~Oct-22~~ N/K	Red	19/08/2021- Management response reported to ARAC August 2021. 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 plan is in place to address this, with the aim to progress in Q1 of2022/23. This recommendation will be dependent on that resource. 28/04/2022- Work is progressing, with an update being requested to ARAC in June 2022. 21/06/2022- update to ARAC June 2022 - In progressing the action relating to R2, work is continuing to understand the skills required by the Planning Team moving forward. To support this work and to understand fully the skills required, the Director of Strategic Developments and Operational Planning along with members of the Strategic Planning Team have been mapping out the planning cycle. In doing so, the key skills required have been identified and will be used to aid the recruitment to the Team. The process has also identified where better collaboration with existing teams and resources could be utilised to support the Planning Cycle. This is expected to be completed by the end of Q2 2022/23. 30/08/2022 - Director of Strategic Developments and Operational Planning advised that being cognisant of the UHB's financial challenges, changes have been made to increase support in Planning Team. These will be further strengthened when WG support the PBC. Building resilience in the team will be completed once the Commissioning Team has been brought within the Planning Directorate's remit. This needs to go through the HR process and therefore the date of completion is likely to be October 2022.
AW_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	AW_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.	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~~ ~~Sep-22~~ ~~Oct-22~~ N/K	Red	19/08/2021- Management response reported to ARAC August 2021, timescale noted as 'Quarter 4 (subject to recruitment timescales)'. 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 if March timescale will be met. 03/02/2022- Director of Strategic Development & Operational Planning confirmed this recommendation is part of the IMTP discussions. An outline plan is in place to address this, with the aim to progress in Q1 of2022/23. This recommendation will be dependent on that resource. 28/04/2022- Work is progressing, with an update being requested to ARAC in June 2022. 21/06/2022- update to ARAC June 2022 - timescale confirmed as Q2 2022/23. 30/08/2022 - Director of Strategic Developments and Operational Planning advised that being congnisant of the UHB's financial challenges, changes have been made to increase support in Planning Team. These will be further strengthened when WG support the PBC. Building resilience in the team will be completed once the Commissioning Team has been brought within the Planning Directorate's remit. This needs to go through the HR process and therefore the date of completion is likely to be October 2022.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_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. 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: 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. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_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~~ N/K	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. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 24/11/2022 - Recommednation changed from red to external as implementation will be dependant on the implementation of the new Datix system
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	N/A	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~~ N/K	Red	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. 05/07/22-As of July 2022 we should have around 80 wellbeing champions fully trained and there is an ongoing programme for induction training for further champions bi monthly. Funding has been made available to support local wellbeing champion initiatives to the value of £250 per champion that have funded initiatives focussing on improving hydration, exercise, relaxation and general wellbeing. 23/08/22- Director of W&OD requested Head of Assurance and Risk to check with recommendation owner for how many champions we have now, and if this is close to 100. 09/09/2022- Senior Workforce Manager confirmed recommendation owner has left, update now requested from Head of Occupational Health. 07/11/2022 - Existing Champions are continuing to be supported and are offered the remaining MECC L2. Applications for funding for wellbeing projects are supported. There is no capacity at present to deliver anymore induction or update training for new champions. This is under review in terms of the project funding commitment and available resource from within Occupational Health, SPWBS nd the Culture & Workforce Experience team.
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	N/A	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~~ ~~Oct-22~~ N/K	Red	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. 23/08/22- Director of W&OD believes this can be covered off in a report to PODCC in Oct-22. 05/09/2022- Update requested from recommendation owner by 16/09/2022. 07/11/2022 - Complete. The Ecotherapy programme is up and running and will continue in 2023 with a further 7 Retreats to be offered to meet the funding commitment.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_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 those staff are managed centrally, ensuring that support available to the operational teams is consistent across the Health Board.	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. A review will be undertaken to enhance the capacity across operational and corporate teams to ensure a consistent approach to managing assurance, risk and safety. It is possible there will be a financial impact of the review and therefore this will need to be considered as part of the IMTP for 2022-23.	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). 12/08/22- Review has been undertaken and findings shared with Director of Operations and Director of Nursing, Quality and Patient Experience. It was agreed that further work was required aligned to any possible restructuring within the organisation. The recommendation to establish county level quality governance meetings has now been stood down, as Operational Quality Safety and Experience Sub Committee is now operating more effectively. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October.

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
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_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). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October.
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	N/A	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~~ ~~Jun-22~~ ~~N/K~~ Nov-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 May 2022 timescale. 27/05/2022- The Staff Wellbeing Information Line has been operational now for 6 months and is currently under review. This will be complete by the end of June. 23/08/22- Director of W&OD requested Head of Assurance and Risk to chase recommendation owner for confirmation if this is now implemented. 05/09/2022- Update requested from recommendation owner by 16/09/2022. 07/11/2022 - The Staff Wellbeing Information Line (SWIL) was launched in November 2021 and ran for 9 months and has been evaluated and withdrawn.
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	N/A	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~~ ~~N/K~~ Nov-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 April 2022 timescale. 23/08/22- Director of W&OD unsure if Well-Being Dashboard evaluation is available, Head of Assurance and Risk to check with recommendation owner for update. Director of W&OD suggested it may be a case of an update report to PODCC. The Staff Ecotherapy Programme is available. 05/09/2022- Update requested from recommendation owner by 16/09/2022. 07/11/2022 - Complete. We continue to contribute monthly service data to the wellbeing dashboard and to monitor and evaluate all our one-to-one psychological support and this data feeds back into service learning and development. The Staff Wellbeing Information Line has been evaluated and withdrawn . A Staff Wellbeing Needs Survey was luanched in October which will continue into November. The data collected will inform service review, and planning. The Wellbeing Champions have been surveyed about their need for and use of psychological support in their role.
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	N/A	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~~ Mar-23	Red	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. 05/07/22- There is a delay with this as the person who was taking a lead on this has had a change of role. A DPIA assessment delayed the process as was required to share information with the University who were leading on the evaluation. Work is ongoing but unlikely to be completed before March 2023. 23/08/22- Director of W&OD requested Head of Assurance and Risk to check with recommendation owner for an update on this and if the management response is still unlikely to be implemented by March 2023. 09/09/2022- Senior Workforce Manager confirmed recommendation owner has left, update now requested from Head of Occupational Health.
CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open (external rec)	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_005	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~~ ~~Jun-22~~ N/K	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. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 08/10/21- further national delays to the roll out of EPR due to network concerns. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update by 14/10/22 if HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_002	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~~ ~~Oct-22~~ Mar-23	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 setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_001	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~~ ~~Aug-22~~ Mar-23	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 setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures.
CHC_MCHD1121	Nov-21	CHC	Maternity Care in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	CHC_MCHD1121_001	N/A	Try to identify ways in which women can have more continuity of care so that they are not repeatedly explaining their pregnancy and medical history each time they are seen.	Throughout the Covid pandemic maternity services have continued with no interruption to choices available. All birthing areas remained staffed and available including the Freestanding Midwife Led Unit in Withybush and all homebirth services throughout the health board. • Continuity of Carer is a key All Wales since 2019. Due to Covid issues work within this priority was temporary suspended. Below are plans that we aim to implement In April 2022 following on from our audit in March 2021. • Community midwives have recommenced booking visits and all women will have had a face to face visit by their 16 week appointment. • We do recognise that Bronglais has excellent continuity from a midwifery perspective from our audit. • We aim to have buddy midwives in the community to cover each other, where possible from April 2022. • Review of community midwifery on call provision from 1st April 2022 • Obstetricians will have Junior doctors linked to each consultant to promote continuity of carer. • Document name of lead carer clearly in notes. • All staff to clearly print their name in the hand held records and record any recommendations and reasons for doing so, to enable robust discussions, and ensure evidence based care is supported. • Dedicated Twin specialist clinic in January 2022	Apr-22	~~Apr-22~~ ~~Sep-22~~ ~~Oct-22~~ N/K	Red	11/05/2022 - discussion with the Head of Midwifery and Interim Deputy Head of Midwifery noted that they are reassured that the recommendation has been implemented, would like to undertake a Directorate based audit to satisfy further that the recommendation has been fully implemented. Revised timescale therefore provided of September 2022. 17/08/2022 - Rotas for middle-grade doctors expected to be completed in place by September 2022, at which point the recommendation can be closed

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
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_007	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	N/K	~~Apr-22~~ ~~Oct-22~~ Nov-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 setup 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. 13/07/2022- Funding provided through the approved ARCH Business Case for the delivery of Glaucoma Services. The longer term IT solutions for working and sharing data across Primary and Secondary Care is a work in progress at an all Wales level. The Health Board has appointed a Consultant through a Honorary Contract and currently in an open Procurement tender process for the establishment of ODTC's in Hywel Dda. 30/09/2022- The tendering process is now closed and is waiting for review by Primary Care and lead consultant for Glaucoma (check with Head of Dental and Optometry & Low Vision Services Manager). There is hope this may progress (i.e. awarding contracts) by October. 13/10/2022 - Update from Primary Care: ODTC contracts have been awarded to two Providers, one in Haverfordwest and the other in Llanelli. The internal process is being finalised between PC and secondary care colleagues and it is anticipated that clinics will start in November 2022
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	Mar-23	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. 13/05/2022- SDM provided revised date of March 2024. This will be depending on the regionalisation with Swansea Bay (ARCH), in principle this should cover the whole of UHB. Ceredigion discussions on Mid Wales Collaborative with Powys and Betsi- discussions taking place on Mid Wales lead for Ophthalmology to be advertised, difficulties in recruiting in Ceredigion area. 07/07/2022- Risk stratification of Glaucoma patients now complete. Work continues on outpatient templates to ensure capacity to review patient backlog. Current difficulties with staff capacity March 2023, as per Ministerial measures for addressing backlog. Meeting to take place with WG which will hopefully provide clarity on targets. 30/09/2022- Revised completion date to be kept as March 2023. A discussion has taken place with WG, they want eye care measures and MD to be implemented; the service are micro-managing capacity and booking to ensure both targets are prioritised.
DU_AWCCSTPAR0519	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	DU_AWCCSTPAR0519_003	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~~ Mar-23	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 its 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. 11/07/2022 - discussion with the SDM and Service Manager confirmed that the recommendation has to date been implemented with regards to inpatients, however further work needed with regards to outpatients. Discussions are also ongoing with SBUHB in order to further the implementation of this recommendation, and a revised timescale has been given of March 2023 in relation to this recommendation.
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_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~~ N/K	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. 13/05/2022- SDM updated that IMTP submitted, no decision received on priorities and if IMTP is supported therefore unable to provide further update on this. 07/07/2022- No feedback as yet on plans submitted to IMTP. Awaiting clarity on IMTP response before timescales can be provided. 30/09/2022- No official response from IMTP. The UHB has a funded Glaucoma plan and diabetic retinopathy plan, which are both in place. The overarching plan for the whole service is outlined in the IMTP. Can this now be closed?
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_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-23	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. 13/05/2022- Submitted regional ambition to WG, if supported a project plan will be developed for a regionalised service for cataracts which will be a time bound delivery plan. awaiting response from WG. 07/07/2022- No confirmation yet as to funding beyond current contract from WG (approx. July 2022). No progress on the Shrewsbury & Telford discussions, however the new clinical lead for mid Wales, working across Powys, Betsi Cadwaladr and Hywel Dda (Ceredigion only), has been approved by the Royal College and is currently with medical recruitment. This new clinical lead will drive the long term plans for the north of the Health Board. Funding was provided to WG to develop Amman Valley OPD for Wet AMD to allow day theatre to be released for cataracts - timescale dependent on recruitment of locum consultant, so we will be able to update these in August. 30/09/2022- Amman Valley has commenced cataract operating, we have successfully recruited 2 locum consultants to enable increase theatre sessions. Recommendation to be closed? Appraisal undertaken and option of Amman Valley now in place?
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_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~~ N/K	Red	22/02/2022- If this will be addressed via the IMTP, then once the IMTP is approved the Director of Operations will be happy for this to be closed. 21/03/2022- Recommendation re-opened on the audit tracker. 13/05/2022- IMTP submitted, no decision received on priorities/ if IMTP is supported. Until the decision on the IMTP and regional are made this recommendation cannot be fully implemented. 07/07/2022- No feedback as yet on plans submitted to IMTP. Awaiting clarity on IMTP response before timescales can be provided. 30/09/2022- No official response from IMTP. Sustainable monies have been invested into Glaucoma plan and cataracts, however there are still other areas of the service (such as AMD, plastics, paeds, VR, etc.) that require investment.
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_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-23~~ N/K	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. 13/05/2022- Honorary contract in plan, and substantive Consultant Ophthalmologist to start in March 2023 (from New Zealand) . No further progression on the collaboration with Shrewsbury & Telford . Mid Wales clinical lead to be readvertised. 07/07/2022- Interviews taking place week commencing 11/07/22 for 6 speciality doctors (3 vacancies to fill). In addition, a locum consultant advert has just closed with 5 applicants (clinical lead currently shortlisting). Also, Swansea Bay HB have successfully recruited 2 locum consultants for Glaucoma which will support the regional ARCH plan (Timescale = End of August). 30/09/2022- We have successfully recruited 2 speciality doctors and 2 locum consultants. A second honorory annual contract with Swansea Bay glaucoma consultants is in progress via ARCH. The midwales (Powys and Betsi) clinical lead was readvertised with no applicants. SDM to meet with the County Director Ceredigion for next course of action.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_001	N/A	The Health Board should ensure further engagement with key stakeholders in relation to intended plans and timescales including provision of staffing capacity and workforce development to support implementation of the new service model.	The health board is currently undergoing plans to commence 7 day working within CMHC and CMHT, which will commence in September 2022. Part of this process includes the new service specification, which will be shared with all key stakeholders for comments prior to being implemented and implementation groups will be established.	Dec-22	Dec-22	Amber	03/05/2022 - PAS team are assisting the Directorate with providing management responses to these recommendations, and corresponding timescales. Tracker to be updated on receipt of information 20/05/2022 - confirmation received from the PAS team that they are continuing to support the directorate in formulating responses and they are currently in draft and awaiting sign off. 27/6/22-continuing to waiting for job descriptions to be returned and amended . Proposed date to commence 7 day working to commence is now October 2022 .Memo to be forwarded to staff and unions, to update on delay and new proposed date 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_002a	N/A	The Health Board should review current pathways and processes to identify opportunities to improve access arrangements and patient flow.	The Health Board is currently undergoing a service redesign to a Community Mental Health Centre model. The new service spec will incorporate pathways and processes for referral in and out of services to improve access arrangements and patient flow.	Dec-22	Dec-22	Amber	03/05/2022 - PAS team are assisting the Directorate with providing management responses to these recommendations, and corresponding timescales. Tracker to be updated on receipt of information 20/05/2022 - confirmation received from the PAS team that they are continuing to support the directorate in formulating responses and they are currently in draft and awaiting sign off. 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_002c	N/A	The Health Board should review current pathways and processes to identify opportunities to improve access arrangements and patient flow.	Mental health Liaison service specification is currently being completed which will incorporate pathways into services.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_002d	N/A	The Health Board should review current pathways and processes to identify opportunities to improve access arrangements and patient flow.	The health board are currently implementing a Single Point of Access team, which will increase access to services for service users and ensure that service users are referred to the correct service in a timely manner.	Dec-22	Dec-22	Amber	27/06/2022 - The SPOC is now operational (from 20/6/22) Hours of operation are 09.00 to 23.30 hours .This will extend to 24/7 in October , pending recruitment of staff 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005a	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	The Health Board is currently developing a new assessment form, which will incorporate a section on risk, and safety, to ensure this, is completed at point of assessment.	Dec-22	Dec-22	Amber	03/05/2022 - PAS team are assisting the Directorate with providing management responses to these recommendations, and corresponding timescales. Tracker to be updated on receipt of information 20/05/2022 - confirmation received from the PAS team that they are continuing to support the directorate in formulating responses and they are currently in draft and awaiting sign off. 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005b	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clear process to be identified in both Liaison and CMHC SOP about recording of risk and safety plan.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005c	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	6 Monthly audit of patient risk assessments to be completed by team managers to review quality.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.

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
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_005d	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clinician to attend WARN and Storm training	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_005e	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Process for sharing assessment and intervention outcomes are currently being developed by Team mangers to ensure a consistent and timely approach with the sharing of information with refers.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_006b	N/A	The Health Board must ensure that a safe and appropriate space is available to conduct mental health crisis assessments within each of the DGHs.	Liaison senior nurse to arrange meeting with all four A&E and MIU managers to review current room space and to discuss access to an assessment room in Glangwilli A&E.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_007a	N/A	The Health Board should review current supervision arrangements for Crisis and Liaison Services to ensure clinical supervision is prioritised to support quality, safety, and staff wellbeing.	The Mental health Liaison team are currently implementing reflective practice and clinical discussion sessions in Liaison team increasing access to clinical support practitioners working across Liaison and CRHT.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
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	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_007b	N/A	The Health Board should review current supervision arrangements for Crisis and Liaison Services to ensure clinical supervision is prioritised to support quality, safety, and staff wellbeing.	Supervision matrix to be created for each team to allow for audit and ensure regular supervision.	Dec-22	Dec-22	Amber	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team.
HIW_TRO0116	Jan-16	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	HIW_TRO0116_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~~ Mar-23	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. 13/05/2022- SDM provided revised date of March 2024. Glaucoma clinics and the risk stratification work has started, will be completed by October 2022. Following this the remaining follow up patients (outside of glaucoma) will then need to be addressed, using clinics and See on Symptom (SOS) and Patient Initiated Follow Ups (PIFU). 30/09/2022- No longer doing the See on Symptom (SOS) and Patient Initiated Follow Ups (PIFU) as this is not a viable option, as discussed by clinical lead. Anybody who remains on the waiting list needs a fac-to-face follow up with clinician, which needs to be managed (service micro-managing capacity and booking to ensure both targets are prioritised).
HIW_JTRCMHT	Feb-19	HIW	Joint Thematic Review of Community Mental Health Teams 2017-2018 issued February 2019	Open (External Rec)	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	HIW_JTRCMHT_021	N/A	Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection	The MH/LD Directorate continues its commitment to co-producing the implementation of its Transforming Mental Health Programme. A data and evaluation work stream has recently been established to review data gathering processes and develop means of continuous quality improvement. The UHB are being assisted by Swansea University. Ensure information systems are updated with a move to Welsh Patient Administration System (WPAS) anticipated this year, followed by migration to Welsh Community Care Information System (WCCIS) across health and social care services.	Dec-22	Dec-22	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. 07/09/2022 QAST review, due date December 2022.
HIW_19009_WGHSCWSNW	Sep-19	HIW	St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019 (Publication date 1 September 2019)	Open (external rec)	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason / Kay Isaacs	Director of Operations	HIW_19009_WGHSCWSNW_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~~ ~~N/K~~ Dec-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 setup 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. 07/09/2022 QAST review, chased for update March, April, May, July 2022. Due date December 2022.
HIW_19258_GGHPACUCW	Aug-20	HIW	PACU and Cilgerran Wards, Glangwili General Hospital (Publication date 7 August 2020)	Open	N/A	Women and Children's Services	Women and Children's Services	Paula Evans	Director of Operations	HIW_19258_GGHPACUCW_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~~ ~~Sep-22~~ Dec-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 get this updated. Face to face dates for fire training have been shared with the teams, difficulties with timings of online sessions 11-13 runs through lunch difficult to release cinical staff, other options being explored. 30/11/2021 awaiting response. 15/12/2021 Head Workforce Education & Development confirmed; Face to face training is still not taking place in PACU, Cilgerran or Puffin wards due to the ongoing Covid restrictions, however level 2 Fire training is now available via MS Teams which almost 50% of staff in these areas have now completed. The training is available weekly so the remaining staff will be targeted in the coming months to ensure full compliance. 17/01/2022 - E-learning fire safety currently stands at 86.49% and Fire Safety level 2 at 45.28%. Several staff members have booked on to the level 2 training however capacity to release staff from clinical duties is limited as sessions are only available during the busiest time on the ward. The aim is to reach 85% compliance by July 2022. 02/02/2022 - Fire Training Level 2 now at 65% 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. 18/05/2022 18/05/2022 - action not yet due, no update received. QAST Update 11/07/22 as of 09/05/22 fire training level 2 = 67% e learning = 92% Of the staff not in date or due to expire before the end of July. 6 staff are unable to access ESR as new starters, 6 are on mat leave, 2 are on LTSL , 2 have either just left or are leaving this month. 2 have sessions booked within the next two weeks. These staff make up 14% of the total number of staff so if they are excluded the % increases to 75% All others have been sent a reminder email, copied to their line managers with dates of the next sessions. Service have advised 2 months required to complete, new completion date. 07/09/2022 fire training level 2 = 65.5% e learning = 89.43% according to ESR Of the staff not in date or due to expire before the end of August . 3 staff are unable to access ESR (1 x new starter 2 x lost passwords), 5 are on mat leave, 2 are on LTSL , 4 have attended but their ESR records have not been updated (4 x play staff). 2 have sessions booked within the next two weeks and we are chasing up the rest. These staff make up 13 % of the total number of staff so if they are excluded the % increases to 78.5%. By end of September, the team expect to have achieved 85% 04/11/2022-QAST team chased for update, no update provided.
HIW_20136_GGHMW	May-21	HIW	Quality Check: Morlais Ward, GGH 4 March 2021 (Publication date 5 May 2021)	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	HIW_20136_GGHMW_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	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. 18/05/2022 chased, no update received. QAST update 11/07/2022 Ward manager is aware that works are still not complete. The bathroom refits are outstanding. Estates/operations manager is leading on this recommendation and has been chased for an update February, March, April and May 2022. QAST update 07/09/2022 - Update from Estates the toilets are completed, and a couple of wash hand basins to be fitted (but were additional to the HIW report) QAST update 01/11/22 no further update since Sept 22.
HIW_20136_GGHMW	May-21	HIW	Quality Check: Morlais Ward, GGH 4 March 2021 (Publication date 5 May 2021)	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	HIW_20136_GGHMW_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - chased, no update received. QAST update 11/07/22 Estates have been chased for an update February, March, April and May 2022. QAST update 07/09/22 update requested July/ Aug from Estates. QAST update 01/11/22 update requested from Estates Sept/ Oct.
HIW_20136_GGHMW	May-21	HIW	Quality Check: Morlais Ward, GGH 4 March 2021 (Publication date 5 May 2021)	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	HIW_20136_GGHMW_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~~ Dec-22	Red	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. 23/02/22 Significant percentage increase of compliance since return of training via Microsoft teams. 18/05/2022 - chased, no update received. QAST update 11/07/22 27/05/22 - All staff have resumed L2 fire training. The fire officer has since completed f2f on the ward for the team and there are also Microsoft teams sessions all can attend by booking on via learning and development. QAST update 07/09/22 update requested 18/07. QAST update 01/11/22 requested update Sept / Oct. none received.

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
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_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	~~June 22~~ ~~Oct 22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_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~~ ~~Jul-22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - chased, no update received. QAST update 11/07/2022 PO work is currently being undertaken with a provisional completion date of end of July 2022. QAST update 07/09/2022 requested update 18/07/22, none received to date. QAST 01/11/22 QAST chased for update Sept / Oct none received.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	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. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 chased PPH & GGH for update Feb, April and May 2022, none received. QAST update chased all sites Sept/ Oct Update 27/10/22 (BGH)Patients at risk identified eg ?#NOF prioritised for offload and Xray ,if positive air mattress and facia block . Good communication with WAST Team Leader regarding existing pressure damage or long lie patients for priority pressure relieving measures. Health Board to focus on exit blocks to avoid offload delays (WGH) Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled Care HoN. Utilisation of Rapid assessment area in WGH to support appropriate care delivery when patients are awaiting offload.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 Update GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. ED nursing staff allocated to support care in ambulance and will undertake appropriate assessments and onward Fundamentals of care delivery on patients whilst on the ambulance. QAST update 01/11/22 all sites chased, no futther update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 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. The service management for A&E / AMAU have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST Update 01/11/22 - 27/10/22 (BGH) Free access to kitchen beverages and sandwiches stocked in fridge . Excellent rapport between WAST and Emergency staff regarding fundamentals of care (WGH) Confirmation from WGH that hot food and drinks provided to all patients waiting in department or awaiting handover.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_019	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	N/A – for WAST consideration	N/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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/K	N/K	External	
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ Dec-22	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. 18/05/2022 & 23/02/2022 (BGH & WGH) - 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. For WGH, Handovers and triage are immediate on arrival to department. No specific new roles have been identified; however safety huddles to discuss all patients on ambulances and their escalation plans several times each day. Priority staffing levels are being reviewed with a view to approve elements to support further. Family Liaison Officers are now present in ED to help improve some of the communication processes. The front door multi disciplinary team at will support assessments on the ambulance and help determine whether admission is required or if community support is more appropriate. ENP's & ANP's support to see, treat, assess and discharge patients QAST update 11/07/22 chased PPH & GGH for update Feb, April and May 2022, none received. QAST update 07/09/22 requested update July/ Aug 2022, none received , recommendation due date Dec 22 QAST update 01/11/22 no fruther update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~Mar-22~~ Dec-22	Amber	No update received from QSE team on progress against this recommendation as at 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. 18/05/2022 - not yet due no update received. QAST update 11/07/22 due December 2022, no update therefore requested. QAST update 11/07/22 & 07/09/22 due December 2022, no update requested. QAST update 01/11/22 chased all sites, no further update received.

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
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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 setup chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation. 23/02/2022 (BGH) - Ambulance offload policy arrangements are ongoing. Meetings due to be held in February. Acute stroke pathway has been in place long standing and the crews can handover immediately to teams in the CT scanner area. 18/05/2022 - position in WGH same as BGH (above). QAST update 11/07/22, no update from PPH & GGH to date. 07/09/22 GGH & PPH Ambulance offload policy being updated currently with WAST representatives on group, individual department handover processes are in appendices within this policy. QAST update 01/11/22 chased sites , no further update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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. 23/02/2022 (BGH) - Ambulance offload policy, embedded in which is the Care of the patient in the ambulance policy. Actions are awaiting to be agreed by the Health Board with a meeting due in early March to discuss, led by Unscheduled care HoN with Task and Finish Group. 18/05/2022 - requested, none received. QAST update 11/07/22 requested update from PPH & GHH Feb, March, April and May 2022, none received. QAST update 07/09/22 for GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. QAST update 01/11/22 chased all sites, no further update received.
HIW_21113_TCH	Dec-21	HIW	Tregaron Community Hospital 7/8 September 2021 (Publication date 10 December 2021)	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	HIW_21113_TCH_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~~ ~~Sep-22~~ ~~N/K~~ Jan-23	Red	No update received from QSE team on progress against this recommendation as at 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 requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - training programme started, expecting to be compliant by Aug 2022. Timescale amended to Sept 2022. 11/07/22 update. Amber ALERT training is not required for community hospital staff and ILS training has been advocated for staff to attend. Staff are attending training when available. 5 staff have been trained to date. QAST update 07/09/22 no update received since July. 29/09/2022- ILS trainer has been identified and providing ongoing Training sessions on site . Ongoing sessions planned to ensure all staff are updated and compliant going forward 04/11/22-QAST update: on 03/10/22 ILS trainer identified and providing ongoing sessions onsite. Future planned sessions booked to ensure all staff are updated and compliant going forward.
HIW_21113_TCH	Dec-21	HIW	Tregaron Community Hospital 7/8 September 2021 (Publication date 10 December 2021)	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	HIW_21113_TCH_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~~ ~~N/K~~ Jan-23	Red	No update received from QSE team on progress against this recommendation as at 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. 18/02/2022 recommendation not yet due, no update received. QAST update 11/07/22 Staff have been given access to wellbeing questionnaire with contact details. Wellbeing visit has also been arranged for coach to visit hospital July 22. QAST update 07/09/22 The Organisational Development team are supporting the Tregaron Community Hospital team with regular open sessions on site, the next visit planned for the 21st September 2022. 29/09/2022- Organisational development team are supporting TCH with regular open sessions. 04/11/22 -QAST update: on 03/10/22 Organisational development team are supporting TCH with regular open sessions for staff to attend
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ ~~Jun-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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 27/01/2022 - 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. 18/05/2022 - all fire detector heads have been replaced and all call points are clear and accessible. Fire signage has been updated and fitted. In order to provide additional assurances on this, the estates team have procured an external company to assess all fire doors. This survey has identified further improvements necessary. This work is currently being costed and procured accordingly with anticipated timelines for completion after March 2022 (first quarter of 2022/23). End of March fire doors, single tender action completed, 10 fire doors have been ordered, delivery expected to take 10 – 12 weeks. Anticipated mid-June, 5 days' work time has been identified in readiness to fit the doors when they arrive. Hence new completion date 30th June 2022. QAST Update 11/07/22 Fire/anti ligature doors, Doors are on order and are due for supply and install shortly. They have been on a 12 week order, because they have to be specially manufactured to be fit for purpose. Estates are liaising directly with the company and the work to fit them once they are delivered has been identified as a priority. QAST update 07/09/22 There was a further delay on the installation of the doors as Head of Fire Safety explained the service changed the use of certain rooms with good reason. The HB were not made aware initially and so we have had to change the specification of the doors as a consequence. They were delivered w/c 26/08/22 and all doors EXCEPT 3 were installed. The 3 that were not installed had to be sent back due to the change in specification. The manufacturers have reported a 3-4 week turnaround expected completion by 31/10/22. QAST Update 01/11/22 all work completed from fire plan, further improvements identiied, currently being costed.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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 its 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~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	21/12/2021 - Factual accuracy completed to advise that this was incorrect: The unit is divided into 3 independent care areas each with its 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. 18/05/2022 - The MH&LD 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 during May 2022. An implementation plan will also be presented alongside the procedure for ratification, demonstrating how this will be enacted and adopted going forward. Seclusion and other Mental Health Act matters are reported to, and monitored at, the Mental Health Legislation Scrutiny Group. This group feeds into the Mental Health Assurance Committee and the MH&LD Quality Assurance and Experience Group. April confirmed on course to submit MH&LD Seclusion. QAST update 11/07/22 report was on course to be presented at Committee May 2022, outcome awaited. QAST update 07/09/22 An extraordinary Written Control Document Group was held on the 15th June 2022 to ratify the new Ty Bryn Service Specification, however further work is required to describe the future inpatient service. Senior Nurses and clinicians have visited Learning Disability units across other Health Boards in Wales. Population and benchmarking data have been reviewed. It is anticipated that an SBAR report will be presented to the MH/LD Business performance and planning group on Thursday 28th July 2022. The outcome is awaited. QAST update 01/11/22, outcome fo planning group awaited.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ ~~Jun-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	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. 18/05/2022 - 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. The Health Board dress code policy will be referenced within the service specification. Service specification is on hold whilst staff visit other areas of good practice to inform purpose of unit and the dress code will be informed by this process. Planned completion date 28th June 2022. QAST Update 11/07/22 outcome of service specification awaited. QAST update 07/09/22 dependant on completion of service specification. QAST update 01/11/22 dependant on completion of service specification.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ ~~Jun-22~~ ~~July-22~~ Nov-22	Red	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. 27/01/22 - 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. 18/05/2022 - external landscaping work completed December 2021. Remaining work is due to commence early February 2022, with a view for works being completed by March 2022. The boundary fence is appropriate for the service area and procurement completed and contractors already engaged. Last update 28 March 2022 – Although work has started the new boundary fence is not yet in situ. Hence new completion date 30th June 2022. QAST update 11/07/22 Outside fencing, work will be starting on July 7th 2022 and is anticipated to take three weeks to complete. QAST update 07/09/22 Progress very slow and disappointing from a national supplier. Estates have called the management to a site meeting that is to take place Tuesday 30th August, delays have cited labour issues. QAST update 01/11/22, no further update on progress received.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ ~~Jun-22~~ ~~July-22~~ Nov-22	Red	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. 18/05/2022 - Environmental work commenced early February 2022, with a view for works being completed by 31 March 2022. The unit is currently closed, but when re-opened and patients admitted, individual risk assessments will be undertaken. QAST update 11/07/22 Outside fencing, work will be starting on July 7th 2022 and is anticipated to take three weeks to complete. QAST update 07/09/22 Progress very slow and disappointing from a national supplier. Estates have called the management to a site meeting that is to take place Tuesday 30th August, delays have cited labour issues. 15/09/2022 - Estates have advised that installation to be paused based on the changing needs of the service. Current works due to complete on 26th September, with further work to be paused awaiting outcome from the service. QAST update 01/11/22 The unit is currently closed, but when re-opened and patients admitted, individual risk assessments will be undertaken.

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
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ Dec-22	Red	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. 18/05/2022 - The Mental Health and Learning Disabilities Directorate (MH&LD) have established an accommodation group to manage this work. Each Head of Service also provides a report to the MH&LD Quality, Safety and Experience Group. Where appropriate, unresolved environmental issues or operational risks will be escalated to Operational Quality, Safety and Experience Sub-Committee or to the Health and Safety Assurance Committee. MH&LD and estates will discuss the reintroduction of the regular meetings to monitor and develop environmental action plans to ensure the necessary assurances are satisfactory (these were put on hold due to COVID-19). Awaiting a maintenance plan from Estates going forward. QAST update 11/07/22 maintenance plan awaited from Estates. QAST update 07/09/22, plan awaited once Remainer of work is complete. 16/09/2022 - doors due to be installed September 20th, 2022 as confirmed by Estates QAST update 01/11/22 The Mental Health and Learning Disabilities Directorate (MH&LD) have established an accommodation group to manage this work, expected to be completed by Dec 22. QAST update 01/11/22 work with Improvement Cymru on national priorities for LD services underway.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ Dec-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. 18/05/2022 - 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. 28th March 2022 – Update, training programme is underway, inclusive of but not limited to, medication management and mental health act training. Service specification is on hold whilst staff visit other areas of good practice to inform purpose of unit. The service specification will them be amended and go through approval processes which will inform the training package further. QAST update 11/07/22, awaiting outcome of service specification, which will inform the training package further. QAST update 07/09/22 dependant on approval and finalisation of service specification. Completion date Dec 2022.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ Dec-22	Red	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. 18/05/2022 - update 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. QAST update 11/07/22, awaiting outcome of service specification, which will inform the training package further. QAST update 07/09/22 dependant on approval and finalisation of service specification. Completion date Dec 2022. QAST update 01/11/22 work with Improvement Cymru on national priorities for LD services underway.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ ~~Jun-22~~ Dec-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. 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. 18/05/2022 - Service specification is on hold whilst staff visit other areas of good practice to inform purpose of unit. The service specification will then be amended including staffing establishment that will be required based on the unit. The service specification will then go through approval processes which will inform the training package further. 28th March 2022 update – New interim leadership structure put in place which will support the continued development of the specification in conjunction with AMH colleagues. Hence new completion date 30th June 2022. The staffing establishment may involve recruitment / or consideration of acuity of patients and will be reviewed to account for these aspects. QAST update 11/07/22, awaiting outcome of service specification, which will inform the staffing levels further. QAST update 07/09/22 dependant on approval and finalisation of service specification. Completion date Dec 2022. QAST update 01/11/22 leadership structure put in place which will support the continued development of the specification in conjunction with AMH colleagues. The staffing establishment may involve recruitment / or consideration of acuity of patients and will be reviewed to account for these aspects.
HIW_21003_TB	Jan-22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	HIW_21003_TB_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~~ Dec-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. 18/05/2022 - 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. QAST update 11/07/22 no further update received. QAST update 07/09/22 no update received. QAST update 01/11/22 Workforce and Organisational Development supporting staff, 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.
HIW_21066_PPHW7	Feb-22	HIW	Ward 7, Prince Philip Hospital 2/3 November 2021 (Publication date 4 February 2022)	Open	N/A	Unscheduled Care (PPH)	Workforce & OD	Deputy Head of Nursing	Director of Operations	HIW_21066_PPHW7_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~~ ~~Aug-22~~ ~~Sep-22~~ ~~N/K~~ Jan-23	Red	No update received from QSE team on progress against this recommendation as at 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. 18/05/2022 TNA Meeting was planned for March 2022, focussing on PPH Ward 7, recognising delays of the Health Board TNA process, with the aim of completing by 30/04/2022, however the update in May 2022 is that this piece of work is not yet complete. Aiming for August 2022. QAST update 11/07/22 TNA underway to be completed within 2 months, new completion date of 30/09/22 QAST 07/09/22 update await completion of TNA. QAST update 01/11/22 Clinical Education Manager has met with staff and a Learnng Needs Analysis Toolkit has been drafted and is in review by the Health Board Education team.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001c	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will develop a consistent format for documentation that is meaningful for patients.	Jan-23	Jan-23	Amber	QAST update 07/09/22 T&F group developed.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001d	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will co-produce with service users a leaflet to support the documentation	Jan-23	Jan-23	Amber	QAST update 07/09/22 T&F group developed.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_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.	All CMHT's have identified practitioners who will ensure the annual health checks are undertaken. Each CMHT operates a link worker system with GP practices to promote physical wellbeing for patients.	Sep-22	~~Sep-22~~ ~~N/K~~ Jan-23	Red	18/05/2022 -Current evaluation of the team areas is being conducted –being led by Senior Nurse SC. QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_004b	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.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	Mar-23	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_005b	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.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	Mar-23	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning

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
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_006c	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.	To exponentially increase the SPOC service to 24/7 service.	Dec-22	Dec-22	Amber	QAST update 07/09/22 A SPOC service was rolled out across the Health Board following successful completion of the pilot. The SPOC service was initially be available 09:00hours to 23:59hours / 7 days a week, the service is currently operational 9am – 23.30 7 days a week. Upon recruitment completion this will increase to a full service. QAST update 01/11/22 The SPOC is now operation and will be 24/7 from 6/11/22.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_014b	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.	To review the information and wellbeing advice held on the IAWN App (developed by the service).	Dec-22	Dec-22	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 no update yet received from service.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_014c	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.	To ensure that as the West Wales Action Mental Health (WWAMH) directory is updated it is shared with operational teams for information. The WWAMH directory includes 3rd sector service availability.	Dec-22	Dec-22	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 the directory is automatically updated December each year.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_015a	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.	To progress the work, that is already underway with 3rd sector partners, to understand the issues in the local context.	Dec-22	Dec-22	Amber	18/05/2022 - Understand the issues in the local context before identifying further actions through discussions with WWAMH. Aileen Flynn will support with this QAST update 07/09/22 no update on this recommendation to date. QAST udpate 01/11/22 chased Oct 22. No repsonse yet received.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_015b	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.	To discuss the findings with the WWAMH and identifying further actions as required.	Dec-22	Dec-22	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 no update yet received from service.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_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.	To complete the work that is already underway to outline the steps regarding the development and recruitment of the MH practitioner role.	Sep-22	~~Sep-22~~ N/K Dec-22	Red	18/05/2022 - PAS team to liaise with SDM of Psychological Therapies to develop a response and obtain updates QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no service update received.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_019a	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.	To progress the work, that is already underway with partners, to understand the issues in the local context.	Dec-22	Dec-22	Amber	18/05/2022 - Understand this within our local context through engagement with WWAMH QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no update received.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_019b	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.	To discuss the findings with the WWAMH and identifying further actions required.	Dec-22	Dec-22	Amber	QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no update received.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_001	N/A	Patients are assessed in a timely manner if they have physical health problems and for doctors on the ward to feel supported by their colleagues on the general wards	Senior medical staff from Mental Health Services and General Acute Services in Prince Philip Hospital to liaise and discuss how communication to support timely assessments and support can be improved upon for doctors.	Nov-22	Nov-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_002	N/A	Work must be undertaken to improve the appearance of the garden.	Estates will review the garden and identity work plan to improve appearance.	Nov-22	Nov-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_003	N/A	Appropriate and safe curtains are to be placed in patient bedrooms	Estates to review the environment in bedrooms and identity work plan to replace curtains.	Nov-22	Nov-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_005	N/A	The washing machine is replaced or fixed	Estates work to be carried out and regular maintenance of washing machine to be arranged	Dec-22	Dec-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_007	N/A	Invest in appropriate observation mirrors to enable staff to see concealed areas in section 136 suite.	Estates to review environment and work plan formulated to ensure appropriate observation mirrors are in use.	Dec-22	Dec-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_009	N/A	Staff offices and communal areas require refresh and repainting	Estates to review and build in regular maintenance of surroundings into work plan.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_010	N/A	Carpets need replacing with proper flooring to prevent hazards and risks of infection	Estates work to be carried out and regular maintenance of flooring and surroundings to be arranged.	Dec-22	Dec-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_011	N/A	Tea bay needs a complete refurbishment, and a fridge must be made available for the patients	Estates to review to be carried out including the provision of a fridge and regular maintenance of tea bay and surroundings to be arranged.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_012	N/A	A designated office space is made available on the ward for Dr and medical staff	Senior Nurse and Ward Manager have identified area. Estates work required to modify area.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_015	N/A	Shelving in clinical room is replaced and reorganised.	Estates work to be carried out and regular maintenance of shelves and surroundings to be arranged. Shelves to be reorganised once Estates work has been completed.	Dec-22	Dec-22	Amber	QAST update 01/11/22 chased action Oct 2022.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and 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 costs of destruction. As clarified above this work will be progressed early in the new year.	Mar-19	~~Jul-21~~ Nov-22	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 planned for the February 2021 with a view to implementing the training sessions towards the middle of next year. Revised timescale of July 2021. 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 partially addressed - Current findings - Embargos of health records imposed by the UK Government remain in place. This continues to impact on the Health Board's ability to destroy records. However, the current audit programme of the storage facilities being undertaken by the Information Governance team will enable the Health Board to create an overall view of the location of records and what action will be necessary to take in relation to the retention and destruction of records. 19/04/2022 - update provided to ARAC stated that the following works remain in order to complete the recommendation: 1) Develop a proposal for unifying all patient records management accountabilities under one executive lead (May 2022). 2) Following on from (1) relocation of records to Llangennech and Unit 3 Dafen ahead of scanning (November 2022, subject to review - dependent on freeing up space and notice periods for present arrangements). 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile

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
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and 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 *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	Mar-23	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. 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 partially addressed- Current findings - An audit programme of all storage providers has commenced by the Information Governance team headed by Sarah Bevan. We can confirm that details of the programme and outcomes were being reported through to the IGSC, such as the recent review of the Lloyd & Pawlett storage facility undertaken in July 2021. Issues identified following these audit reviews were placed on the IGSC risk register. 19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and 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) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	Mar-23	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. 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 partially addressed - Current findings - An audit programme of all storage providers has commenced by the Information Governance team headed by Sarah Bevan. We can confirm that details of the programme and outcomes were being reported through to the IGSC, such as the recent review of the Lloyd & Pawlett storage facility undertaken in July 2021. Issues identified following these audit reviews were placed on the IGSC risk register. 19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and 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~~ Nov-22	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 to lack of resource and the impact of Covid. Training was discussed at the last Welsh Health Records Management Group in regard to the development of an All Wales training materials over the next six months to supplement to the mandatory e-learning or in house records management training. This item remains of the agenda of the Health Records Management Advisory Group and further discussions are planned on developing records management training, unfortunately more urgent issues have surpassed the training element and have required more attention. Discussions at January 2022 Information Governance Sub Committee meeting confirmed that discussions are ongoing at a national levels to provide records management training as part of the services providing by e-learning and the e-learning model. The Health Board's Information Governance (IG) Manager has also confirmed that additional slides/information in regards records management will be included within the IG training. 19/04/2022 - update provided to ARAC with the following work remaining to be undertaken in order to close the recommendation 1) Identify shortfalls in records management processes and non-compliance with appropriate standards, within relevant services (November 2022). 2) Following on from (1) develop a plan for records management training within those areas (November 2022). 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile
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	Director of Communications	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~~ ~~Apr-22~~ 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. 02/11/2021-Demo has been provided of the new e-learning module, should be ready by December 2021. 29/03/2022- WL Service Manager confirmed draft was shared in a meeting earlier in March and should be live end of April 2022. 11/05/2022- Director of Communications confirmed this has been delayed at an All Wales level but a revised timescale is not yet known. 08/09/2022- Director of Communications to check current position with All Wales work and feedback to the Assurance and Risk Team.
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~~ ~~Jul-22~~ ~~Sep-22~~ Mar-23	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. 22/10/2021 - We are still experiencing some technical issues with a 3rd party supplier, however we have started the roll out of the tests switchboards across all 4 sites and are currently working closely with our supplier to resolve the technical issues, part of the delay has been trying to upgrade some existing live equipment to be compatible with the new solution. We envisage the technical solution to be in place by the 30/10/2021 when testing of the new solution can begin in earnest. We envisage the new solution to be in place and fully functioning by the end of February 2022, taking into account the feedback from existing operators with regard to making software tweaks and the training of, in excess of, 60 members of staff on the new switchboard solution. 04/11/2021 - Contract with third party supplier now finalised (29th October 2021) therefore HB now in position to move forward. Meeting has been scheduled for the w/e 5th November 2021 to discuss rollout plans - still on schedule for Feb 22 delivery. 11/01/2022 - still on course for Feb 22 completion 17/03/2022 - the first switchboard has been installed in GGH, and the remaining Switchboards will be operational by April 2022. When this recommendation can be formally closed. 03/05/2022 - update from internal audit: request for update sent on 27/04/2022 11/05/2022 - discussion with Digital Director confirmed that new virtual switchboard is live across all four sites, but is being parallel run at GGH, BGH and PPH. WGH is currently live on the new infrastructure. Envisaged that remaining three sites will be solely using the new switchboard by July 2022. 18/07/2022 - Withybush Switchboard has been live on the new infrastructure for the past 3 months, this has highlighted some technical issues in the new infrastructure and we are working with suppliers to overcome these challenges. Currently the other three sites have the new switchboards operating in a test environment where there are additional challenges owing to a mixture of Philips and Mitel phone systems. In addition due to the recent TUPE arrangements for the Withybush switchboard staff where they have moved employing organisation from Welsh Ambulance Services NHS Trust to Hywel Dda we have to pause some technical elements of the project which has caused the go live dates on GGH, BGH and PPH to move to the middle of September 01/11/2022 - awaiting completion of the final stages of work in order to close this recommendation, revised timescale provided. This is in line with the risk action plan as noted on the corresponding risk on the Digital register.

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-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~~ Jan-24	Amber	21/03/2022- Recommendation turned from red 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. 03/05/2022- January 2024 revised completion date provided to align with AHMMW report timescales, recommendation to remain amber as this future action cannot yet be evidenced as completed. Director of Estates, Facilities and Capital Management to send detail of the analysis of in house resources required for Major Infrastructure PBC. 18/07/2022- Documentation has been shared with Internal Audit, however further clarity required if this satisfies the recommendation requirement. 12/08/2022- Further detailed evidence required from IA - dates, plans and resources submitted to WG, more detail has been requested including phasing over the next 7 years. Further funding provided for wider delivery model- when that is signed off the UHB will issue resources required for full business case. Estates has progressed as much as possible at this stage. 12/09/2022-- On 22/07/22 funding of £150k of fees to develop the Business Continuity PBC. Further discussions with WG around future fee contributions will be had FY 23/24. 11/11/2022- coping work is now well underway and the current programme will present the outcome of this work in circa January 2023. Update being reported to SDODC November 2022. Internal Audit to check what is still required for this recommendation to be noted as completed.
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~~ Jan-24	Amber	21/03/2022- Recommendation turned from red 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. 03/05/2022- January 2024 revised completion date provided to align with AHMMW report timescales, recommendation to remain amber as this future action cannot yet be evidenced as completed . 18/07/2022- Documentation has been shared with Internal Audit, however further clarity required if this satisfies the recommendation requirement. 12/08/22-Further detailed evidence required from IA - dates, plans and resources submitted to WG, more detail has been requested including phasing over the next 7 years. Further funding provided for wider delivery model- when that is signed off the UHB will issue resources required for full business case. (same as above). The advanced piece of work will give us an opportunity of initial assessment of additional projects which are unrelated but in the same location, etc, but can only happen at the BJC stage. Estates has progressed as much as possible at this stage. 11/11/2022- Estates to send Internal Audit potential evidence to close this recommendaton.
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~~ Jan-24	Amber	21/03/2022- Recommendation turned from red 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. 03/05/2022- January 2024 revised completion date provided to align with AHMMW report timescales, recommendation to remain amber as this future action cannot yet be evidenced as completed . 18/07/2022- Documentation has been shared with Internal Audit, however further clarity required if this satisfies the recommendation requirement. 12/08/22-Further detailed evidence required from IA - dates, plans and resources submitted to WG, more detail has been requested including phasing over the next 7 years. Further funding provided for wider delivery model- when that is signed off the UHB will issue resources required for full business case. (same as above). The advanced piece of work will give us an opportunity of initial assessment of additional projects which are unrelated but in the same location, etc, but can only happen at the BJC stage. Estates has progressed as much as possible at this stage. 11/11/2022- Estates to send Internal Audit potential evidence to close this recommendaton.
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 Strategic Development and Operational Planning	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. 02/03/2022 & 03/05/2022- Expected to remain open until July 2023. 03/05/2022- outstanding rec expected to remain open until July 2023. Exec Lead amended from Director of Operations to Director of Strategic Development and Operational Planning as remaining recommendation is for Strategic Development and Operational Planning Directorate to implement. 12/08/22-Date remains July 2023 30/08/2022 - Director of Strategic Developments and Operational Planning confirmed no change. 10/11/2022 - Head of Captial Planning confirms no change.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	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~~ N/K	Red	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. 11/05/2022- Dedicated Exec Director responsible for Welsh Language now in post. WL Non-compliance assessment for Operational and Nursing Directorates will now be focused on (these directorates did not complete their self-assessments in 2021, and were not chased previously due to Covid-19/Operational pressures). 08/09/2022- Director of Communications is going to meet with recommendation owners to establish current position and feedback to the Assurance and Risk Team. 09/11/2022 - follow up rview currently underway, with report due to be presented at ARAC in December 2022
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	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~~ N/K	Red	02/11/2021- The Welsh language team are supporting those teams who are engaging, in the development of their action plans. 11/05/2022- Dedicated Exec Director responsible for Welsh Language now in post. WL Non-compliance assessment and action plans for Operational and Nursing Directorates will now be focused on (these directorates did not complete their self assessments in 2021, and were not chased previously due to Covid-19/Operational pressures). 08/09/2022- Director of Communications is going to meet with recommendation owners to establish current position and feedback to the Assurance and Risk Team. 09/11/2022 - follow up rview currently underway, with report due to be presented at ARAC in December 2022
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	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	Dec-22	Red	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. 11/05/2022- Dedicated Exec Director responsible for Welsh Language now in post. New Director of Communications has agreed a revised timescale of December 2022. WL Non-compliance assessment for Operational and Nursing Directorates will now be focused on (these directorates did not complete their self-assessments in 2021, and were not chased previously due to Covid-19/Operational pressures). 08/09/2022- Director of Communications is going to meet with recommendation owners to establish current position and feedback to the Assurance and Risk Team. 09/11/2022 - follow up rview currently underway, with report due to be presented at ARAC in December 2022
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	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	Apr-23	Red	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. 29/03/2022- WL Service Manager confirmed this is delayed. WL Discovery process planned for 2022/23. To seek the views of staff, patients, partners, exemplar organisations and the local population regarding ways to make Hywel Dda a model public sector organisation for embracing and celebrating Welsh Language and Culture (in the way we communicate, offer our services and design our estate and facilities for example). Steering Group will be looked at as part of this process. The aim is to have the WL plan in place to action by April 2023. Review progress of Discovery Process every quarter. 11/05/2022- Director of Communications confirmed date of April 2023. This Steering group will tie into the discovery report being written to establish the current gap. 08/09/2022- Director of Communications is going to meet with recommendation owners to establish current position and feedback to the Assurance and Risk Team. 09/11/2022 - follow up rview currently underway, with report due to be presented at ARAC in December 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_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 potential for achieving a single, consistent model.	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	~~Sep-22~~ N/K	Red	31/10/2022- Focusing on the ask of the original recommendation, across the Regional UEC Programme Delivery Group undertakes a monthly review of the agreed high level 3Cs outcome measures (Conveyance, Conversion and Complexity) and, to highlight any worsening trends, and focus through the delivery groups the expectation will be that focused outcome measures will be agreed by each Policy Goal Delivery Group, with exception reporting feeding up to the programme delivery board. This will develop equitable outcomes across the Hywel Dda patch, even if separate models across the counties is required and regardless if a dashboard is in place.Through the Policy Goals 5 & 6, the outcome measures that have been identified will be shared with all the Policy Goals Delivery Groups as required. Recommendation to be requested to be closed once the above is being reported through the Delivery Groups and explicit within the workplans, approximate date not yet known, this will be a long term recommendation to fully implement with the date currently not known. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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 potential for achieving a single, consistent model.	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.	Jul-22	~~Jul-22~~ N/K	Red	31/10/2022-This recommendation is being driven through the delivery groups of the UEC programme, as described above. These recommendations are to be included in the workstream workplan, along with the WG guidance once received. Timescale not yet known as awaiting WG guidance. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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~~ Mar-23	External	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 31/10/2022- agreed by Director of Primary Care, Community and Long Term Care that this recommendation is changed to 'external'. Discharge requirements are being reviewed at an All Wales basis, in light of developments following Covid-19.Once these are reissued (the All Wales review is expecting to be completed imminently), the UHB discharge policy will be refreshed. The current discharge policy will be requested to be extended for three months, whilst the UHB awaits guidance from WG following the All Wales review, as well as awaiting ministerial advice on the Delayed Transfer of Care (DTOC), which will also feed into the amended policy. Revised date of March 2023 timescale provided, and the recommendation is requested to be changed from red (overdue) to external (outside the gift of the UHB to implement) whilst the outcome of All Wales review is awaited. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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. 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 care packages are put in place.	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. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days	Apr-22	N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme.

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-2122-34	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. 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. 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 care packages are put in place.	Important to note that there is still work to be done on data quality,, which is being considered via performance teams and UEC board. 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 commence on admission and information can be provided to facilitate a conversation.	Apr-22	~~Sep-22~~ N/K	Red	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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	R9. 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 care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	~~Jun-22~~ N/K	Red	31/10/2022- Director of Primary Care, Community & Long-Term Care confirmed this recommendation is to remain open- even if it is picked up under UEC as it is clear from recent reviews across all sites that in the main the discharge planning process commences at too late a stage following admission. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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. The importance across the Region is that the key principles and standards within the discharge policy are met and considered within the partnership boards. 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).	Sep-22	~~Sep-22~~ Aug-23	Red	31/10/2022- Discharge to Recover then Assess (D2RA) pathways are being reviewed as part of the All Wales level work which feeds into the Policy Goal 6 work. Local Authority representatives are advising this national work. The Policy Goal 6 work is reviewing the processes and looking at a consistent approach. This is linked to the Programme delivery group structure now in place, as noted in the recommendation above. We recognise there is more work to do and therefore the work of this recommendation will be added into the relevant workstreams. Work is continuing however the UHB is mindful of the All Wales guidance which is expected imminently. Assurance and Risk Officer awaiting confirmation this recommendation has been added to the releavnt workstream. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Digital and Performance	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	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 has requested an urgent response from Deputy Digital Director. 03/05/2022-clarifying with Internal Audit if any update received from lead officer. 10/05/2022- Reporting officer continues to chase the Digital Director for a response. 23/08/22- Director of W&OD - possibly superseded by new IA report that went to last ARAC, may not need electronic leavers form if managers use ESR correctly? check new IA report. Director of W&OD believes this can be closed. 30/09/22-Electronic starter forms key to many further actions eg: could alert a potential new vacancy, could link with new ID/Control Access forms (stop access), stop over payments etc (I understand the Fraud team are keen on this also)... - I understand HDUHB are one of the only HB not to have Electronic Starter Forms (to avoid lack of payments to new starters etc) and Electronic Leaver forms have been on our list as part of our digital wish list for years. Getting managers to use eg ESR or Trac properly is easier said than done; Assurance team are awaiting clarity from Internal Audit 08/11/2022-Lead officer confirmed this recommendation is still with the Digital team 09/11/2022 - to obtain clarification whether this recommendation is relaiant on external digital factors such as DHCW, in which case the status of the recommendation can be changed to "External", if the development sits with HB digital teams, then a revised timescale will be sought
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	~~Jun-22~~ Aug-23	Red	31/10/2022- There are processes in place through the weekly panels, where process issues are identified, however as a UHB we are aware the learning is not routinely fed back. As part of the Policy Goal 5 Delivery Group work Safer review, learning will be considered and processes identified to support embedding this learning. As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by Improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the PG5 workplan, approximate timescale August 2023 for this process to be embedded. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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 reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	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 assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-22~~ Mar-23	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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 although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	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	~~Jun-22~~ Aug-23	Red	31/10/2022- Related to the Policy Goal 5 Delivery Group Safer review and outcome measures. Approximate timescale of August 2023. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate
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~~ N/K	Red	06/01/2022 - request for update sent as part of service update e-mail 08/07/2022 - discussion with internal audit confirmed that Financial Management Review due this financial year, where outstanding recommendations will be picked up 31/08/2022 - request for update sent to Finance as part of service update e-mail. 07/11/2022 - request for update sent to Finance as part of service update e-mail. 09/11/2022 - confirmation received from internal audit that a follow up is planned, and awaiting confirmation of scope of the review prior to fieldwork commencing
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~~ N/K	Red	06/01/2022 - request for update sent as part of service update e-mail 08/07/2022 - discussion with internal audit confirmed that Financial Management Review due this financial year, where outstanding recommendations will be picked up 31/08/2022 - request for update sent to Finance as part of service update e-mail. 07/11/2022 - request for update sent to Finance as part of service update e-mail. 09/11/2022 - confirmation received from internal audit that a follow up is planned, and awaiting confirmation of scope of the review prior to fieldwork commencing
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	11/11/2022-Progress to be requested in early 2023 to ensure this is on track.

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-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_001a	Medium	R1. The circumstances in which the engagement of non-clinical temporary staff is permitted and the processes to be followed in doing so should be reviewed and agreed, then formally documented and communicated with appropriate staff. Directorates involved in the engagement of non-clinical temporary staff should have input into the development of these processes.	No agencies should be engaged with to directly hire staff without prior approval. A protocol will be developed by the Workforce & OD Directorate to cascade to all Directors and managers for implementation. The Directorates identified in the sample for the engagement of temporary staff will be asked to contribute to the development of this process.	May-22	~~May-22~~ ~~Oct-22~~ N/K	Red	10/05/2022- Internal Audit confirmed May 2022 timescale is still correct. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-The requirement for Managers to engage with workforce & OD before any agency is contacted to supply workers was communicated to Eds March 2022. Draft Managers Guide for all agency usage has been developed and circulated to Managers previously involved in the engagement of non-clinical temporary staff for comment by end July 2022. Aim to present the final document to PODCC in October 2022. 23/08/2022- Director of W&OD confirmed on track for Oct-22, to be presented to PODCC by Senior Workforce Manager. 26/10/2022 - AG1 form for seeking approval for non-clinical agency usage has been drafted. Process for agency spend authorisation to be agreed with Director of WOD. 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022- A managers guidance and application forms for non-clinical agency staff has been developed. The guidance is based on the 'Control measures to reduce expenditure on agency staff' guidance drafted for all staff groups and previously circulated to managers involved in the engagement of non-clinical temporary staff. The application forms request information on efforts to fill the role prior to seeking agency use. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_002	Medium	R2. The rationale for engaging temporary staff should be clear and discussed with Workforce to explore suitable alternatives (such as upskilling, fixed term contract or secondment) prior to engagement. Where an engagement relates to additional capacity/expertise for a specific task (e.g., the delivery of a project), the resource requirement should be clearly set out within the approved business case/project documentation, with evidence of approval for extensions.	The Workforce Efficiency Team in the Resourcing and Utilisation function of the W&OD Directorate will develop a process for the engagement of non-clinical temporary staff. This process will include reference to the steps which need to be completed prior to any temporary staff engagement being authorised to ensure all efforts to avoid the need for temporary staffing are exhausted.	May-22	~~May-22~~ ~~Oct-22~~ N/K	Red	10/05/2022- Internal Audit confirmed May 2022 timescale is still correct. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Managers guide referred to in HDUHB-2122-39_001a will include the process for booking agency workers and the specific arrangements for each staff group. 23/08/2022- Director of W&OD confirmed on track for Oct-22, to be presented to PODCC. 26/10/2022 - draft guidance for agency usage across all staff groups has been developed. Process for ED sign off to be agreed. 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022- A managers guidance and application forms for non-clinical agency staff has been developed. The guidance is based on the 'Control measures to reduce expenditure on agency staff' guidance drafted for all staff groups and previously circulated to managers involved in the engagement of non-clinical temporary staff. The application forms request information on efforts to fill the role prior to seeking agency use. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_003a	High	R3. NWSSP Procurement Services should be engaged for support and advice in the procurement of non-clinical temporary staff to ensure procurements represent value for money and are compliant with the Public Contract Regulations. Framework documentation must be completed and approved by both parties for procurements via framework supplier. Purchase orders should be raised at the point of engagement rather than retrospectively.	Director of Workforce & OD and Director of Finance to meet with Head of Procurement to develop a management guide which ensures all managers are aware of the actions they are required to take when procuring workers via frameworks.	Apr-22	~~May-22~~ ~~Oct-22~~ N/K	Red	03/05/2022- update via Internal Audit- response indicates request that date should be May 2022, therefore to follow up at later date. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Managers guide referred to in HDUHB-2122-39_001a will include the requirement for budget holders to engage with NWSSP Procurement Services in the procurement of temporary staff from external suppliers. 23/08/2022- Director of W&OD confirmed on track for Oct-22, to be presented to PODCC. 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022 - Complete. The guidance had already been developed by finance colleagues and was resubmitted to procurement for implementation. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_003b	High	R3. NWSSP Procurement Services should be engaged for support and advice in the procurement of non-clinical temporary staff to ensure procurements represent value for money and are compliant with the Public Contract Regulations. Framework documentation must be completed and approved by both parties for procurements via framework supplier. Purchase orders should be raised at the point of engagement rather than retrospectively.	All paperwork to be linked into process identified in action above and documentation to be submitted to and checked by Resourcing team prior to authority to proceed is given.	May-22	~~May-22~~ ~~Oct-22~~ N/K	Red	10/05/2022- Internal Audit confirmed May 2022 timescale is still correct. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Process to be developed with NWSSP 23/08/2022- Director of W&OD confirmed on track for Oct-22, to be presented to PODCC. 26/10/2022 - AG1 form for seeking approval for non-clinical agency usage has been drafted. Process for agency spend authorisation to be agreed with Director of WOD. 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022 - A managers guidance and application forms for non-clinical agency staff has been developed. The guidance is based on the 'Control measures to reduce expenditure on agency staff' guidance drafted for all staff groups and previously circulated to managers involved in the engagement of non-clinical temporary staff. The application forms request information on efforts to fill the role prior to seeking agency use. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_004a	High	R4. A central record of temporary staff usage should be maintained by Workforce so that they can proactively engage with appointing managers to assess resource requirements and explore longer-term, more cost-effective alternatives to agency usage. This information can also be used to inform the wider workforce planning and recruitment arrangements through the identification of gaps in resource /expertise and hard-to-fill posts. Appointing managers should liaise with finance colleagues to ensure the accuracy of temporary staff expenditure coding within the ledger. This would facilitate the maintenance and monitoring of a central record of temporary staff usage. Expenditure on non-clinical temporary staffing over and above the agreed establishment should be monitored and reported to an appropriate forum.	regular reporting of all agencies spend (clinical and non-clinical) to be sent to Assistant Director of Workforce & OD (Resourcing & Utilisation) monthly to ensure all non-clinical spend is known and any breaches to agreed procedure is managed appropriately.	Apr-22	~~May-22~~ ~~Oct-22~~ N/K	Red	03/05/2022- update via Internal Audit- response indicates request that date should be May 2022, therefore to follow up at later date. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Process for the recording of temporary staff usage requests to be developed 23/08/22- Director of W&OD to check with Senior Workforce Manager as she doesn't believe she has seen these regular reports yet. 27/09/2022- Senior Workforce Manager to provide update following meeting with Director of W&OD taking place on 30/09/2022. 03/10/2022 – monthly reports requested from Finance on non-clinical agency spend 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022 - Procurement sending through weekly reports on requisitions received in respect of non-clinical agency usage. Current expenditure on current assignments has been identified and FBPs asked to support identification of workers with a view to linking with services to develop exit strategies. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_004b	High	R4. A central record of temporary staff usage should be maintained by Workforce so that they can proactively engage with appointing managers to assess resource requirements and explore longer-term, more cost-effective alternatives to agency usage. This information can also be used to inform the wider workforce planning and recruitment arrangements through the identification of gaps in resource /expertise and hard-to-fill posts. Appointing managers should liaise with finance colleagues to ensure the accuracy of temporary staff expenditure coding within the ledger. This would facilitate the maintenance and monitoring of a central record of temporary staff usage. Expenditure on non-clinical temporary staffing over and above the agreed establishment should be monitored and reported to an appropriate forum.	The issuing of guidance referred to in point 1 will ensure managers are aware of their need to ensure regular discussion with Workforce and Finance to ensure usage is correctly recorded.	May-22	~~May-22~~ ~~Oct-22~~ N/K	Red	10/05/2022- Internal Audit confirmed May 2022 timescale is still correct. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Will be included in Managers Guide 23/08/22- Director of W&OD confirmed on track for Oct-22, to be presented to PODCC by Senior Workforce Manager. 26/10/2022 - Approval form for non-clinical agency usage drafted. Process for agency spend authorisation to be agreed with Director of WOD. 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022 - A managers guidance and application forms for non-clinical agency staff has been developed. The guidance is based on the 'Control measures to reduce expenditure on agency staff' guidance drafted for all staff groups and previously circulated to managers involved in the engagement of non-clinical temporary staff. The application forms request information on efforts to fill the role prior to seeking agency use. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-39	Mar-22	Internal Audit	Non-Clinical Temporary Staffing	Open	Limited	Workforce & OD	Workforce & OD	Assistant Director of Workforce & OD	Director of Workforce & OD	HDUHB-2122-39_004c	High	R4. A central record of temporary staff usage should be maintained by Workforce so that they can proactively engage with appointing managers to assess resource requirements and explore longer-term, more cost-effective alternatives to agency usage. This information can also be used to inform the wider workforce planning and recruitment arrangements through the identification of gaps in resource /expertise and hard-to-fill posts. Appointing managers should liaise with finance colleagues to ensure the accuracy of temporary staff expenditure coding within the ledger. This would facilitate the maintenance and monitoring of a central record of temporary staff usage. Expenditure on non-clinical temporary staffing over and above the agreed establishment should be monitored and reported to an appropriate forum.	All non-clinical agency will be reported as part of the workforce controls planning objective regardless of funded establishment as agency if not used in the right circumstances if poor financial management. This will be reported to the Executive Team.	Apr-22	~~May-22~~ ~~Oct-22~~ 30/11/22	Red	03/05/2022- update via Internal Audit- response indicates request that date should be May 2022, therefore to follow up at later date. 08/07/2022 - advised by internal audit that a follow up report is scheduled for 2022/23, with report due to ARAC in Feb 22 18/07/22-Process to be developed 23/08/22- Director of W&OD to ask Senior Workforce Manager for clarity, as she doesn't believe she has seen these regular reports which were being developed with Finance. 27/09/2022- Senior Workforce Manager to provide update following meeting with Director of W&OD taking place on 30/09/2022. 03/10/2022 – monthly reports requested from Finance on non-clinical agency spend 27/10/22: IA are currently undertaking a follow up review on tese so should be able to provide the Assurance Team with rec's that have been addressed or remain open. 07/11/2022 - A People Effectiveness Team has been developed with the Workforce and OD Directorate who will oversee all Workforce Effectiveness Programmes and from 7th November will develop a dashboard to report on compliance across a number of areas of non-clinical agency usage and exit plans being one of the metrics. Recommend either close as plan in place or extend deadline to 30/11/22 for first draft of dashboard. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022
HDUHB-2122-24	Mar-22	Internal Audit	Primary Care Clusters	Open	Reasonable	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Rhian Bond	Director of Primary Care, Community & Long Term Care	HDUHB-2122-24_002	High	R2. Management should ensure arrangements are in place for assurance reporting to the appropriate subcommittee of the Board on key aspects of Primary Care Clusters.	A Cluster IMTP Progress Report will be provided to an appropriate Health Board / Committee meeting on a quarterly basis. The exact committee will be identified with relevant officers in due course, with the intention of implementation in time for Quarter 1 reporting.	Jul-22	Dec-22	Red	18/05/2022- Quarter 1 IMTP progress report will go to the Strategic, Development and Operational Delivery Committee (SDODC) in August 2022, and then quarterly thereafter. 29/06/2022: A report will be going to SDODC on the 25/08/2022. 27/09/2022- Director of Primary Care, Community & Long Term Care confirmed revised date of December 2022. Assistant Director of Primary Care to meet with Board Secretary to clarify and agree the governance arrangements for Primary Care, including Primary Care clusters. 09/11/2022 - follow up due to be undertaken in Q4
HDUHB-2122-18	Apr-22	Internal Audit	Network and Information Systems (NIS) Directive	Open	Substantial	Digital and Performance	Digital and Performance	Paul Solloway/ Anthony Tracey	Director of Finance	HDUHB-2122-18_001	Medium	R1. Management should report the NIS Directive to the Board in a private session due to the risk of sharing cyber security details in the public domain, and ensure that members are presented with information including, but not limited to: • NIS Directive and Health Board requirements as an Operator of Essential Services (OES); • Repercussions of non-compliance including potential fines; • Current compliance position of the Health Board; and • Cyber Security Programme.	As part of the NIS Directive compliance, an 18-month programme is in development. One of key elements is the requirement for each Board Member to be aware of Cyber Security issues, and as such a suitable Board Seminar session is under discussion with the Board Secretary.	Aug-22	~~Aug-22~~ Nov-22	Red	11/05/2022 - recommendation on course to be implemented within noted timescales., with discussions currently being held to determine if the presentation should be given at Board, Board Seminar or a specific meeting. 06/10/2022 – seminar has been rescheduled for November 2022 as the September 2022 was impacted by the additional bank holiday. Revised completion date noted, and recommendation to be closed once Board Seminar has been undertaken.
SSU_WHSSC_2122-02	Apr-22	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Reasonable	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	SSU_WHSSC_2122-02_003b	Low	R3. Additional labour rates should be contractually agreed.	3.2 Agreed. Evidence that the additional labour rates have been contractually agreed to be submitted to Capital Audit.	Sep-22	~~Sep-22~~ Mar-23	Red	08/07/2022: Update received from Assistant Major Capital Development Manager that progress is ongoing. 12/08/2022-No changes, Interim General Manager Women & Children needs to respond. 09/11/2022 - Internal audit to request progress updates and revised timescales. 11/11/2022- Capital Development Manager has provided a revised date of March 2023. NWSSP-SES are advising draft PCG with Tilbury Douglas (external company) for final comment before they will be issued out to HB's to formally send to TD for execution prior to return for HB execution.
SSU_WHSSC_2122-02	Apr-22	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Reasonable	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	SSU_WHSSC_2122-02_005	Medium	R5. The Health Board should confirm provision of a Parent Company Guarantee in respect of Phase II of the Women and Childrens project at Glangwili.	5.1 Agreed. A new Parent Company Guarantee which includes changes to registered head office for both contractor and parent company, and the rebranding of the contractor, are in the process of being completed. The SCP is currently actioning, and has advised that this could take a further two months to complete.	Jul-22	~~Jul-22~~ ~~Sep-22~~ Mar-23	Red	08/07/2022: Update received from Assistant Major Capital Development Manager as follows - "Extension of time agreed. The SCP has announced that it is becoming an independent company. Framework Managers to confirm new company status, and whether PCG or other form of guarantee is required." Revised extension of September 2022 provided, this is outside of our control to action and could take longer. 12/08/22-No changes, Interim General Manager Women & Children needs to respond. 09/11/2022 - Internal audit to request progress updates and revised timescales. 11/11/2022- Welsh Government has issued revised Parent Company Guarantees to Tilbury Douglas (external company) and are awaiting their response/sign off. Should be rceived by end November 2022. Revised timescale March 2023. This is not a scheme specific problem, but a framework problem across the whole of Wales re. Tilbury Douglas contracts.

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-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_002b	High	R2. Training should be made available to staff to ensure that they are able to identify and manage ligature risks and perform ligature audits in line with the guidance.	A bespoke training session will be arranged for key members of staff already involved in POL audit work which will include but not be limited to the procedure, audit forms and process for managing action plans	Jun-22	Jun-22 Dec-22	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/22 - request for update sent to Head of Health and Safety, with the following response received: Training has commenced with three wards and one Nurse Forum meeting attendance - This is continuing. To confirm with internal audit if the ongoing process is sufficient to close this recommendation. 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - Tim Harrison has added to H&S training and bespoke training. 03/10/2022 - training content has been updated, and is currently being delivered to key staff. Revised recommendation date of December 2022. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_003c	High	R3. Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile.	There will be a process introduced whereby the HB Quality Assurance and Safety Team to oversee the closure of all actions on completion. This will be included in the SOP.	Jul-22	~~Jul-22~~ Dec-22	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - The service are in discussion with internal audit in order to obtain assurance that this recommendation has been implemented. 03/10/2022 - query raised by the Chair of the Accommodation Group, Assistant Director of Nursing, MHLD and Head of Health, Safety and Security that the Quality team will be involved in the walkabout, however action plans should be closed and agreed at the accommodation group. To request confirmation from internal audit if this satisfies the original recommendation. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_005a	High	R5. Where remedial action is required, these actions should be captured in an action plan and assigned a priority RAG rating, responsible officer and deadline for completion. A single, centralised MH&LD ligature action plan may be appropriate as this would facilitate central oversight (for example, by the Quality & Safety Team, as for HIW actions), monitoring and sharing of risks identified for consideration at other sites.	As part of the development of the WCD the template will be amended to ensure that the RAG rating, responsible officer and deadline for completion are able to be captured.	May-22	~~May-22~~ ~~Sep-22~~ Dec-22	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update, with the following response received: Recommended for wards to start using this latest template to document their assessments and action plans. Completion date revised in line with formal approval of the procedure at HSAC scheduled for September 2022. 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - Will be completed once guidance document has gone through HSC on 12/09/2022. Revised date of 30/09/2022. 03/10/2022 - WCD approved at 11th September HSAC meeting, however the RAG status not currently included on the template. The risk score is included on the template in lieu of the RAG status, and is felt to be more meaningful than the use of a RAG status. To confirm with internal audit if this is sufficient to close the recommendation. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_006	High	R6. Actions should be monitored through to implementation, with assurance reported to an appropriate forum/sub-committee.	Actions should be monitored through to implementation, with assurance reported from the MH/LD accommodation group to the MH/LD QSEG.	Aug-22	~~Aug-22~~ ~~Sep-22~~ Dec-22	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - To be included in report to BPPAG end of Sept 2022 and verbal update from Liz to QSEC in October 2022. 03/10/2022 - actions arising from the accommodation group are escalated to MHLD BPPAG, and where necessary to MHLD QSE. As this is a new mechanism in place, revised completion date suggested of December 2022 in order to evidence the process. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-01	May-22	Internal Audit	Risk Management & Board Assurance Framework	Open	Substantial	Governance	Governance	Assistant Director of Assurance & Risk	Board Secretary	HDUHB-2122-01_001	Medium	R1. Assurance arrangements and responsibilities for monitoring principal risks in the longer-term should be reviewed and clarified. If it is determined that Board committees will be responsible for principal risks on the BAF, committees should be provided with sufficient information to enable them to discharge this duty.	The Board previously agreed that they would receive the principal risks as these provide the Board with information on how the organisation is progressing against its strategic objectives. Reporting arrangements for principal risks will be considered as part of the review of both the Risk Management Strategy and Committee business/workplans planned for 2022/23.	Dec-22	Dec-22	Amber	
HDUHB-2223-32	Jul-22	Internal Audit	Follow-up: Deployment of WPAS into MH&LD, issued July 2022	Open	Substantial	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2223-32_001	Medium	2.4 The outline testing plan should be further developed and documented for the remaining services, to include but not limited to: • roles and responsibilities • scope • testing strategies and acceptance criteria • schedules Testing results should be appropriately reviewed and signed-off to ensure that an accurate assessment of readiness can be determined prior to go-live.	2.4 The Project Team will strengthen the readiness work and testing process for each service going forward, capturing this detail in the mapping documentation.	Nov-22	Nov-22	Amber	25/07/2022 - This report now supersedes HDUHB-2122-42. 25/07/2022 - Whilst a testing plan document has not been developed, the risk assessments undertaken for the next services to go live, namely Children's Neurodevelopmental Service and Admiral Nurse Service, include migration of data and data cleansing on the risk action plan. Action logs from Project Team meetings capture discussions and actions relating to testing data prior to go live, therefore, demonstrating that testing has been considered and progressed. We conclude partial implementation of recommendation 2.4.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004a	Medium	R4. Future Contracts - The timely completion of all contract documentation for respective parties involved at the project.	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22-evidence will be provided via a future action- for all approved contracts all are in place. Internal Audit to check on the background on the recommendation to establish when this can be closed. 07/09/22- IA to obtain clarification of what is required for this recommendation to be closed, or may need to remain open as a future action. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004b	Low	R4. The Project Manager's report should be updated to reflect an accurate assessment of the status of project contract documentation	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22- Completed- Capital Development Manager to send evidence to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004c	Low	R4. The supervisor's contract should also be included within the Project Managers reports in the NEC contract status schedule (until completion)	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22 Completed- evidence to be sent to Internal Audit. 07/09/22- Estates to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_005	Medium	R5. Figures within the Welsh Government Dashboard report should be consistent with the Project Managers, Cost Advisers and any other reports that accompany the submission.	Agreed. The current and additional reporting proposed to WG will reconcile.	Aug-22	~~Aug-22~~ N/K	Red	12/08/22-this will be picked up between the cost advisor and Finance team, on track for end of August. 07/09/22- Capital Development Manager to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007a	Medium	R7a. Identity checks should be undertaken to ensure correct labour rates are being applied.	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007b	Medium	R7b. Additional labour rates should be contractually agreed by the UHB.	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007c	Low	R7c. Additional information should be supplied differentiation disallowed and unsubstantiated costs.	Agreed	Aug-22	~~Aug-22~~ N/K	Red	12/08/22-Internal Audit to check what is required to sign off recommendation. 07/09/22- IA to obtain clarification of what is required for this recommendation to be closed, or may need to remain open as a future action. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_009	Medium	R9. The UHB should ensure the interim cost benchmarking exercise is completed, providing assurance on the ongoing affordability (or otherwise) of the project.	Agreed – A draft affordability exercise has been undertaken and will be presented to the Project Group for discussion.	Sep-22	~~Sep-22~~ N/K	Red	12/08/22-on track 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_010	Medium	R10. Further efforts are required to resolve the performance issue within the design team; and an effective audit trail of evidence needs to be maintained that supports the performance issues raised.	Agreed Whilst issues have been consistently raised locally, a meeting has been planned with the Directors/Senior Team of the Supply Chain Partner to further highlight performance issues.	Sep-22	~~Sep-22~~ N/K	Red	12/08/22-on track 07/09/2022- PA to Director of Estates & Facilities to send minutes/actions from WGH FEPG Meetings as evidence to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
HDUHB-2223-26	Aug-22	Internal Audit	Fire Governance	Open	Substantial	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	HDUHB-2223-26_001a	Medium	R1a. Engagement with directorate senior management to reinforce mandatory training requirements and target compliance of >85%	The training performance statistics for levels 1-3 will now be reported to each Strategic Operations Board. Performance will be monitored on a monthly basis. Individual Clinical and General Manager leads will be required to present assurances that the 85% target is on program to be achieved.	Nov-22	Nov-22	Amber	12/08/22-DOO flagging at his operational group. Director of Estates, Facilities and Capital Management to provide the information required for senior group reporting. Director of Operations to encourage teams re. mandatory training 07/09/2022- on track. Raised at Strategic Operations Board requesting directorate support, including statistics provided. Minutes from Strategic Operations Board to be shared IA when available to close off this recommendation. 10/11/2022- Estates to send evidence to Internal Audit to close this recommendation.

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-2223-26	Aug-22	Internal Audit	Fire Governance	Open	Substantial	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	HDUHB-2223-26_001b	Medium	R1b. Monitor Level 4 & Level 5 fire safety training compliance and include in the report to the H&S Committee.	The training performance statistics for levels 4-5 will now be reported to each Strategic Operations Board: Performance for level 4 will report on training delivered to the volunteer Fire Wardens in the HB, (delivered by a specialist external contractor). Performance for level 5 will report on training delivered to managers at 8b and above and will be generated by the ESR system.	Feb-23	Feb-23	Amber	12/08/22-DOO flagging at his operational group. Stats required from ESR, cleansing exercise required with ESR time. 10/11/2022- On track to be included in papers reported to Strategic Operations Board. in February 2023.
HDUHB-2223-26	Aug-22	Internal Audit	Fire Governance	Open	Substantial	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	HDUHB-2223-26_001c	Medium	R1c. Fire Door Inspection training to be completed by the remaining four identified individuals	Remaining individuals (4) to receive their specialist fire door installation training	Nov-22	Nov-22	Amber	12/08/22-On track 07/09/2022- on track. 10/11/2022- Head of Estates Risk & Compliance to check if this work has been completed.
HDUHB-2223-08	Aug-22	Internal Audit	Overpayment of Salaries	Open	Limited	Workforce & OD	Workforce & OD	Head of Workforce	Director of Workforce & OD	HDUHB-2223-08_002	High	R2. Workforce & OD to scrutinise the monthly under and overpayment of salaries reports to identify themes and trends and engage with managers to identify the root causes of overpayments, providing the necessary support and guidance to prevent recurrence.	This has been done previously but on an ad hoc basis and not recorded. This will now be undertaken monthly with details recorded on the overpayments report received from NWSSP Payroll. This will also facilitate reporting to the W&OD Business Group per matter arising 4.	Aug-22	~~Aug-22~~ N/K	Red	20/09/2022- Update requested from service by 27/09/2022. 27/09/2022- August and September 2022 reports have been shared with Workforce colleagues for follow up with managers and this practice will continue monthly. Updates on specific actions will appear in reports to Business Group on an ongoing basis. Process in place to enable this activity to be undertaken as part of normal business operations. Clarifying with Internal Audit team if this can now be closed. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022, pending progress of fieldwork
HDUHB-2223-08	Aug-22	Internal Audit	Overpayment of Salaries	Open	Limited	Workforce & OD	Workforce & OD	Head of Workforce	Director of Workforce & OD	HDUHB-2223-08_003b	High	R3. Workforce & OD to reinforce with line managers the requirement to use MSS for changes to payroll data, including terminations and assignment changes, where possible. Workforce & OD to monitor MSS use to identify areas with low MSS / high manual form use and provide refresher training to ensure that line managers are confident in using MSS to process changes to payroll data.	ESR Team/Payroll to produce a monthly report for Head of Workforce on number of manual versus online forms submitted by department/line manager and overall percentage of forms submitted via MSS	Sep-22	~~Sep-22~~ N/K	Red	18/09/2022- Update requested from service by 27/09/2022. 27/09/2022- Actions completed with managers and refresher training also provided.First of the monthly reports sent to Head of Workforce on 22/9/22. Report details monthly percentage rates over past two years with highest being 20% and lowest being 3%. Sep 22 was 11%. This will be monitored going forward. N.B. the system is unable to identify which terminations required pay adjustments. These require manual forms to be submitted. Clarifying with Internal Audit team if this can now be closed. 07/11/2022 - The recommendation has been completed and managers are reminded of changes that can be completed via Self Service. Assurance and Risk Team waiting for clarification from Internal Audit that it can be closed. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022, pending progress of fieldwork
HDUHB-2223-08	Aug-22	Internal Audit	Overpayment of Salaries	Open	Limited	Workforce & OD	Workforce & OD	Head of Workforce	Director of Workforce & OD	HDUHB-2223-08_004	High	R4. Overpayments, including the root causes, actions taken and lessons learned to be reported to and monitored by an appropriate Workforce & OD forum.	SBAR report to be submitted to W&OD Business Group on a quarterly basis commencing with next meeting on 8/9/22	Sep-22	~~Sep-22~~ N/K	Red	18/09/2022- Update requested from service by 27/09/2022. 27/09/2022- Agenda item submitted on 2/9/2022. Business Meeting was cancelled for 8/9/2022. Next one will take place on 13/10/2022 SBAR Report submitted for issue with papers for 13/10/2022 meeting. Clarifying with Internal Audit team if this can now be closed. 09/11/2022 - Confirmation from internal audit that a follow up on this matter is currently underway, with the findings and report to be presented at ARAC in December 2022, pending progress of fieldwork
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_001a	Medium	R1. Develop Terms of Reference for both the Quality, Safety and Assurance Group and the Budget & Management Group, with due regard to the Health Board's template agenda for Directorate Quality, Safety & Experience groups.	Terms of reference to be developed for all Management meetings.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_001b	Medium	R1. Develop Terms of Reference for both the Quality, Safety and Assurance Group and the Budget & Management Group, with due regard to the Health Board's template agenda for Directorate Quality, Safety & Experience groups.	Review template agenda for Quality, Safety and Assurance Group.	Aug-22	~~Aug-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_002	Medium	R2. The risk relating to financial performance should be reviewed and reassessed based on current performance and forecast outturn for 2022/23, with new actions identified to mitigate.	Revised savings plan across Carmarthenshire system to be in place which will be reviewed at monthly finance operational meeting.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_003	Medium	R3.1. Ensure that complaints are investigated and a final response provided within 30 working days where possible.	Weekly meetings with Concerns Team & DHoN/SNM to escalate and progress with actions. Datix and Concern data is being feedback into Quality, Safety & Assurance meeting every other month.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_004	Low	R3.3. We would recommend that continued effort is made to clear all outstanding incidents.	Monthly review of outstanding incidents with Patient Safety & Assurance Team & DHoN agreeing timescales to action.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_006	High	R5. Line managers to be reminded of the requirements of the All-Wales Managing Attendance at Work Policy. Evidence of Return-to-Work Interviews, self-certificates and fit notes must be retained on the individuals personal file to demonstrate compliance with the policy.	Workforce are undertaking a peer review of the sickness absence for the 5 top areas at the moment - Cadog, Steffan, Teifi, Padarn and Towy. This will be a piece of work we will filter through to all areas eventually to see what support/training etc. is needed to best manage this going forward. Also, will identify key reasons of absence so we can see any themes and how to address this.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updats from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_005	Medium	R4. The directorate should target areas with low compliance rates and set a deadline for achieving the Health Board target compliance rate of 85%.	Statutory and Mandatory Training Compliance being reviewed within Sister/Charge Nurse & SNM 1:1 on a monthly basis. Plans to be devised to work towards compliance rate of 85% by November 2022. To monitor compliance through monthly Budget & Management meeting – and target areas of non-compliance (also looking at allocated staff time/flexible working to support). Review individual statutory & mandatory compliance through PADR (especially with implementation of pay progression PDR).	Nov-22	Nov-22	Amber	
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_001	High	R1. Determine an appropriate forum for the monitoring and scrutiny of finance related matters/performance.	Reinstate the business/ performance forum to include scrutiny of finance related matters/ performance.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_003	Medium	R3a. Identify actions to mitigate the finance risk (ref 980), seeking input from the Finance Team where appropriate	Update financial risk to include mitigation and main drivers for year to date and end of year projected overspend.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_004	Medium	R3b. Update the risk register to reflect the new actions agreed following annual review, and ensure that these are completed within the stipulated timescales.	Risk Register to update to reflect current position, agreed actions with revised timescales.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_005b	Medium	R4. Develop an action plan and timeline to improve the Directorate position for incidents and complaints.	Action plan to be developed to support the continued reduction in outstanding incident reports.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_006a	Medium	R5. Identify and prioritise service areas with the lowest training compliance rates (relative to staff numbers)and set a reasonable deadline for improving compliance, allowing staff protected time to complete mandatory training.	Continued review of nursing compliance rates and monthly scrutiny.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_007	Medium	R6. Line managers to be reminded of the requirements of the All-Wales Managing Attendance at Work Policy.	Updated version of Management at Work Policy to be circulated to all Dept leads reinforcing policy requirements.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_006b	Medium	R5. Identify and prioritise service areas with the lowest training compliance rates (relative to staff numbers)and set a reasonable deadline for improving compliance, allowing staff protected time to complete mandatory training.	Service Delivery Manager to develop action plan with consultant leads to improve mandatory training compliance for medical staff	Nov-22	Nov-22	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_001	Medium	R1. Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	In-patient falls group set up and Task & Finish group established to update Falls Policy.	Dec-22	Dec-22	Amber	

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-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_002	Medium	R1. Consider re-launching the updated policy with an awareness campaign to ensure all clinical staff are au fait with the requirements	Falls policy following completion to be ratified through relevant Goverance committees. Relaunch following approval	Feb-23	Feb-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_003	High	R2. An MFRA must be completed for all eligible patients (as identified in the NICE guidance and Health Board Falls Policy) within 6 hours of admission.	Staff reminded of the importance of completing the MFRA on admission in line with guidance. Through professional forums, Practice Development Nurses on sites and monitored through site scrutiny meetings	Dec-22	Dec-22	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_004	High	R2. Consider implementing independent checking controls to ensure the existence and quality of MFRAs, particularly in falls 'hot spots'. This control has been observed at other Welsh Health Boards.	Spot check audits of MFRA quality and forms to be undertaken quarterly and actions fed back to relevant sites. Action to be monitored through PNMFThe audit findings will be included as an agenda item to enable discussion with the Heads of Nursing and the Executive Director of Nursing will write to Senior Nurse Management Team members to highlight the findings and necessary actions.	Jan-23	Jan-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_005	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	Apr-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_006	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	Apr-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_007	Medium	R5. Monitoring/review of falls incidents to identify those not investigated in a timely manner and noncompliance with the requirement for focused review. Issues identified should be addressed with the responsible individual(s), with action taken for repeated non-compliance where appropriate.	Scrutiny meetings to be reviewed and Terms of reference will be updated to include monitoring of falls incidents and quality of the investigation. Action identified to be reviewed at each meeting.	Jan-23	Jan-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_008	Medium	R6. Review existing governance arrangements for falls prevention and management and identify an appropriate forum for Health Board-wide sharing of lessons learned.	The Goverance arrangements will be considered via the In-patient falls group and discussed with Assistant Director of Assurance and Risk.	Dec-22	Dec-22	Amber	
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_001	Medium	R1. Ensure that all directorates adopt the Health Board standard ToR and agenda templates for directorate QS&E groups.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include use of the template Terms of reference and agenda. Members will receive a copy of the templates.	Nov-22	Nov-22	Amber	
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_002	Medium	R2. QSE Group minutes should clearly document the key points discussed and identified for further discussion/escalation.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include clear documentation of key points and consideration of all items (as recommended above).	Nov-22	Nov-22	Amber	
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_003	Medium	R3. Minutes should demonstrate consideration of all items on the standard agenda template, even if only to confirm that there is nothing to report.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include clear documentation of key points and consideration of all items (as recommended above).	Nov-22	Nov-22	Amber	
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 Strategic Development and Operational Planning	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 • Business continuity Infrastructure Investment Enabling Plan to be signed off as part of IMTP	Jan-22	~~Jan-22~~ ~~Feb-22~~ ~~Mar-22~~ ~~Sept-22~~ N/K	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. 03/05/2022 - Prioritisation of schemes currently included in our Infrastructure Plan was undertaken for the submission of a draft 10 Year NHS Wales Plan to WG. Feedback from this national exercise will be utilised to inform the next steps in this process. Revised date of September 2022 provided. 07/07/22 On hold pending feedback from WG on 10 Year Infrastructure Plan 01/08/22 Continues to be on hold. Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K 12/08/22-N/K until feedback from WG received 12/09/22- Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K. 10/11/2022- Same comment as above- Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K.
MHRA-28172/119309-0018	May-22	MHRA	Insp BLCA 28172/119309-0018 - Withybush General Hospital	Open	N/A	Pathology	Pathology	Hannah Albery	Director of Operations	MHRA-28172/119309-0018_012c	High	R12. Laboratory training was inadequate in that there has been no assessment to determine staff training requirements for the maintenance and troubleshooting of the Ortho Vision analyser. For example, staff could not demonstrate how to troubleshoot analyser maintenance failures to bring the analyser back into operational use.	Review training and competency documentation for Ortho Vision analyser to ensure it adequately covers maintenance and troubleshooting.	Jun-22	~~Jun-22~~ ~~Sep-22~~ Feb-23	Red	05/09/22 - will be reviewed post training on 07/09/22. 25/10/22 - training provided by OD but it was felt that this didn't fully address the training the MHRA has noted in the finding. Funding has been agreed to send the blood bank manager at WGH and one other member of staff to the advanced operator training that OCD provide.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	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~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	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. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	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_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~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	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. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/ 00175421/00175428/ 00175426/00175425	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 Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	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. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 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
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	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 open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	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. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022.
BFS/KS/SJM/00114719- KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719- KS/890/04	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 and pass through any false ceiling provided.	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. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	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-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	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. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022.
KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	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. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this 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 of time becomes necessary.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_008	High	Item 4- R8. All door release devices (Including floor pneumatic release devices) should work in accordance with the relevant British standard: BS 7273-4:2015 actuation of release mechanisms for doors and comply with WHTM 05-02 Appendix C: Door Closers and Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. • Diabetic unit • This action should be carried out over the whole site and as part of the fire door survey mentioned in item 1 Compliance with this or an equivalent	Full action plan held by Estates.	Oct-22	~~Oct-22~~ N/K	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_002	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_003	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_005	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_007	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.

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/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_013	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Aug-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_001	High	R1. A fire door survey is required at the Tenby cottage hospital site due to a number of defects found at the time of inspection. The findings of this survey must be completed within the mentioned timescale. Fire resisting doors need to be fitted with: • A self-closing devices including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_002	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. WHTM 05-02 Chapter 5 and paragraph 5.12. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_003	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_001	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_002	High	R2. Due to a number of defects found at the time of inspection. A fire door survey is required at the Cwm Seren site.	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Full fire door survey to be undertaken by AFT on all doors. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_003	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_004	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_005	High	R5. The cross-corridor doors in "Picu" was missing a self-closing device. A self-closing device is required on this door to ensure it closes fully into its rebate.	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.

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/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_008	High	8. A hold open device (or alternative solution) is required on the "Step Down" kitchen door. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ N/K	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ N/K	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ N/K	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_009	High	R9. 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: •Suppression system •Automatic operated vent (AOV) linked to the fire alarm system It is recommended the records are kept in a logbook	Full action plan held by Estates.	Sep-22	~~Sep-22~~ N/K	Red	02/11/2022- IT have confirmed there is a contract in place for suppression systems across the site. Copies of records have been requested by the Estates team. Once the evidence has been received this recommendation will be closed. 10/11/2022- IT dept have changed maintenance providers and are awaiting the visit.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ N/K	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_001	High	R1. 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-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_002	High	R2. 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.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Blue Block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_008	High	R8. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms Jan 2023 date.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_001	High	R1. 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-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.

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/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_002	High	R2. 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.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout the block. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_008	High	R8. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion January 2023.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_001	High	R1. Additional electrical sockets are to be provided where trailing leads, adapters or extension leads are in use. Multi-plug adaptors can be hazardous and are not to be used.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_003	High	R3. All combustible materials, ignition sources and obstructions should be removed from all the means of escape routes, internally and externally. Ensuring good housekeeping is maintained.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_004	High	R4. A Review of signage is required throughout the property. Indicate the nearest way out (in case of fire) with fire exit signs that comply with BS 54F. Exit Signs must be visible for people that might need to refer to them.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_005	High	R5. 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: •Suppression system •Roller shutter •Dampers •Automatic operated vent (AOV) linked to the fire alarm system It is recommended the records are kept in a logbook	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_001	High	R1.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-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_002	High	R2. 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.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_004	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_006	High	R6. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.

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/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_ 008	High	R8. An assessment should be undertaken to ensure all Internal and external escape routes are 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.	Dec-22	Dec-22	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion December 2022.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_ 010	High	R10. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion January 2023.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 001	High	R1. 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-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 002	High	R2. 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.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_ 006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/0011506 8_001	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/0011506 8_002	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/0011506 8_003	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/0011506 8_004	High	R4. Remove the printer photocopier from within the area F84. This appliance should be located within a hazard room.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/0011506 8_005	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	

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/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_006	High	R6. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided at; • All external escape routes Signs should be designed and installed in accordance BS 5499-4:20	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_007	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_008	High	R8. Locate the solar PV isolator in a position away from the roof area or add a device that would allow isolation away from an area of risk.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
PR_RCR0616	Jun-16	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	PR_RCR0616_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. 12/05/2022 Anna Thomas is now in place as SDM for Respiratory Medicine. Weekly meetings are in place for Keir Lewis and SDM. The overall respiratory Plan has had to dynamically change due to failure to recruit respiratory consultants after voluntary resignations, issues with personal circumstances and planning for imminent retirement. This has put huge stress on the respiratory system at the time when the Covid pandemic has increased demand for respiratory physicians worldwide. Recruitment continues to be ongoing and although there has been a lack of interest in the past, there seems to be an appetite recently so we are hopeful. A plan is in place to train-up known junior doctor staff but this is a medium term plan. Other avenues are being explored to support the service including approaching neighbouring trusts. Realistic and operational short term plans are now in place to release specialist physicians from work that other physicians can undertake (acute on call, General ward rounds), in order to free up specialist time providing input on a health board wide basis. This of particular relevance to Lung cancer where Dr Robin Ghosal has taken responsibility as Lung Cancer lead running the Lung Cancer service single handed. This interim service provision will continue until we can recruit. Respiratory service are arranging an Away Day in June which will focus on strategic planning and review of the service model with the support of the Quality Improvement & Service Transformation.
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_001	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~~ ~~Oct-22~~	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 evaluation of points raised and actions. The Shift Supervisors are being encouraged to manage the shifts more robustly to enable a more efficient service and access to care by patients contacting the service. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 - The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (eg SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_003	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~~ ~~Oct-22~~ N/K	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 unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 – The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (eg SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_006	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~~ ~~Oct-22~~ N/K	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 workforce. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 – The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (eg SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_014	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~~ ~~Oct-22~~ N/K	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 to identify good practice and areas requiring improvement. Regular contact with the Deputy Medical director and Associate Medical Director and their inclusion in meetings is allowing a timely response to discussion points and access to further support and advice. The SDM has begun discussion to design and implement a staff survey which will be made available to the entire OOH workforce. The results will enable a meaningful evaluation of the OOH workforce, allowing consideration of the needs and opinions in service improvement. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 - Deputy Director of Operations to meet with ED of Operations to determine if this recommendation is relevant as at March 2022, given initial report raised in November 2019. 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Digital and Performance	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ Dec-22	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 IT system development under way- work has commenced and categories to record and prioritise have been identified- awaiting completion by IT team and then paeds teams will need to commence data inputting. Project is more significant and labour intensive than initially predicted - this is reflected in the amended completion date 05/08/2022 - work is ongoing with system development 18/8/2022 - e-mail from IT Gareth Beynon. Following meeting with SDMs implementation put on hold as part of wider work in paediatric IT system
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_015	N/A	Governance arrangements across the Children's Congenital Heart Network must ensure that the training and skills of all echocardiographic practitioners undertaking paediatric echocardiograms are kept up to date.	Revise current governance process around this.	Nov-22	Nov-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/6/22- This is reflected in the appraisal and revalidation processes- and will also be reflected in job planning in terms of protected time. 18/08/2022 - reflected in the appraisal, and awaiting job planning

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PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_016	N/A	Nurses working within Local Children's Cardiology Centres must be offered allocated rotational time working in the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre, to enhance development of clinical knowledge and skills enabling professional development and career progression. A formal annual training plan should be in place.	Revise current governance process around this.	Jun-22	~~Jun-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- new specialist nurse post in development- this will be reflected in the job plan of that role. 05/08/2022 - Job description is currently with matching for approval, and awaiting confirmation 18/08/2022 - JD completed waiting for comments back from job match in panel
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_017	N/A	Paediatricians with expertise in cardiology (PECs) should have a named cardiologist within the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre who acts as a mentor; this mentor would normally be the link cardiologist.	Names to be formalised	Mar-22	~~Mar-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/2022 Mentors have been identified and willing to support. This is in progress and the HB is leading the project within the cardiology network. 18/08/2022 - in progress
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_021	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	Nov-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_022	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	Nov-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_023	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment.	Response requested from lead officer.	Nov-22	Nov-22	Amber	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	~~Mar-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - discussions have commenced with the dental pathways, awaiting further response to progress the recommendation. 30/06/22- HB Dental leads continue to review the process- update requested from deputy director today 18/08/2022 - Awaiting update
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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	External	03/05/2022 - Health Board are still awaiting receipt of the standardised national template. Unable to progress the recommendation until received, therefore status amended to External. 30/06/22 no update to position- template awaited. However, access to "Cardiobase" for Cardiff- based cases has now been formally secured for all HD PECs 18/08/2022 - standard national template still awaited
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- cardiac clinical team have improved engagement with tertiary education program and clinical discussion via virtual technology- Job planning has yet to formalise this but support to attend is given- new clinical lead has been appointed and all job plans are now under review with SDM- with a view to protecting time for tertiary centre visits. 18/08/2022 - awaiting job planning
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- all clinicians actively engaging as per descriptor- yet to be formulated in job planning but this is to be addressed following appointment of new clinical lead 18/08/2022 - actions completed however need embedding in job plan
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - submission sent to IMTP, but no official response as yet received on the outcome of the submission which is key to deliver this recommendation. 30/06/22 Funding has been secured for the appointment of a dedicated nursing resource- the Job Description for which is now in development and will be reviewed as a part of the HB recruitment processes. 05/08/2022 - Job description is currently with matching for approval, and awaiting confirmation 18/08/2022 - post has been advertised
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health professionals.	Job plan review	Mar-22	~~Mar-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - every cardiac clinic has a PEC when held, and covers all sites. Further clarification on job plans required and a revised timescale. 30/06/22- all clinicians actively participate within the network and work in collaboration with the tertiary consultants. Job planning activity yet to be completed but will now be revisited following appointment of new clinical lead. Job planning will also support the development of formalised honorary contracts. 18/8/2022 - Awaiting job planning & honorary contract
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ ~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - submission sent to IMTP, but no official response as yet received on the outcome of the submission which is key to deliver this recommendation. 30/06/2022 - No funding forthcoming from IMTP submission to support county- based nurse support, Nurse leads to revisit possible developments within nursing establishment 18/08/2022 - JD completed waiting for comments back from job match in panel
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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~~ ~~Aug-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 No funding forthcoming form IMTP submission to support county- based nurse support, Nurse leads to revisit possible developments within nursing establishment 05/08/2022 - Nurse leads continue to review establishment, however due to lack of funding, recommendation difficult to proceed. 18/08/2022 - awaiting update
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22 SDM in discussion with Cardiac services to support additional resourcing for paeds workload 18/08/2022 - discussions ongoing
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Digital and Performance	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_018	N/A	Each Local Children's Cardiology Centre will have a robust internal database for congenital cardiac practice with seamless links to that of the Specialist Children's Surgical Centre.	Needs to be developed/improved	Jun-22	~~Jun-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/2022- The HB system in development will support this - and in collaboration with "cardiobase" this situation will improve 18/08/2022 - awaiting IT to finalise

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PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_019	N/A	A Children's Cardiac Nurse Specialist must be available at all outpatient appointments to help explain the diagnosis and management of the child/young person's condition and to provide relevant literature.	(as above - linked nurse case, just need local named nurse to progress this to Amber - this will be sufficient)	Jun-22	~~Jun-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- New role in development 18/08/2022 - position advertised
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_020a	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Information boards to be progressed in all sites	N/K	~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- This continues to be managed from UHW - no robust groups are in existence- there are peer-to-peer support groups but this is not widely available. New Specialist nurse will be tasked to develop when in post 18/08/2022 - Information boards are in progress, and the nurse role will also support this recommendation
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_020b	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Ensure patients provided with information/contact of named CNS (in L1/2)	Mar-22	~~Mar-22~~ ~~Oct-22~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- CNS post in development- UHW cardiologists already provide info as required. 05/08/2022 - Job description is currently with matching for approval, and awaiting confirmation 18/08/2022 - Information boards are in progress, and the nurse role will also support this recommendation
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_001	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Approach is via ARCH. 24/08/2022 - DB to update PR.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_002	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Currently working with SBUHB to update the Oncology Strategy that was put in place in 2015. This will include the BGH Oncology service. Cover is currently provided by Dr S Gwynne, SBUHB along with CNS support/ Telephone advice for Dr E Jones/CNS when away. SBUHB have now also appointed Dr C Barringtom to cover the LGI Oncology service within HDUHB.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_003a	N/A	R3. Pathway Performance. The SCP pathway performance is 51.8% for the Health Board (see appendix 4), however the SCP target is 75%.It is acknowledged that achieving this target while recovering from the pandemic is challenging.	Need to carry out an audit to understand the bottlenecks in the pathway. To explore installation of another CT Scanner in WGH.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Actively auditing the pathway to identify the bottlenecks. Radiology has had a huge impact on the pathway.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_003b	N/A	R3. Pathway Performance. The SCP pathway performance is 51.8% for the Health Board (see appendix 4), however the SCP target is 75%.It is acknowledged that achieving this target while recovering from the pandemic is challenging.	Develop a FIT in Primary Care pathway	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. We are developing a FIT Testing pathway for Primary care. This is anticipated to streamline our referral pathways and facilitate optimised use of diagnostic resources. This should potentially significantly improve pathway time compliance.
PSOW_202004109	Apr-22	Public Service Ombudsman (Wales)	202004109	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Olivia Barker	Director of Operations	PSOW_202004109_005	N/A	70 e) Provides the Ombudsman with evidence of the development of an escalation policy in relation to managing contacts with Section 12 approved doctors (i.e., an explicit stepwise system that clarifies the actions to be taken).	Action plans held with Ombudsman Liaison Manager	Oct-22	~~Oct-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - discussed with Sara Rees 07/04/22. 14/09/2022 Reminder sent to Kay Isaacs, Sara Rees, Amanda Davies 01/09/22 10/11/22 The deadline for this recommendation has not been met, an extension was requested from the PSOW but no response as yet. This is due to be discussed on 14.11.22 at a multi disciplinary scrutiny meeting.
PSOW_202003517	Jul-22	Public Service Ombudsman (Wales)	202003517	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	GP Practice Manager	Director of Primary Care, Community and Long Term Care	PSOW_202003517_003	N/A	R3. I recommend that within 6 months of this report the GP should receive training on the various types of scan available for identifying cancer and which type to request and when.	Action plans held with Ombudsman Liaison Manager	Jan-23	Jan-23	Amber	14/09/2022- Updates to be requested via Ombudsman Case Manager.
PSOW_202003517	Jul-22	Public Service Ombudsman (Wales)	202003517	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	GP Practice Manager	Director of Primary Care, Community and Long Term Care	PSOW_202003517_004	N/A	R4. I recommend that within 6 months of this report the GP should hold a Significant Event Analysis meeting to reflect on this report	Action plans held with Ombudsman Liaison Manager	Jan-23	Jan-23	Amber	14/09/2022- Updates to be requested via Ombudsman Case Manager.
PSOW_202003517	Jul-22	Public Service Ombudsman (Wales)	202003517	Open	N/A	Primary Care, Community and Long Term Care	Cancer Services	Olivia Barker	Director of Primary Care, Community and Long Term Care	PSOW_202003517_007	N/A	R7. I recommend that within 6 months of the final version of this report, the First Health Board should have commissioned a service that enables patients to access or be discussed at CUP MDT meetings at the South West Wales Cancer Centre, in line with the NICE Guidance.	Action plans held with Ombudsman Liaison Manager	Jan-23	Jan-23	Amber	14/09/2022- Updates to be requested via Ombudsman Case Manager.
PSOW_202003189	Sep-22	Public Service Ombudsman (Wales)	202003189	Open	N/A	Nursing	Nursing	Sian Passey Helen Dawkins	Director of Nursing, Quality and Patient Experience	202003189_003	N/A	R3. Develop a TNP care plan/template for clinical staff to complete so that there is evidence to demonstrate that a consistent approach has been given to the therapy from all disciplines.	Action plans held with Ombudsman Liaison Manager.	Dec-22	Dec-22	Amber	
PSOW_202003189	Sep-22	Public Service Ombudsman (Wales)	202003189	Open	N/A	Nursing	Nursing	Sian Passey Helen Dawkins	Director of Nursing, Quality and Patient Experience	202003189_004	N/A	R4. As part of the Standard Operating Procedure, prepare a plan to provide nursing staff with training on the correct nursing documentation standards in respect of evidencing detailed dressing treatment plans.	Action plans held with Ombudsman Liaison Manager.	Mar-23	Mar-23	Amber	
PSOW_202100614	Oct-22	Public Service Ombudsman (Wales)	202100614	Open	N/A	Women and Children's Services	Women and Children's Services	Sarah Rees Lisa Humphreys	Director of Nursing, Quality and Patient Experience	202100614_001	N/A	R1. Apology - Write to the patient to apologise for the failings identified.	Reflect on the report findings and issue an appropriate apology letter	Nov-22	Nov-22	Amber	
PSOW_202100614	Oct-22	Public Service Ombudsman (Wales)	202100614	Open	N/A	Women and Children's Services	Women and Children's Services	Sarah Rees Lisa Humphreys	Director of Nursing, Quality and Patient Experience	202100614_002	N/A	R2. Financial redress (for referral delay) - Pay £1,000 in recognition of the fact that the delayed referral to the Cancer Centre delayed the revision of the patients cancer diagnosis and the provision, by the Other Health Board, of the surgery that she required as well as adding to her distress.	Make offer of payment in apology letter	Nov-22	Nov-22	Amber	
PSOW_202100614	Oct-22	Public Service Ombudsman (Wales)	202100614	Open	N/A	Women and Children's Services	Women and Children's Services	Sarah Rees Lisa Humphreys	Director of Nursing, Quality and Patient Experience	202100614_003	N/A	R3. Financial redress (for failure to provide support) - Pay £500 in recognition of the distress and potentially unmet need that arose because of the failure to provide support for her following her surgery at the Other Hospital.	Make offer of payment in apology letter	Nov-22	Nov-22	Amber	
PSOW_202100614	Oct-22	Public Service Ombudsman (Wales)	202100614	Open	N/A	Women and Children's Services	Women and Children's Services	Sarah Rees Lisa Humphreys	Director of Nursing, Quality and Patient Experience	202100614_004	N/A	R4. Key Worker Guidance revision - Revise the Key Worker Guidance to ensure that the treatment position of patients who are receiving cancer-related treatment from an alternative healthcare provider, such as the Other Health Body, is regularly reviewed and that these patients are contacted by their Key Worker following the completion of that treatment and, where appropriate, are assessed and supported by them.	Update local Key Worker guidance, improved documentation of key worker interaction and support.	Dec-22	Dec-22	Amber	
PSOW_202100614	Oct-22	Public Service Ombudsman (Wales)	202100614	Open	N/A	Women and Children's Services	Women and Children's Services	Sarah Rees Lisa Humphreys	Director of Nursing, Quality and Patient Experience	202100614_005	N/A	R5. Referrals to the Cancer Centre - Take action to ensure that referrals to the Cancer Centre are made as soon as possible.	Action plans held with Ombudsman Liaison Manager	Dec-22	Dec-22	Amber	
RCP_NDQP0420	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP), issued April 2020	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	RCP_NDQP0420_011a	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition programme suspended due to COVID 19. HB to support all Clinicians across all areas to participate in the Transition programme when re-started.	N/K	~~Dec-21~~ ~~Jun-22~~ N/K	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 26/05/2021 initial discussions started ongoing. 12/07/2021 SDM confirmed this work is likely to be completed by Dec 2021. 15/09/2021 SDM confirmed this work is likely to be completed by Dec 2021. 14/12/2021Further wave of Covid has delayed progress. 02/02/2022 - progress delayed due to workforce and covid pressures.
RCP_NDQP0420	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP), issued April 2020	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	RCP_NDQP0420_011b	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition is more successful by an employed youth worker. Paper to be developed to evidence best practice.	Aug-21	~~Aug-21~~ ~~Mar-22~~ ~~Sep-22~~ N/K	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 25/05/2021 No update 12/07/2021 No further progress at this time. 15/09/2021 No progress at this time. 14/12/2021 Further wave of Covid has delayed progress. 02/02/2022 - progress delayed due to workforce and covid pressures. 30/06/2022 - SDM to contact the service to evaluate the current transition arrangement, and to reconsider the original management response.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	~~Mar-21~~ Mar-23	Red	23/03/2022- GM working closely with other sites of the Health Board to ensure safe services, e.g. through channels such as the senior Ops team meetings. Good collaboration between community and acute services. GM looking at scheduled care elements. Real challenges in terms of tertiary level pathways and getting the right patient in the right place for the right clinical supervision. Exploring joint consultant posts with Powys and Betsi, however progress has been significantly hampered due to Covid. This is in the recovery phase and the UHB has restarted this process with neighbouring Health Boards post Covid. Clinical advisory group for Mid Wales in place which started pre-Covid. Working with Powys to establish optimal flow for their patients using Hywel Dda services, and how to work together to deliver care. This is less developed with Betsi. GM is hopeful to make significant progress and have a programme of work in place by March 2023.

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
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.2 Improve networking and collaboration with other sites and health boards	Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid.	Mar-21	~~Mar-21~~ Mar-23	Red	23/03/2022- Covid has been problematic in progressing this recommendation however there are Immensely improved relationships between BGH and scheduled care. Working with team to deliver elective care and repatriate back where appropriate.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	Mar-24	Red	23/03/2022- GM to liaise with officer on digital strategy of the UHB for current progress on virtual systems. A lot of changes still taking place and Covid still presents challenges for this. Revised date of March 2024 provided
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth |University. Both developments will include clinical skills facilities.	Sep-22	~~Sep-22~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	~~Dec-21~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_006	N/A	6.3 Ensure training posts are attractive with time for research, teaching and quality improvement	Potential for a Rural Medicine module (rotation) in the future to be based at Aberystwyth University in line with evolving Royal College thinking.	Mar-23	Mar-23	Amber	23/03/2022- This has been started, GM will check for update with relevant colleagues.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_004	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility.	Dec-20	~~Dec-20~~ N/K	Red	23/03/2022- GM will pick up with recommendation owner for current position of this recommendation. 05/05/2022- Requested revised timescale from GM, no response received as of 18/05/2022.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	~~Sep-22~~ N/K	Red	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	WLC_PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments.

Reports closed on the Audit Tracker since ARAC October 2022

Report name	Lead Executive/Director
HIW: National Review of Maternity Services - Phase 1, issued November 2020	Director of Operations
HIW: Ward 6 - PPH - Unannounced DECI - 23 September 2014 (Elective Orthopaedic) (Publication date 9 January 2015)	Director of Operations
HIW: Wards 7 & 11, WGH, 4-5 February 2020 (Publication date 19 July 2020)	Director of Operations
HIW: Nuclear Medicine Department, Withybush General Hospital 27/28 July 2021 (Publication date 29 October 2021)	Director of Operations
HIW: Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER) 23/24 February 2021 (Publication date 25 May 2021)	Director of Therapies and Health Sciences
Internal Audit: Follow-up: TriTech Institute Governance Review	Medical Director
MWWFRS: Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF BFS/KS/SJM/00115877	Director of Operations
MWWFRS: Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719-/KS/890/02	Director of Operations
Peer Review: Children & Young People Diabetes MDT & Hospital measures for CYP services Peer, issued November 2016	Director of Operations

Reports opened on the Audit Tracker since ARAC October 2022

Report name	Lead Executive/Director	Final report received at
HIW: Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Director of Operations	Quality, Safety and Experience Committee
Internal Audit: Directorate Governance – GGH Unscheduled Care	Director of Operations	Audit and Risk Assurance Committee
Internal Audit: Directorate Governance – WGH Unscheduled Care	Director of Operations	Audit and Risk Assurance Committee
Internal Audit: Falls Prevention and Management	Director of Nursing, Quality and Patient Experience	Audit and Risk Assurance Committee
Internal Audit: Quality and Safety Governance, issued October 2022	Director of Nursing, Quality and Patient Experience	Audit and Risk Assurance Committee
Internal Audit: Follow-up: TriTech Institute Governance Review	Medical Director	Audit and Risk Assurance Committee
MWWFRS: Letter of Fire Safety Matters	Director of Operations	Health & Safety Committee

Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY		
Public Service Ombudsman (Wales): 202101855	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 202100614	Director of Nursing, Quality and Patient Experience	Sustainable Resources Committee

Report	Number of Recommendations	Service Area	Progress Update
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board	1	Director of Operations	Assistant Director of Assurance and Risk with the Deputy Director of Operations to establish a revised process and timescale for implementation for the recommendation.
Audit Wales - Structured Assessment 2021: Phase 1 Operational Planning Arrangements	1	Strategic Development and Operational Planning	Confirmation is being requested from the Director of Strategic Development and Operational Planning to close these outstanding recommendations. *This recommendation is being reported for the first time as a "not known".*
Audit Wales – Taking Care of the Carers	2	Workforce & OD	Awaiting revised timescales from the service, which will be discussed with the Director of Workforce & OD at the WF&OD Business Group in December 2022.
Community Health Council – Maternity Care in Hywel Dda	1	Women and Children's Services	Awaiting confirmation from the service that the recommendation has been implemented and can therefore be closed.
Delivery Unit - Review of progress towards delivery of Eye Care Measures	3	Scheduled Care	Assurance and Risk Officer met with Service Delivery Manager (SDM) in September 2022 to clarify progress. 2 of the recommendations cannot be implemented as no decision has yet to be received from IMTP submitted in May 2022. Based on this, the SDM has enquired whether these can be closed on the tracker. The recommendation on recruitment has shown significant progress but to date there have been no applicants for the clinical lead role in Mid Wales.

Report	Number of Recommendations	Service Area	Progress Update
Internal Audit - Directorate Governance – GGH Unscheduled Care	5	Unscheduled Care (GGH)	Internal Audit are contacting the directorate for evidence to close recommendations. *These recommendation are being reported for the first time as "not knowns".*
Internal Audit - Directorate Governance – WGH Unscheduled Care	6	Unscheduled Care (WGH)	Internal Audit are contacting the directorate for evidence to close recommendations. *These recommendation are being reported for the first time as "not knowns".*
Internal Audit - Financial Planning, Monitoring and Reporting	2	Finance	Discussion with Internal Audit confirmed that a Financial Management Review is due this financial year, with the scope currently being determined, where any outstanding recommendations will be reviewed.
Internal Audit - Non-Clinical Temporary Staffing	4	Workforce & OD	Confirmation from internal audit that a follow up currently underway, with the findings and report to be presented at ARAC in December 2022, the outcomes of which will inform the progress made against these 4 recommendations. *These recommendation are being reported for the first time as "not knowns".*
Internal Audit – Discharge Processes	3	Primary Care, Community and Long Term Care	Progress updates have been obtained and recommendations are to be incorporated into the UEC programme workstreams, at which point revised timescales will be available. Since the previous report to ARAC, revised timescales have been obtained for three recommendations previously noted as "not known".

Report	Number of Recommendations	Service Area	Progress Update
Internal Audit – Medical Staff Recruitment	1	Workforce & OD	Awaiting confirmation from internal audit as to whether this recommendation can be re-classified as “External”, as the Health Board may be reliant on external organisations in order to complete this recommendation.
Internal Audit - Overpayment of Salaries	3	Workforce & OD	Confirmation from internal audit that a follow up currently underway, with the findings and report to be presented at ARAC in December 2022, the outcomes of which will inform the progress made against these 3 recommendations.
Internal Audit - Welsh Language Standards	1	CEOs Office (Welsh Language)	A follow-up report by IA is planned to be reported at December ARAC which will cover all outstanding recommendations. *This recommendation is being reported for the first time as a “not known”.*
Internal Audit - WGH Fire Precautions Works: Phase 1	5	Estates	Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. Some evidence is already being submitted to Internal Audit from Estates for review.
Internal Review - Capital Governance Review	1	Strategic Development and Operational Planning	Timescale currently not known as the service is awaiting a response from Welsh Government on the 10 Year Infrastructure Plan.

Report	Number of Recommendations	Service Area	Progress Update
MWWFRS - Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	1	Estates	A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. *This recommendation is being reported for the first time as a "not known".*
MWWFRS - Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	1	Estates	Estates have issued the Fire Management Plan to the BGH Management team and are awaiting their response. *This recommendation is being reported for the first time as a "not known".*
MWWFRS - Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	1	Estates	Estates have issued the Fire Management Plan to the BGH Management team and are awaiting their response. *This recommendation is being reported for the first time as a "not known".*
MWWFRS - Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	2	Estates	Estates have issued the Fire Management Plan to the BGH Management team and are awaiting their response. In addition IT have changed maintenance providers and are awaiting the visit for the suppression system. *This recommendation is being reported for the first time as a "not known".*

Report	Number of Recommendations	Service Area	Progress Update
MWWFRS - Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	1	Estates	Estates have issued the Fire Management Plan to the BGH Management team and are awaiting their response. *This recommendation is being reported for the first time as a "not known".*
Peer Review – Respiratory Cancer	1	Respiratory	Assurance and Risk Team to clarify with SDM if recommendation is in a position to be closed. If not the management response is to be clarified and strengthened with a revised date of completion, as requested by the Director of Operations.
Peer Review - Out of Hours	3	Central Operations	Peer review conducted in July 2022 on the Out of Hours Service, with the service having recently received the draft report. Management responses currently being drafted, and once finalised, recommendations from the new report will supersede the three historic recommendations. *These recommendations are being reported for the first time as a "not known".*
Peer Review - Congenital Heart Defect Provider	10	Women and Children's Services	Head of Assurance and Risk to meet with the Service Delivery Manager for Acute Paediatrics in early December 2022 to obtain progress updates against outstanding recommendations in this review, and revised completion dates for recommendations where the completion date of October 2022 have recently lapsed. *These recommendations are being reported for the first time as a "not known".*

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Public Service Ombudsman for Wales - 202004109	1	Mental Health & Learning Disabilities	An extension was requested from the PSOW but no response received as yet. The outstanding recommendation is due to be discussed in mid-November at a multi-disciplinary scrutiny meeting.
Royal College of Paediatrics & Child Health - National Diabetes Quality Programme (NDQP)	1	Women and Children's Services	Awaiting update from the service for a revised completion date. *This recommendation is being reported for the first time as a "not known".*
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report	2	Unscheduled Care (BGH)	General Manager (BGH) to discuss recommendations with County Director of Ceredigion, following which an update will be provided to the Head of Assurance and Risk.