Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 August 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Beare, Assistant Director of Assurance and Risk

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

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)

The rolling programme to collate updates from services has reverted back to bi-monthly, to coincide with reporting to ARAC. As advised in the previous report, HIW inspection activity and the corresponding follow up to determine progress of recommendations raised is now undertaken and managed by the Patient Safety and Assurance team with progress provided to the Assurance and Risk team for the Audit and Inspection Tracker.

Since the previous report, 4 reports have been closed or superseded and 11 new reports have now been received by the UHB.

As of 19th July 2022, the number of open reports has increased from 97 to 98. 45 of these reports have recommendations that have exceeded their original completion date, which has decreased from the 48 reports previously reported in June 2022. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is an increase in recommendations where the original implementation date has passed from 115 to 128. 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 decreased to 30 from 36 reported in June 2022. The table overleaf provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC June 22	New reports since June 22	Closed reports since June 22	Open reports at ARAC August 22	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	5	0	0	5	3	6	3
CHC	4	0	0	4	4	9	2
CHC / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	5	0	1	4	2	7	5
HEIW	0	0	0	0	0	0	0
HSE	0	0	0	0	0	0	0
HIW	17	0	1	16	9	28	5
HTA	0	0	0	0	0	0	0
IA	26	0	1	25	14	34	6
Internal Review	1	0	0	1	1	4	1
MHRA	1	1	0	2	1	2	0
MWWFRS	23	5	4	24	0	0	0
Peer Reviews	5	0	0	5	3	23	4
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	7	3	1	9	5	11	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	**97**	**9**	**8**	**98**	**45**	**128**	**30**

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

Appendix 1 provides a full list of 281 open recommendations (increase from 254 reported in June 2022) on the audit tracker. In addition to the new recommendations issued since the previous report, Appendix 1 includes the 23 recommendations highlighted as an 'external recommendation' (recommendation is outside the gift of the UHB to currently implement, for example reliant on an external organisation to implement). These are marked as 'External' in the RAG status column. For completeness these recommendations are now included as part of

the ‘Total number of recs July 22’ column in the ‘Audit Tracker Summary Per Service / Directorate’ table below.

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

There are 66 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 56 previously reported. The Assurance and Risk team continue to work with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented.

An annual review of the Audit Tracker with Executive Leads is planned for late Autumn, to review the current relevancy of audit recommendations given the age of some the recommendations and the context the Health Board is currently working within.

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 19th July 2022, including trends since the last report to ARAC in June 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 July 22	Overdue reports As at July 22	Total number open recs July 22*	Total overdue (red) recs July 22	Recs overdue by more than 6 months	Comments
Acute Services	1 (➔)	0 (➔)	6 (🡻)	6 (🡻)	1 (➔)	• HIW National Review on WAST - 6 overdue recommendations outstanding which has reduced from 7. The Patient Safety and Assurance Team are awaiting a response from the service.
Cancer Services	1 (➔)	1 (➔)	4 (➔)	4 (➔)	0 (➔)	• 1 Peer review on Colorectal Cancer - 4 overdue recommendations with revised completion dates to the end of July 2022, which are expected to be confirmed as implemented once the service manager meets with the clinical lead scheduled in August 2022.
CEO Office (Welsh Language)	2 (➔)	1 (➔)	3 (➔)	2 (➔)	0 (➔)	• 2 IA reports - one report has 2 overdue recommendations, and the other report has an 'external' recommendation.
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 (➔)	1 (➔)	2 (🡻)	1 (🡻)	0 (➔)	• AW report - 1 'External' recommendation remaining. • HIW report – Overdue recommendations reduced from 2 to 1.
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 overdue recommendations with revised timescales ranging from November 2022 to March 2023. A further assurance report is due to take place and reported to ARAC in Q4 2022/23. • 1 Peer Review – 4 recommendations (over 6 months overdue) previously delayed by COVID-19. Revised timescales of October 2022 have been provided by the service however a new peer review on OOH was undertaken in July 2022, and the service is currently awaiting the final report which may superseded these outstanding recommendations. • 1 HIW report (Unannounced Hospital Visit for Unscheduled Care Directorate and Surgical Assessment Unit from August 2015) – Report closed since previous report on direction from the Director of Operations as recommendation has now been addressed by the digital scanning programme, and also links to corporate risk 1337. • IA report on Field Hospital Decommissioning – closed since previous report.

Digital and Performance	3 (➔)	2 (➔)	3 (➔)	2 (➔)	1 (➔)	• IA report on Network and Information Systems (NIS) Directive – 1 recommendation due for completion by August 2022. • IA report on Follow Up: Deployment of Welsh Patient Administration System (WPAS) into MH&LD – 1 overdue recommendation relating to the roll out of WPAS to other services within MHLD. A follow up review has been undertaken by IA which will report substantial assurance to ARAC in August 2022, with an updated recommendation and revised completion date of November 2022. • IA IM&T Assurance (Follow Up) - 1 overdue recommendation regarding compliance with European Working Time Directive. New virtual switchboards are live across all four acute sites, however being parallel run at GGH, PPH and BGH. It is expected that all will be fully functional by September 2022.
Service	**Open reports as at July 22**	**Overdue reports As at July 22**	**Total number open recs July 22***	**Total overdue (red) recs July 22**	**Recs overdue by more than 6 months**	**Comments**
Estates	27 (🡅)	0 (🡇)	95 (🡅)	0 (🡇)	0 (🡇)	• Number of recommendations has increased from 73 to 95 (the majority of these recommendations are from the 6 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)), with an increase in recommendations due to 1 LOFSM and 4 Letters of Fire Safety Failures received for the BGH block of flats, which supersedes the previous 4 LOFSM received in 2021, which have now been closed on the audit tracker. • The number of overdue recs has decreased 13 to 0 due to MWWFRS agreeing revised dates of completion to align with the UHB's programme of works. • MWWFRS continues to be kept fully up to date with any adjustments to the programme of phased works at GGH and WGH, and work undertaken at BGH. • All MWWFRS recs overseen by HSC via the Fire Safety Update Report provided to every meeting by the Director of Estates, Facilities and Capital Management. • 2 IA reports - recommendations on schedule for implementation. • 1 HIW report to be closed following approval by Director of Operations.
Finance	1 (➔)	1 (🡅)	2 (➔)	1 (🡅)	0 (➔)	• IA on Financial Planning, Monitoring and Reporting report - 2 recommendations. Confirmation received from IA that the outstanding recommendations will be picked up in a Financial Management Review planned for Q2/3 of 2022/23.
Governance	1 (➔)	0 (➔)	1 (➔)	0 (➔)	0 (➔)	• IA report on Risk Management and Board Assurance Framework – 1 recommendation with completion date of December 2022.
Medical	1 (➔)	0 (➔)	6 (➔)	5 (🡅)	0 (➔)	• IA report on TriTech Institute – 6 recommendations remain outstanding, where 5 completion dates have gone beyond schedule, however awaiting approval for closure of these by Internal Audit, who are currently seeking evidence. A follow up review is planned for Q3 of 2022/23.
Medicines Management	1 (➔)	1 (➔)	1 (➔)	1 (➔)	1 (➔)	• 1 AW report - 1 'external' recommendation and 1 overdue recommendation with revised date of September 2022.

MH&LD	11 (🡻)	6 (➔)	44 (🡹)	22 (🡹)	2 (➔)	• 1 CHC – 1 overdue recommendation with a revised completion date of September 2022. • 1 DU report – All Wales Assurance Review of Crisis and Liaison Psychiatry Services for Adults – 6 recommendations with completion date of December 2022. • 6 HIW reports – Reports on the Joint Thematic Review of Community Mental Health Teams, and St Caradog Ward and St Non Ward (June 2019) both have one recommendation each which are considered external. 1 national review, where the Patient Safety and Assurance team have assisted the Directorate in devising management responses. The remaining 3 reports are Quality Checks/Inspections, 2 of which the Patient Safety and Assurance team have not received any update from the service (one of which is reliant on updates from Estates for confirmation of completion). Recommendations also remain outstanding on the Ty Bryn Quality Check as unable to confirm as completed while the unit is closed to admissions, and also awaiting completion of works at the Unit. • IA Directorate Governance Review closed since the previous ARAC meeting and awaiting approval by Director of Mental Health and Learning Disabilities at the next review meeting scheduled for August 2022. • IA on Prevention of Self Harm – 6 open recommendations due to be completed by August 2022. • PSOW report - recommendations on schedule for implementation. • 1 DU report on All Wales Assurance Review of Crisis and Liaison Psychiatry Services – closed since previous report.
Service	**Open reports as at July 22**	**Overdue reports As at July 22**	**Total number open recs July 22***	**Total overdue (red) recs July 22**	**Recs overdue by more than 6 months**	**Comments**
NQPE	7 (➔)	5 (🡹)	9 (➔)	6 (🡹)	1 (➔)	• AW report - 1 overdue recommendation. • 3 IA reports – 1 report with 2 overdue recommendations (clarification has been received since 19th July (date the tracker was run off for this report) and will be reflected in the next Audit Tracker paper to ARAC), and 2 reports to be closed following approval from Director of Nursing, Quality and Patient Experience. • 3 PSOW reports - 1 overdue recommendation, PSOW informed. Awaiting confirmation of compliance from PSOW to close 2 of the 3 reports, which includes 3 recommendations currently noted as overdue.
Pathology	2 (🡹)	1 (🡹)	7 (🡹)	2 (🡹)	0 (➔)	• 1 new MHRA report for WGH with 7 outstanding recommendations, 2 of which have only recently reported as overdue. • 1 MHRA report for PPH – all recommendations implemented and awaiting formal approval for closure by the Head of Pathology.

Primary Care, Community and Long Term Care	4 (↑)	2 (↑)	18 (↑)	10 (↑)	2 (→)	• 3 IA reports – total of 10 overdue recommendations. • IA Partnership Governance report - 2 recommendations overdue by over 6 months with timescales not known. Clarification has been received since 19th July (date the tracker was run off for this report) and will be reflected in the next Audit Tracker paper to ARAC. • IA Discharge processes report - 7 overdue recommendations, 5 of which the timescales are not known. USC Lead is meeting with Assistant Director of Nursing in late July to discuss the work to be taken forward under the Transforming Urgent and Emergency Care Programme. Updates will be reflected in the next Audit Tracker paper to ARAC. • IA Primary Care Clusters - 1 overdue recommendation to be implemented by end of July 2022. • 1 PSOW report - 7 recs 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.*
Service	**Open reports as at July 22**	**Overdue reports As at July 22**	**Total number open recs July 22***	**Total overdue (red) recs July 22**	**Recs overdue by more than 6 months**	**Comments**
Radiology	2 (→)	2 (→)	2 (↓)	1 (↓)	1 (↓)	• HIW IRMER (WGH) – 1 remaining recommendation with completion date of October 2022 • HIW IRMER (PPH) - 1 remaining recommendation however no revised timescale provided.
Scheduled Care	7 (↑)	4 (↑)	16 (↑)	15 (↑)	6 (→)	• CHC report – 1 'External' recommendation and 2 recommendations delayed by over 6 months with timescales not known. • 2 DU reports – 5 overdue recommendations by over 6 months. • HIW report - 1 overdue recommendation by over 6 months. • 2 PSOW report (1 re-assigned from BGH service as confirmed by Ombudsman Case Manager) - Awaiting confirmation of compliance from PSOW to close 6 recommendations currently noted as overdue.
Strategic Development & Operational Planning	3 (→)	3 (→)	6 (→)	5 (↑)	2 (↑)	• AW report - 1 overdue recommendation by over 6 months. • Internal review of Capital Governance - 4 recommendations overdue (1 by over 6 months) with revised date of September 2022. • 1 IA report – no overdue recommendations.
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 - 3 overdue recommendations by over 6 months. • 1 PSOW report moved to Scheduled Care following confirmation from Ombudsman Case Manager.

USC GGH	2 (➔)	1 (➔)	6 (🡻)	3 (🡹)	1 (🡻)	• DU report All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review – 1 recommendation completed and 1 recommendation overdue with a revised completion date of March 2023. • PSOW report – 3 recommendations with expected completion date of November 2022. Awaiting confirmation of compliance from PSOW to close 2 recommendations currently noted as overdue.
USC PPH	2 (➔)	0 (➔)	2 (➔)	2 (➔)	0 (➔)	• 1 HIW report – 1 overdue recommendation, with a revised completion date of August 2022. • 2016 Peer Review on Respiratory Cancer report - 1 overdue recommendation. The new SDM will be reviewing the respiratory pathway with the clinical lead in order to address the recommendation, and confirm the revised date of completion.
USC WGH	1 (➔)	1 (➔)	0 (➔)	0 (➔)	0 (➔)	• HIW report- 1 'External' recommendation
Women & Children	7 (➔)	4 (➔)	28 (🡻)	22 (🡹)	2 (➔)	• 1 CHC report – 6 recommendations overdue with revised timescales provided for 5 and awaiting confirmation from Public Health in relation to the 6th recommendation, • 1 HIW report - 1 recommendation overdue by more than 6 months (revised completion date of September 2022), • 1 HIW report awaiting formal approval of closure from the General Manager. • 1 IA report – 2 recommendations with expected completion date of September 2022. • 2 Peer Reviews – 2 'External' recommendations, and 14 recommendations overdue, with revised completion dates provided. • 1 Royal College report - 1 recommendation overdue by more than 6 months, with a revised completion date of September 2022.
Workforce & OD	6 (➔)	5 (🡹)	9 (🡻)	8 (🡹)	0 (➔)	• WLC report - 1 'External' recommendation. • 4 IA report – 5 recommendations overdue (4 recommendations with revised completion dates of October 2022 and 1 recommendation with timescale currently not known). 1 report to be closed following evidence being submitted to IA. • 1 AW report – 3 recommendations overdue, awaiting revised timescales from the service.
Unscheduled Care	1 (➔)	1 (➔)	0 (➔)	0 (➔)	0 (➔)	• CHC report - 1 'External' recommendation to be closed following approval from Director of Operations.
Total	**102**	**45**	**281**	**128**	**30**	

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

Services of Concern

The services of concern below are being monitored and recommendations will be clarified as part of the annual review of the Audit Tracker with Executive Leads.

Mental Health & Learning Disabilities

There has been an increase in the number of overdue recommendations since the previous meeting, from 13 to 22, 19 of which the service do not have a revised completion date, and are currently classed as "Not Known". 18 of these are HIW recommendations which the Patient Safety and Assurance Team are clarifying revised timescales with the directorate. 10 recommendations from the reports listed on the tracker had original completion dates of June 2022, and therefore have only recently become overdue by one month.

Women & Children Overdue recommendations have increased from 6 to 22. 14 of those recommendations are from a recent Peer Review on Congenital Heart Defects, and 6 from a CHC report on Maternity Care in Hywel Dda where revised timescales have been obtained from the service. Progress against these recommendations will be obtained in August 2022 via a meeting with service leads within the Directorate.
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:	ARAC – Audit and Risk Assurance Committee

Glossary of Terms:	AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CHC – Community Health Council DCP – Discretionary Capital Programme DU – Delivery Unit EWTD – European Working Time Directive GGH – Glangwili General Hospital HEIW – Health Education and Improvement Wales HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IGSC – Information Governance Sub Committee IRMER – Ionising Radiation (Medical Exposure) Regulations Management & Technology Sub Committee MH&LD – Mental Health & Learning Disabilities 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 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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
AW_295SA2015	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.	Jenny Pugh-Jones	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_295SA2015	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.	Jenny Pugh-Jones	Apr-16	Sep-22	Red	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. Update provided 09/12/2021- The short term vision for pharmacy services are identified within the IMTP. Development of the strategic HB document is delayed due to the impact on Covid and the need for the Health Board to reassess its own Clinical Strategy. Work will be undertaken to develop a vision for the profession within the Health Board based on the National, WG endorsed, Pharmacy: Delivering a Healthier Wales. A draft document will be signed off through MMOG (Medicines Management Operational Group) , through to QSEAC and Board. Revised timescale of September 2022. 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_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.	N/K	Jan-19	~~Mar-20~~ ~~Nov-20~~ ~~Dec-21~~ ~~N/K~~ Sep-22	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.
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.	Director of Strategic Development and Operational Planning	Sep-21	~~Sept-21~~ ~~Dec-21~~ ~~Jun-22~~ Sep-22	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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	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.	Executive Director of Operations	Dec-22	Dec-22	Amber	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error).
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	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.	Board Secretary	Dec-21	Jul-22	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	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.	Executive Director of Operations	Dec-22	Dec-22	Amber	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error).
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	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).	Board Secretary	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.
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.	N/K	May-22	~~May-22~~ ~~Jun-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 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.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_002d	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.	The Health Board will ensure that our recovery plans are aligned to any workforce planning implications that may impact on wellbeing.	Tracey Walmsley	Mar-22	~~Mar-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 March 2022 timescale.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Leony Davies	Sep-22	Sep-22	Amber	4/11/2021- 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. Leony - is this on track to be completed by September?- 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.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	Sharon Richards	Director of Workforce & OD	AW_TCOTC_003a	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.	User satisfaction feedback and clinical outcomes monitoring is in place for all 121 psychological support services and trend analysis is conducted monthly. User satisfaction and clinical outcomes are monitored on an ongoing basis with monthly reporting to the Wellbeing Dashboard. Evaluation plans are in place for the new Staff Wellbeing Information Line as well as the Staff Ecotherapy Programme. A Well-Being Dashboard is produced monthly.	Suzanne Tarrant	Apr-22	~~Apr-22~~ ~~Jun-22~~ N/K	Red	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting. 11/02/2022 - The Ecotherapy pilot will be evaluated on completion with a target date of April 2022. 22/02/2022- update to ARAC confirms April 2022 timescale. 27/05/2022- The first Recovery in Nature: Ecotherapy Retreat for Staff was run in March/April. The second was due to start on 22nd April but had to be deferred due to participants having covid and is now due to commence on 10th June. Each Retreat is being evaluated with pre, post and follow up measures. A preliminary Evaluation on Retreat 1 will be available by the end of June.
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.	Suzanne Tarrant	May-22	~~May-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.
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.	Suzanne Tarrant	Apr-22	~~Apr-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.
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.	Leony Davies	Sep-22	~~01/09/2023~~ March 2023	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 22/02/2022- update to ARAC confirms Sept 2022 timescale. 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.
CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open (external rec)	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	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	Carly Buckingham	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. Approxiate 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.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	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.	Carly Buckingham / Stephanie Hire / Keith Jones	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ N/K	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and set up plans is being led by the Primary Care Optometric Leads who need to update on this action. 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.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Buckingham	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.	Carly Buckingham / Stephanie Hire / Keith Jones	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ N/K	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and set up plans is being led by the Primary Care Optometric Leads who need to update on this action. 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.

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CHC_MHCIOP0821	Aug-21	CHC	Mental Health Care In Our Pandemic, August 2021	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	CHC_MHCIOP0821_003	N/A	Whilst people may not be able to have face-to-face support or therapy, some people may feel that phone calls are helpful in the interim and these may need to be part of an active offer by the Health Board.	This will be addressed through the MH/LD 'keeping in touch group'.	Selina Marshall	Mar-22	~~May-22~~ Sep-22	Red	Progress update provided to CHC as part of the management response in August 2021: 'Keeping in touch' Task and Finish Group has been established, next meeting 27th September 2021. 12/10/2021 - some of these actions are dependent in implementation of WPAS, therefore any services with a waiting list is being prioritised in Phase 2. WPAS can prompt MHLD to keep in touch. 13/01/2022 - The implementation of WPAS into IPTS is in preliminary discussions but not confirmed roll out date yet. 04/03/2022 - Use of Third Party contract via Informatics team has been used to send initial set of letters to individuals awaiting an appointment with the MAS Team in Pembrokeshire. This is now being progressed for other MAS Teams. Other areas of the Directorate are also working towards this position. Informatics development work for IPTS use of WPAS nearing completion. Initial migration of data due to take place within the next 6 weeks. 27/06/22. The task and finish group continues to be held once a month, to date the older Adult MAS team and CDAT team are now sending letters to clients to keep in touch. The IAS team are facilitating the process currently. The group continues to be run as there is a tender process underway for the provider of the mail shot service with the additional facility of a SMS text option. Based on if this comes to fruition services could also implement the SMS service as a form of keeping in contact plus a reminder service for appointments. This is pending the tender completion.
CHC_MCHD1121	Nov-21	CHC	Maternity Care in Hywel Dda	Open	N/A	Women and Children's Services	Public Health	Lisa Humphrey	Director of Operations	CHC_MCHD1121_011	N/A	Consider whether health visiting can be strengthened and provided more consistently across the area as this was identified as a gap by new mums.	Meeting held with the Health Visitors when we were planning to redesign our Face Book pages. • Plans in place to signpost to the Health Visitor web page once they have it in place. • Share report with Health Visitors to provide joint Maternity and Health Visiting response to actions • Shared central email to ensure seamless and accurate communication	Health Visiting Lead	Mar-22	~~Mar-22~~ N/K	Red	11/05/2022 - recommendation to be assigned to Public Health (Liz Wilson)
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	Head of Midwifery & Women's Services Consultant Midwife Consultant Obstetrician/Clinical Lead for Women & Children's	Apr-22	~~Apr-22~~ Sep-22	Red	11/05/2022 - discussion with the Head of Midwifery and Interim Deputy Head of Midwifery noted that they are reassured that the recommednation 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.
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_002	N/A	Revisit maternity arrangements for first time mothers to identify if there is scope to provide more information or support. In particular, identify ways of addressing some of the smaller information needs that can cause a lot of unnecessary worry such as ward routines and what to do with your newborn when you need a shower or when you have a catheter or a drip etc.	Maternity services have continued to provide visiting for partners for all ante, intra and post natal women despite recent restrictions within the rest of the Health Board. Maternity Voices partnership has recommenced and we have a service user as the chair. • Ward manager has updated written information informing women on how to ask for assistance and day to day information including meal times /ward rounds Add information to the current post natal ward welcome letter to include laminated signs encouraging women to ask to speak to a midwife privately if they wished to share personal information. • Clinical Supervisor for Midwives will be instrumental in ensuring this message is circulated and feedback to all staff regarding the findings of the survey. • Maternity Experience Midwife to be appointed December 2021	Head of Midwifery & Women's Services	Mar-22	~~Mar-22~~ Sep-22	Red	11/05/2022 - discussion with the Head of Midwifery and Interim Deputy Head of Midwifery noted that they are reassured that the recommednation 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. Service also undertaking a consultation where surveys have been sent to first time mothers for feedback, and await outcomes of these in order to satisfy that the recommendation has been implemented.
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_004	N/A	Remind staff that clear, consistent and kind communication with women is needed throughout their pregnancy, delivery and postnatal care from all healthcare staff they encounter. This will help them know what is happening, when things are changing and what options they may have.	All health care professional leads will be involved in formatting the recommendations from this survey and are responsible for implementing them. • Survey results will be sent to all staff with recommendations included. • Clinical Supervisor of Midwives will reiterate the evidence of this sharing of information. • Learning is identified and shared in the Maternity Newsletter • Audit results from how women felt undergoing induction has been shared on various forums and lessons learned. • On 08.12.2021 Birth Rights training day for staff has been supported by the RCM and is free for midwives to attend. This is fully booked with plans to roll this out to all health care professionals once we have had feedback from the participants • Consent and choice is discussed in all forums. Further work is necessary to improve on our use of language and how we discuss perceived risk with each individual woman. Consultant midwife to undertake virtual session on human rights and choices in pregnancy	Head of Midwifery & Women's Services	Mar-22	~~Mar-22~~ Jul-22	Red	11/05/2022 - discussion with the Head of Midwifery and Interim Deputy Head of Midwifery noted that they are reassured that the recommednation 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 July 2022 as awaiting formal feedback from the PALS team.
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_006	N/A	Review existing breastfeeding support arrangements as these do not appear to be working effectively for a significant proportion of women. Consider undertaking some in-house evaluation on a regular basis to see if this area is improving.	Breast feeding support midwives available across all 3 areas of the HB • Discussions with Breastfeeding support midwives on ways to improve advice and support ante/intra and postnatally • Improve signposting to support available in the community. 'Llaeth Mam' etc • Breastfeeding clinics are available • Increased Breastfeeding support via TEAMS –mothers are rang in the postnatal period • HCSW Band 2 allocated as breastfeeding support and training link • Breastfeeding Support Midwives in place to support training and virtual consultations • Review Breastfeeding Champions in the acute sites • Review breastfeeding peer support on acute sites	Head of Midwifery & Women's Services	Mar-22	~~Mar-22~~ Dec-22	Red	11/05/2022 - discussions ongoing with Public Health in order to determine an appropriate pathway and funding options in order to fully implement this recommendation. Due to the scale of this work, revised timescale provided of December 2022.
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_008	N/A	Consider whether mums need more information about discharge processes and arrangements, whether this is for mums with normal deliveries or more complex births.	• Ward managers to review postnatal information processes • Discharge from hospital video to be completed by April 2022	Head of Midwifery & Women's Services	Apr-22	~~Apr-22~~ Sep-22	Red	11/05/2022 - Welcome to the Ward book being developed by the service, with the intention for this to be handed to any patients admitted. Discharge videos are also currently being filmed to further communciate. Delays due to staffing across the Health Board
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	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	Mary Owens	N/K	~~Apr-22~~ N/K	Red	22/02/2022- SDM, Scheduled Care commented that this action needs to be updated & owned by Head of Dental & Optometry Services & Optometric Advisor as the Diagnostic Treatment Centre (ODTC) funding and set up plans is being led by the Primary Care Optometric Leads. 23/02/2022- update from Head of Dental and Optometry- The first stage was to develop ODTs in Primary care to deliver The Glaucoma pathway and this has been delayed because of the appointment process for a lead consultant with a sub specialist interest in glaucoma and the installing of IT systems to support the pathway. Plans are in place to start the pathway providing there is a recurrent source of funding available from the 01/04/2022. 12/07/2022- 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.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Buckingham	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	Carly Buckingham	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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	N/K	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 it's recommendation re development of an electronic referral system by March 2022. 16/03/2021 – Discussions continuing between HDUHB and SBUHB Cardiology Management Teams concerning need/feasibility of developing SharePoint system. 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 Buckingham	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.	Carly Buckingham	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.
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 Buckingham	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.	Carly Buckingham	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.
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 Buckingham	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.	Carly Buckingham	Mar-20	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ Mar-23	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 Zeland) . 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).
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 Buckingham	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.	Carly Buckingham	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.
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_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.	Marc Nichols	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 frmo 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 . Prposed date to commnec 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_AWARCLPSA0322_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.	Marc Nichols	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 frmo 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_AWARCLPSA0322_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.	Marc Nichols	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_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.	Marc Nichols	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_AWARCLPSA0322_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.	Marc Nichols	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 frmo 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_AWARCLPSA0322_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.	Marc Nichols	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_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.	Marc Nichols	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_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	Marc Nichols	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.	Marc Nichols	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.

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DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	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.	Marc Nichols	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.	Marc Nichols	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.	Marc Nichols	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 Buckingham	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.	Carly Buckingham	N/K	~~Mar-23~~ Mar-24	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).
HIW_JTRCMHT	Feb-19	HIW	Joint Thematic Review of Community Mental Health Teams 2017-2018 issued Febuary 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.	Head of Clinical Innovation & Strategy MHLD Sara Rees / Kay Isaacs	Dec-22	N/K	External	4/12/2020 update requested, response received: WPAS migration has been completed however some issues between the interfaces of the systems are being ironed out. 19/02/2021 This recommendation is partially completed by the HB. The HB has agreed with the Delivery Unit to deliver a presentation on any outstanding actions. Outlining the thematic actions that are considered unachievable. (Outside of gift of the HB). 12/10/2021 - CarePartner - integrated record system in place and being utilised. Have the facility to grant access to records to people should they need them. quality improvement is undertaken between operational services and QAPD. Ward Managers Forum (clinical) in place, and Community Management Forum being considered with relevant TORs to be updated to reflect this - forums where service improvements are being discussed. Standing agenda items such as PSOW reports, Level 1 incidents etc. Local Authority element of the recommendation remains outside of the gift of the HB. Phase 1 of WPAS has been completed, with CMHTs included in forthcoming Phase 2. 07/12/2021 - Local Authority attendance at twice daily meetings, and working collaboratively with the Health Board to ensure effective patient flow and managing patients in the community. The situation with regards CarePartner remains the same. 01/02/2022 - as per December update. WPAS and Care Partner in place, however confirmation needed from Digital re: the progress on WCCIS. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW.
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.	Neil Mason/ Kay Isaacs Deprivation of Liberty Safeguards Coordinator	Jul-20	~~Apr-22~~ N/K	External	22/10/2020 response received Head of AMH to request information from Sarah Roberts Administration Manager, as whilst new legislation not due we can use what is current. Internal DOLS policy currently being used until new legislation in April 2022. 4/12/2020 Recommendation outside gift of Health Board until new legislation is in place. 12/10/2021 - review of the Mental Health Act, new legislation still being developed and will be looked at through the Mental Health Capacity Group. To send copy of the HIW report to Sarah Roberts for further review and discussion, and to possibly amend ownership and timescales for this recommendation as legislative changes will impact the whole Health Board and not specifically OAMHS. 07/12/2021 - Code of Practice consultation completed, however no new legislation in place. To set up meeting with Madeleine Peters to discuss the ownership of the recommendation. 01/02/2022 - as per December. RW to send on to Liz to discuss with Madeleine. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper.
HIW_19097_WGHW711	Jul-20	HIW	Wards 7 & 11, WGH, 4-5 Febuary 2020 (Publication date 19 July 2020)	Open (external rec)	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Janice Cole-Williams / Carol Thomas	Director of Operations	HIW_19097_WGHW711_026	N/A	R26: The Deprivation of Liberty Safeguards (DoLs) policy is updated to reflect the Liberty Protection Safeguards in line with the Mental Capacity (Amendment) Act 2019	Protocol drafted for managing the MHA/MCA interface. Currently out for consultation. Final version to be approved by the MCA and Consent Group	Steven Hughes, Deprivation of Liberty Safeguards Coordinator	Aug-20	~~Aug-20~~ ~~Apr-22~~ N/K	External	16/09/2020 Update received: SH advised A report on this is to be submit to the mental capacity and consent group next week for approval. It's been delayed as some of the key consultees in mental health haven't been available and the consent group hasn't met since February due to Covid response issues. If approved by the group next week it will still need to go for approval by the equivalent Mental Health scrutiny group, I'm not sure when they next meet. Further progress to be issued next week. 6/11/2020 update received from DOLS Co-ordinator. We have a DoLS policy that is within its review date. LPS will be completely new legislation and the DoLS policy will become obsolete on its introduction as it completely replaces DoLS. The work on the interface could be added to the current DoLS policy as an appendix detailing procedures to be followed, it can then be added to a future LPS policy as very similar issues will remain under the new legislation. Unable to provide a new date new LPS not expected before April 22. 11/03/2021 Recommendation currently outside the gift of the Health Board until new legislation is in place. 27/08/2021 Deprivation of Liberty Safeguards Coordinator advised, the changes to the DoLS policy regarding the MHA/MCA interface were approved and have been implemented. The LPS implementation date is still April 2022, but it is widely expected to be postponed again until at least October 2022. The implementation of LPS, including development of a policy, is being led by Madeleine Peters, Head of Mental Capacity and Consent. One option being considered is to incorporate policy relating to LPS into an amended Mental Capacity Act policy, as this will also need to be updated. No final decision made on that at present however. 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.
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	Fire Officer for face to face training	Aug-21	~~Aug-21~~ ~~Dec-21~~ ~~Jul-22~~ Sep-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. OAST 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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Natasha Mitchell/Operations Manager and Assistant Operations Manager	May-21	~~May- 21~~ ~~Nov- 21~~ ~~Jan-22~~ N/K	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.
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	Mental Health & Learning Disabilities	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.	Operations Manager and Assistant Operations Manager	Mar-22	~~Mar-22~~ N/K	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.
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.	Director of Estates, Facilities and Capital Management	N/K	N/K	Amber	19/05/2021 Awaiting WG relaxation of current of social distancing rules to be approved prior to face to face training being recommenced. 07/09/2021 - Fire training has recently commenced via Microsoft Teams and members of staff are booking on and attending 29/11/2021 - 21 staff of the 30 on the ward have now undertaken the fire training and a further session has been agreed with the Ward Sister and Head of Fire Safety Management scheduled for the week of 29th November 2021 to complete the training for the remaining 9 members of staff. 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.
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.	Jason Woodll- Major Capital Development Manager	Jun-22	~~June 22~~ N/K	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.
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.	Duncan Evans Estate Operations Manager	Nov-21	~~Nov 21~~ ~~Jan 22~~ N/K	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 Febraury, April and May 2022 none received from the service.
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.	Karen Roberts - Deputy Directorate Support Manager Phillip Astles Estates Project Manager	Apr-22	~~Apr 22~~ Jul 22	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 11/07/22 PO work is currently being undertaken with a provisional completion date of end of July 2022
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	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	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	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	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	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	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_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.	Head of Nursing	Mar-22	~~Mar-22~~ N/K	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.
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	Head of Nursing	Mar-22	~~Mar-22~~ N/K	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.
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.	Executive Director of Nursing, Quality and Patient Experience	Mar-22	~~Mar-22~~ N/K	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.

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	Recommendation Owner	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_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	Head of Nursing	Dec-21	~~Dec-21~~ N/K	Red	16/02/2022 Previous management response - Audit tool to be introduced to support the evaluation. 23/02/2022 (BGH) - Beginning of February 2022, a digital system for handover is being used by doctors. EPCR team have been at BGH from 8th February 2022, providing training for the Terrapace portal web. 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.
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_03c	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	There has been a meeting with WAST colleagues in January representatives from each HB were in attendance. An agreement was reached that each HB shared their self – assessments with WAST and the ADN f or WAST would meet with HIW to discuss next steps	Assistant Director for Patient Experience	Mar-21	~~Mar-21~~ ~~Mar-22~~ N/K	Red	16/02/2022 Previous management response - • The family liaison officers (FLO's) Are present in ED across the HB, these have a role in ensuring that there is good communication being maintained between the patients, staff and relatives. The Health Board are reviewing these roles and consideration will be given to extending funding 23/02/2022 (BGH) - Designated Team Leaders on every shift, and Family Liaison Officers are present in ED to improve the process of handover. Frailty team at front door will undertake an assessment on the ambulance and determine whether admission is required or if community support is more appropriate. ENP's, see, treat, assess and discharge using the Manchester Triage Tool shared with WAST. 18/05/2022 - not yet due no update received. QAST update 11/07/22 chased PPH & GGH for update Feb, April and May 2022, none 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.	Assistant Director of Nursing for Quality, Assurance and Professional Regulation	Dec-22	~~Dec-22~~ ~~Mar-22~~ N/K	Amber	No update received from QSE team on progress agaisnt 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.
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.	Head of Nursing	Mar-22	~~Mar-22~~ ~~Mar-22~~ N/K	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 set up 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 upate 11/07/22, no update from PPH & GGH to date.
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.	Head of Nursing	Mar-22	~~Mar-22~~ N/K	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.
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.	Clinical lead nurse	Mar-22	~~Mar-22~~ Sep-22	Red	No update received from QSE team on progress agaisnt 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.
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.	Team leader/Clinical lead nurse	Sep-22	Sep-22	Amber	No update received from QSE team on progress agaisnt 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.
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.	Fire Safety Officer	Mar-22	~~Mar-22~~ ~~Jun-22~~ N/K	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.
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 it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired.	Senior Nurse	Jun-22	~~Jun-22~~ N/K	Red	21/12/2021 - Factual accuracy completed to advise that this was incorrect: The unit is divided into 3 independent care areas each with it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired 20/01/2022 - noted that no response from HIW received relating to the comments raised in the factual accuracy form, which queried this recommendation. 26/01/2022 - noted that separate flats are all open access, with no locked doors. 27/01/2022 - The MHLD Seclusion Procedure is currently under review by the Consultant Nurse, Reducing Restricted Practice Lead and Senior Nurses. The procedure will include guidance on long term segregation or seclusion in line with the Mental Health Act. The first draft is expected to be reviewed at the Written Control Group in March 2022, with final ratification expected in May 2022. An implementation plan will also be presented alongside the procedure for ratification, demonstrating how this will be enacted and adopted going forward. 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.
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	Senior Nurse	Mar-22	~~Mar-22~~ ~~Jun-22~~ N/K	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.

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	Recommendation Owner	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.	Director of Estates/Head of LD services	Mar-22	~~Mar-22~~ N/K	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 maintainance plan from Estates going forward. QAST update 11/07/22 maintainance plan awaited from Estates.
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.	Head of Learning Disabilities	Feb-22	~~Feb-22~~ N/K	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.
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.	Senior Nurse	Mar-22	~~Mar-22~~ N/K	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.
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.	Head of Learning Disabilities	Feb-22	~~Feb-22~~ ~~Mar-22~~ ~~Jun-22~~ N/K	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.
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.	Head of Culture and Workforce / senior nurse	Feb-22	~~Feb-22~~ ~~Jun-22~~ N/K	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.
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.	Director of Estates/Head of LD services	Mar-22	~~Mar-22~~ ~~Jun-22~~ July 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.
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.	Director of Estates	Mar-22	~~Mar-22~~ ~~Jun-22~~ July 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.
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.	Head of Education & Training / Head of Nursing	Mar-22	~~May-22~~ ~~Aug-22~~ Sep 22	Red	No update received from QSE team on progress agaisnt 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
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 Mental Health	HIW_NRMHCPC0322_0016b	N/A	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	A SPOC service to be rolled out across the Health Board following completion of the pilot. (The SPOC service will initially be available 09:00hours to 23:59hours / 7 days a week.)	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	

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	Recommendation Owner	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 Mental Health	HIW_NRMHCPC0322_002b	N/A	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	A Single Point of Contact (SPOC) pilot has commenced within the Health Board. The aim of the SPOC pilot is to: •Offer a timely initial assessment after which service users will access the most appropriate pathway into Mental Health and Learning Disability services for intervention/support or via 3rd sector agencies if they are not admitted •Ensure that follow up plans are clearly formulated and shared with service user/carer and GP for clarity of the plan of care thereafter.	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_002c	N/A	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	A SPOC service to be rolled out across the Health Board following completion of the pilot. (The SPOC service will initially be available 09:00hours to 23:59hours / 7 days a week.)	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_002d	N/A	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	To exponentially increase the SPOC service to 24/7 service.	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_006b	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.	A SPOC service to be rolled out across the Health Board following completion of the pilot. (The SPOC service will initially be available 09:00hours to 23:59hours / 7 days a week.)	Warren Lloyd / Dr Sion James / Dr Catherine Burrell	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_007b	N/A	Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	A SPOC service to be rolled out across the Health Board following completion of the pilot. (The SPOC service will initially be available 09:00hours to 23:59hours / 7 days a week.)	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_009b	N/A	To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	A SPOC service to be rolled out across the Health Board following completion of the pilot. (The SPOC service will initially be available 09:00hours to 23:59hours / 7 days a week.)	Amanda Davies	Jun-22	~~Jun-22~~ N/K	Red	
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 Mental Health	HIW_NRMHCPC0322_0016c	N/A	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	To exponentially increase the SPOC service to 24/7 service.	Amanda Davies	Dec-22	Dec-22	Amber	
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 Mental Health	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.	Amanda Davies	Jan-23	Jan-23	Amber	
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 Mental Health	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	Amanda Davies	Jan-23	Jan-23	Amber	
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 Mental Health	HIW_NRMHCPC0322_002e	N/A	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	To develop a communication plan which will raise awareness as to what the SPOC service is. The communication plan is to be developed in conjunction with the Health Board Communication Team. This will support wide reaching communication about the new SPOC service.	Amanda Davies	Dec-22	Dec-22	Amber	
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 Mental Health	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.	Amanda Davies / Senior Nurse	Sep-22	Sep-22	Amber	18/05/2022 -Current evaluation of the team areas is being conducted –being led by Senior Nurse SC
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 Mental Health	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.	Consultant Psychiatrist/ /Deputy Medical Director Primary Care/Deputy Associate Medical Director Primary Care	Mar-23	Mar-23	Amber	
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 Mental Health	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.	Warren Lloyd / Dr Sion James / Dr Catherine Burrell	Mar-23	Mar-23	Amber	
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 Mental Health	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.	Warren Lloyd / Dr Sion James / Dr Catherine Burrell	Dec-22	Dec-22	Amber	
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 Mental Health	HIW_NRMHCPC0322_007c	N/A	Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	To exponentially increase the SPOC service to 24/7 service.	Amanda Davies	Dec-22	Dec-22	Amber	
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 Mental Health	HIW_NRMHCPC0322_009c	N/A	To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	To exponentially increase the SPOC service to 24/7 service.	Amanda Davies	Dec-22	Dec-22	Amber	
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 Mental Health	HIW_NRMHCPC0322_010	N/A	Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.	Requirement to undertake an organisational change process to establish 7 days working within Community Mental Services with an aim of ensuring that there is timely care to prevent crisis available in all localities.	Amanda Davies	Dec-22	Dec-22	Amber	18/05/2022 - Update:- awaiting the completion of the OCP and expectation date of services being 7 days a week is September 2022

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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 Mental Health	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).	Sara Rees	Dec-22	Dec-22	Amber	
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 Mental Health	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.	Sara Rees	Dec-22	Dec-22	Amber	
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 Mental Health	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.	Amanda Davies	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
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 Mental Health	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.	Amanda Davies	Dec-22	Dec-22	Amber	
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 Mental Health	HIW_NRMHCPC0322_016a	N/A	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	Single Point of Contact operational within the HB, currently in pilot stage but anticipated to be fully operational by June 2022, however there are potential variables that need to be considered with regard to the time frame.	Amanda Davies	Dec-22	Dec-22	Amber	18/05/2022 - as per original management response
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 Mental Health	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.	Service Manager	Sep-22	Sep-22	Amber	18/05/2022 - PAS team to liaise with SDM of Psychological Therapies to develop a response and obtain updates
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 Mental Health	HIW_NRMHCPC0322_018a	N/A	Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.	To open a sanctuary in Ceredigion county which will mean that the Health Board has a sanctuary in each of its counties (Carmarthenshire, Pembrokeshire and Ceredigion).	Amanda Davies	Sep-22	Sep-22	Amber	18/05/2022 - Completed 20/06/2022 - update provided at MHLD QSE had a different action and response noted to the recommendation, which was previously noted as complete and now has a timescale assigned of September 2022
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 Mental Health	HIW_NRMHCPC0322_018b	N/A	Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.	To consider further service improvement funding bids to increase the opening hours of the sanctuaries. The sanctuaries are currently open Thursday to Sunday from 18:00 hours to 02:00 hours.	Amanda Davies	Sep-22	Sep-22	Amber	
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 Mental Health	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.	Amanda Davies / Aileen Flynn	Dec-22	Dec-22	Amber	18/05/2022 - Understand this within our local context through engagement with WWAMH
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 Mental Health	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.	Amanda Davies / Aileen Flynn	Dec-22	Dec-22	Amber	
HIW_20255_PPHRIV	May-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER) 23/24 February 2021 (Publication date 25 May 2021)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	HIW_20255_PPHRIV_002	High	The health board is required to inform HIW of the action taken to provide information to patients of their replies to surveys, with actions taken on feedback	As above. Information board to include a 'you said .. we did' section updated monthly. This will be rolled out in radiology departments across all four acute sites	Head of Radiology	Jun-21	~~Jun-21~~ ~~Sep-21~~ N/K	Red	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021. 23/09/2021 - A notice board has been ordered and is due to arrive by the end of September. This will display patient and staff feedback. We are also working with the Head of Culture and Workforce experience team to align staff experiences with patient experiences. 10/02/2022 - confirmation received that "You said, we did" boards in place at PPH, with other sites awaiting receipt of theirs. To confirm progress in February 2022 Radiology service update 09/03/22 update received the link to patient experience has been added to the shared drive for staff members to use and have widely distributed this information across all modalities. We are in the process of making the 'you said we did' notice board in the waiting area to display feedback to patients and to provide information for patients on how to give feedback. The service has nominated a radiology assistant to take this up. It has been very difficult to get this done within the initial specified timeline due to the critical service needs/staffing. QAST update 11/07/22 You Said We Did information board in place at PPH, to be pursued at other acute sites.
HIW_21021_WGHNMD	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital 27/28 July 2021 (Publication date 29 October 2021)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_21021_WGHNMD_012	High	Delivery of safe and effective care - The employer must ensure that training and competency records are maintained for all duty holders working within the department, including practitioners, non-medical referrers and those staff providing medical physics support.	Ensure that practitioner and non-medical referrer and medical physics training records meet competency requirements and undergo regular review. Work to develop an electronic version which can be both read, updated and signed by users	Radiology services manager	Oct-22	Oct-22	Amber	16/11/2021 - Risk raised on Datix in relation to electronic document management (1269). In lieu of a central electronic document management system, the service is uploading items to Teams as a file, with the same approach expected to be taken for EPs. 09/02/2022 - completed, and creating a folder on the Radiology shared drive as well for electronic version.
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.	Director of Operations	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.

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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.	Director of Operations	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.
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.	Director of Operations	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.
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.	Health Records Manager	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.
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.	Enfys Williams	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 shoulf 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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Assistant Director of Informatics	May-19	~~May-21~~ ~~Aug-21~~ ~~Oct-21~~ ~~Nov-21~~ ~~Feb-22~~ ~~Apr-22~~ ~~Jul-22~~ Sep-22	Red	28/07/2021 - The Digital Team have encountered a number of issues, outside of their control, which has affected the implementation of the new Switchboard solution. Therefore there has been a delay in the ability for lone workers (nights and weekends) to be able to have a compulsory break from the switchboard. The work is due to be completed by September/October 2021, in line with the wider network improvements within the Health Board. This will allow staff to switch over between sites to allow them to have a break. The system will installed on sites shortly to allow for training and testing and for the staff to become familiar with the new system before the full switch over. Work is also being carried out with the switchboard supervisors to look at streamlining processes and making information available across sites. 27/09/2021 - The completion of this recommendation is linked to the improvements on the network which has been delayed due to BT. The Health Board has been held up by the remedial work required to unblock a duct under the main road outside PPH, which required the council to dig up the road. This work has now been completed and we anticipate finalisation of the network upgrade by mid-October. Once the work outlined above has been completed, the Team will be able to release the required bandwidth for the Switchboard infrastructure to go live. 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. 21/07/2022 - 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
HDUHB 2021-08	Oct-20	Internal Audit	Partnership Governance (Integrated Care Fund)	Open	Limited	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Anna Bird	Director of Primary Care, Community & Long Term Care	HDUHB 2021-08_004	High	R4. Management should establish whether sufficient detail and scrutiny is being undertaken by the Regional Partnership Board in order to provide assurance to the Health Board that projects are being delivered of target, in terms of delivery and financially, and where delays/overspend have occurred, the reasons have been noted and promptly reported.	Level of detail within update reports to the RPB to be reviewed in consultation with RPB members. Agreed changes to reporting implemented.	Head of Regional Collaboration	Nov-20	~~Nov-20~~ N/K	Red	ARAC October 2020- agreed that report will be highlighted to Integrated Executive Group (which reports to the RPB) for discussion to agree how the recommendations within the report will be addressed. 13/01/2021-Head of Regional Collaboration confirmed level of detail reviewed and changes will be introduced from Quarter 3. There will be ongoing review of the level of detail in reports in consultation with RPB members. Recommendation noted as complete as process is in place for ongoing review going forward. 21/07/2021- Director of Primary, Community and Long Term Care happy with the suggestion to close this report. 22/04/2022 - Follow-up paper HDUHB-2122-26 noted previous recommendations are partially implemented (Further action required) - Current findings - ICF panel meetings were wound down in 2021 due to both the impact of the Covid-19 Pandemic and limited proposals due to the move to the new funding scheme due to be implemented in April 2022. The Regional Programme and Change Manager Co-ordinator confirmed that projects were not discussed at an individual level at the RBP meetings. This was confirmed following a review of the RPB minutes across 2021 where brief ICF updates had been provided. However, the RBP minutes reviewed did not demonstrate any challenge or additional scrutiny by RBP members of the ICF scheme or projects, or presentation by ICF Leads, and no requests for information were noted in the minutes or action logs. 06/05/2022- Update report to be reported to June 2022 ARAC, audit tracker will be updated following the outcome of this meeting. 07/07/2022 - Current findings from ARAC June 2022: ICF panel meetings were wound down in 2021 due to both the impact of the Covid-19 Pandemic and limited proposals due to the move to the new funding scheme due to be implemented in April 2022.The Regional Programme and Change Manager Co-ordinator confirmed that projects were not discussed at an individual level at the RBP meetings. This was confirmed following a review of the RPB minutes across 2021 where brief ICF updates had been provided. However, the RBP minutes reviewed did not demonstrate any challenge or additional scrutiny by RBP members of the ICF scheme or projects, or presentation by ICF Leads, and no requests for information were noted in the minutes or action logs.
HDUHB 2021-08	Oct-20	Internal Audit	Partnership Governance (Integrated Care Fund)	Open	Limited	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Anna Bird	Director of Primary Care, Community & Long Term Care	HDUHB 2021-08_006	Medium	R6. Identified ICF Leads should ensure that the completion of project proposal forms by project owners is accurate and complete prior to their submission and approval, and where appropriate support project owners not familiar with project management with the bid writing process.	Designated ICF leads to ensure full completion of project proposal forms. Review submitted proposals for 2020-21 and ensure all forms are complete.	Head of Regional Collaboration and Designated ICF Leads	Nov-20	~~Nov-20~~ N/K	Red	ARAC October 2020- agreed that report will be highlighted to Integrated Executive Group (which reports to the RPB) for discussion to agree how the recommendations within the report will be addressed. 13/01/2021-Head of Regional Collaboration confirmed project proposal reforms for all projects will be reviewed for compliance and IEG will be advised of any breaches. Recommendation noted as completed as process is in place. 21/07/2021- Director of Primary, Community and Long Term Care happy with the suggestion to close this report. 22/04/2022 - Follow-up paper HDUHB-2122-26 noted previous recommendations are partially implemented (Further action required) - Current findings - Since the outbreak of the Covid-19 Pandemic in March 2020, all ICF panel meetings were suspended with limited proposals reported to the RPB due to the move to the new funding scheme due to be implemented in April 2022.A sample of four project proposals were reviewed during this audit to establish whether the submissions were fully completed. Our observations noted two of the sampled proposal forms did not explicitly quantify the additionally/ benefits of the project and did not highlight risk or identify timescales or detailed resource plans for implementation. 06/05/2022- Update report to be reported to June 2022 ARAC, audit tracker will be updated following the outcome of this meeting. 07/07/2022 - Current findings from ARAC June 2022: Since the outbreak of the Covid-19 Pandemic in March 2020, all ICF panel meetings were suspended with limited proposals reported to the RPB due to the move to the new funding scheme due to be implemented in April 2022. A sample of four project proposals were reviewed during this audit to establish whether the submissions were fully completed. Our observations noted two of the sampled proposal forms did not explicitly quantify the additionally/ benefits of the project and did not highlight risk or identify timescales or detailed resource plans for implementation.
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.	Assistant Director of Strategic Planning / Director of Estates, Facilities & Capital Management	Feb-21	~~Feb-23~~ Jan-24	Amber	06/05/2021- Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses, which is dependent on WG decision. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 08/11/2021- Meeting arranged to discuss ownership of recommendation. Action to be changed from external to amber as this is a future action that cannot yet be evidence as completed, but is within the gift of the HB to implement. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022. 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 Auidit, however further clarity required if this satisfies the recommendation requirement.
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.	Director of Estates, Facilities & Capital Management	Sep-21	~~Sep-21~~ Jan-24	Amber	06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). 15/09/2021- This recommendation is for future action and can only be demonstrated once the BJCs or OBCs are produced therefore will remain amber. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022. 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 Auidit, however further clarity required if this satisfies the recommendation requirement.
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.	Director of Estates, Facilities & Capital Management	Sep-21	~~Sep-21~~ Jan-24	Amber	06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). These recommendations can only be demonstrated once the BJCs or OBCs are produced. 15/09/2021- This recommendation is for future action and can only be demonstrated once the BJCs or OBCs are produced, therefore will remain amber. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022. 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 Auidit, however further clarity required if this satisfies the recommendation requirement.
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	Head of Capital Planning	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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Yvonne Burson (Assistant Director of Communications)	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).
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.	Enfys Williams (Welsh Language Support Manager)	Sep-22	Sep-22	Amber	02/11/2021- it was advised by the CEO to stand down anything not absolutely critical to support the front-line teams. The Planning day for strategic objectives was called off. 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).
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.	Enfys Williams (Welsh Language Support Manager)	Sep-22	Sep-22	Amber	02/11/2021- The Welsh language team are supporting those teams who are engaging, in the development of their action plans. 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).
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.	Yvonne Burson (Assistant Director of Communications)	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.
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	Improvement Team	Apr-22	N/K	External	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- USC Lead confirmed 'It has been recognised during a recent baseline audit undertaken nationally that is not related just to HDuHB and therefore the national policy goals are working on a consistent training package which health boards can then apply locally'. Timescale is to be determined by this National Work and therefore the recommendation has been amended from red to external (outside the gift of the UHB to currently implement). Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001b	N/A	R1b. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Task and Finish group to be established as part of the UEC programme under policy goal 6, to set consistent principles and standards, with staff reps from across HB community and acute and work through the recommendations together – appreciating that localities may have differing processes this group could share best practice and consideration given as to whether these practices can be taken forward across HB. This approach may also aid identifying training required.	Policy Group Lead	Sep-22	Sep-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC does not provide a timescale, to be confirmed with the service. 11/05/2022- September 2022 provided by USC Lead as timescale for this action. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_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).	SRO UEC Programme	Sep-22	Sep-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC does not provide a timescale, to be confirmed with the service. 11/05/2022- September 2022 provided by USC Lead as timescale for this action.. Baseline assessment section of management response has been implemented. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_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.	County Directors	Apr-22	Sep-22	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- Revised date of September 2022 provided by the USC Lead. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_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 PGS & 6 workstream.	Policy Goal Implementation Leads	Jul-22	Jul-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC does not clarify if action has been implemented, to be confirmed with the service. 11/05/2022- July-22 provided by USC Lead as timescale for this action. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress 13/07/2022- USC Lead confirmed she is meeting with Assistant Director of Nursing on 25/07/2022 due to diary availability. This work will be taken forward in programme Policy Goals 5 (PG5) which sits under the Transforming Urgent & Emergency Care Program – the structure is going to our Programme Delivery Group (PDG) for agreement on the 28/07/2022 and then the groups will be established soon after

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	Recommendation Owner	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.	Policy Goal Implementation Leads	Apr-22	Sep-22	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- Revised timescale of September 2022 provided by USC Lead.Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress
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.	Assistant Director of Nursing for Quality, Assurance and Professional Regulation	Mar-22	~~Mar-22~~ N/K	Red	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms March 2022 timescale. 20/05/2022- Awaiting clarification if this policy has been updated. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress
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.	County Directors / Secondary Care Director alongside Policy Implementation Lead	Apr-22	~~Jun-22~~ N/K	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- Comment from USC lead- This will form part of the governance structure for the new transforming urgent and emergency care program to be launched in June 2022. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress 13/07/2022- USC Lead confirmed she is meeting with Assistant Director of Nursing on 25/07/2022 due to diary availability. This work will be taken forward in programme Policy Goals 5 (PGS) which sits under the Transforming Urgent & Emergency Care Program – the structure is going to our Programme Delivery Group (PDG) for agreement on the 28/07/2022 and then the groups will be established soon after
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.	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	Apr-22	~~May-22~~ N/K	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms revised timescale of May 2022 in a phased approach. The audit tracker has been amended with the revised management response reported to ARAC.Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress 13/07/2022- USC Lead confirmed she is meeting with Assistant Director of Nursing on 25/07/2022 due to diary availability. This work will be taken forward in programme Policy Goals 5 (PGS) which sits under the Transforming Urgent & Emergency Care Program – the structure is going to our Programme Delivery Group (PDG) for agreement on the 28/07/2022 and then the groups will be established soon after
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.	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	Apr-22	~~Jun-22~~ N/K	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- USC Lead provided revised date of June 2022 with comment 'In May 2022 a baseline review at ward level of the utilisation of the SAFER methodology and board roads to support was undertaken nationally. A national and local report will be circulate within the next few weeks and action plan to deliver the required improvement will form part of the overall 6 Goals Transformation plan. WG are expecting this plan to be submitted by Q1 2022/23'. Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress 13/07/2022- USC Lead confirmed she is meeting with Assistant Director of Nursing on 25/07/2022 due to diary availability. This work will be taken forward in programme Policy Goals 5 (PGS) which sits under the Transforming Urgent & Emergency Care Program – the structure is going to our Programme Delivery Group (PDG) for agreement on the 28/07/2022 and then the groups will be established soon after
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	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	Apr-22	~~Jun-22~~ N/K	Red	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 22/02/2022- Update to ARAC confirms April 2022 timescale. 11/05/2022- Internal Audit are undertaking a planned audit of Discharge Process, which will also review the recommendations from this report, which are planned to be reported to October 2022 ARAC. 08/07/2022 - internal audit currently requesting updates on progress 13/07/2022- USC Lead confirmed she is meeting with Assistant Director of Nursing on 25/07/2022 due to diary availability. This work will be taken forward in programme Policy Goals 5 (PGS) which sits under the Transforming Urgent & Emergency Care Program – the structure is going to our Programme Delivery Group (PDG) for agreement on the 28/07/2022 and then the groups will be established soon after
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001a	High	R1a. The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Continue to deliver formal training at the New Consultant Development Programme and any other relevant leadership/management development programmes for those responsible for staff in the Medical & Dental staff group to ensure recruiting managers are aware of their responsibilities and key performance indicators.	Head of Recruitment & Workforce Equality, Diversity and Inclusion	Mar-22	~~Jun-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 confirmed this recommendation is on track- Training session is scheduled be delivered to the Medical Leadership Development programme (the next available session) in May 22. Training content will include an overview of the responsibilities of Recruiting Managers and an update on key performance indicators in order to deliver improvements. It has also been requested that a link to training animations which are already available on the L&D platform be published in the Medical Directors Newsletter ensuring easy access. These links will feature in the next issue of the Medical Directors newsletter which is due to be distributed in March 22. 03/05/2022- update via Internal Audit- Recruitment training (bitesized animations, Values Based Recruitment, Trac Training, Inclusive Recruitment) is now all available on the L&D site for staff to book themselves on. This has been promoted widely via Global messages, Staff social media, bulletin board as well as the Medical Newsletter (March edition). The formal agenda for the May Consultant Development Programme was ameded by the Medical Director therefore a new date for training has been selected in June 2022. Each month the Recruitment team also send KPI performance information to the Director of Operations which includes outliers to ensure sighted on performance. This ensures best practice/good performance is shared as well as where improvements can be made.
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.	Deputy Digital Director	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.
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.	Assistant Directors of Finance	Jul-22	Jul-22	Amber	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
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.	Deputy Director of Finance	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

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2122-42	Feb-22	Internal Audit	Follow-up: Deployment of WPAS into MH&LD	Open	Reasonable	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-42_001	Medium	2.1 Once a decision has been reached to progress the remaining service areas, the Project Group should undertake a detailed risk analysis of those areas and document any identified risks, and also develop a training plan as per the assigned action.	2.1 Agreed. The Project Team have been requested to consider the development of a risk analysis approach for future service areas, following the implementation within Integrated Psychological Therapies Service (due to go live during February 2022)	Director of Mental Health and Learning Disabilities / Digital Director	Mar-22	~~Mar-22~~ Sep-22	Red	28/02/2022 - This report now supersedes HDUHB-2122-16. 17/03/2022 - On track for completion by March 2022 03/05/2022 - update from internal audit: request for update sent on 27/04/2022 11/05/2022 - first service has gone live, and the process to be replicated (including risk logs and assessments) with other service areas. AT to discuss with Karen Amner in MHLD for a revised completion date 19/05/2022 - follow up due Q3 2022/23 27/05/2022 - Update from MHLD: paper was tabled at BP&PAG on 26th May to seek guidance from the SMT within the Directorate as to the next schedule of services to be prioritised. HoS were asked to give thought to enable a decision at the July meeting. 08/07/2022 - internal audit to seek progress update
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.	Senior Environmental Officer	Oct-23	Oct-23	Amber	
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 withappropriate 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.	Assistant Director of Workforce & Organisational Development	May-22	~~May-22~~ Oct 22	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.
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.	Assistant Director of Workforce & OD	May-22	~~May-22~~ Oct 22	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.
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.	Director of Workforce & OD and Director of Finance	Apr-22	~~May-22~~ Oct 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-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.
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.	Assistant Director of Workforce & OD	May-22	~~May-22~~ Oct 22	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
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.	Director of Finance and Assistant Director of Workforce & OD	Apr-22	~~May-22~~ Oct 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 for the recording of temporary staff usage requests to be developed
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.	Assistant Director of Workforce & OD	May-22	~~May-22~~ Oct 22	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
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.	Director of Workforce & OD	Apr-22	~~May-22~~ Oct 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
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_001	Medium	R1. Management should introduce the use of standardised action logs at Cluster Meetings, with actions to be reviewed in subsequent meetings.	Primary Care Service Managers will ensure ongoing completion of a 'Table of Actions' following each Cluster meeting. This will include the action description; date raised; responsible officer; and status i.e. completed / work in progress. An audit to confirm compliance will be undertaken in May 2022.	Assistant Director of Primary Care & Primary Care Manager	May-22	~~May-22~~ July-22	Red	18/05/2022- An audit to confirm compliance is underway. Findings will be reported to SMT by the end of May. 29/06/2022: 5 out of 7 cluster meetings have been held and the Action Log has been incorporated into the agenda and minutes. A follow up review will be undertaken in late July once the final 2 cluster meetings have been held. 14/07/22: 5 out of 7 cluster meetings have been held and the Action Log has been incorporated into the agenda and minutes. A follow up review will be undertaken in late July once the final 2 cluster meetings have been held.
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.	Assistant Director of Primary Care & Primary Care Manager	Jul-22	Jul-22	Amber	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.
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_006	Medium	R6. Management should ensure the position of the Head of TriTech is formalised and a job description is developed, approved and promptly issued.	4.1 The job description has been developed and has been through the A4C matching panel. Funding has been secured and recruitment will begin in April 22. Pending successful recruitment, we envisage the new Head of Tritech to be appointed and in post by the end of August 22. The Medical Director, Chief Operating Officer, and Director of Therapies & Health Science have agreed a clear plan to ensure appropriate governance and managerial arrangements are in place for the intervening period.	Director of Research, Innovation & University Partnerships	Aug-22	Aug-22	Amber	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_001	High	R1. A formal business plan is currently being developed for TriTech. Management should ensure the business plan is submitted to the Health Board for scrutiny and include, but not limited to, the following in order to provide the Health Board the information on this collaborative initiative: • the scope, objectives and mission statement of TriTech; • detailed financial breakdown including the establishment of budgets and resources; • an exit strategy setting out the risk appetite and tolerances; • required quality and safety standards are explicitly outlined; and • key performance indicators.	1.1 The original case, presented as an SBAR, contained detailed activity and financial assumptions and has been instrumental to the set up phase and first year of TriTech's activities. A detailed five-year business plan, informed by the set up phase, is now being developed, with a first draft to be completed by the end of April 2022 and a final draft in place by May 2022. The business plan will contain: The scope, objectives and mission statement of TriTech; • Governance • Service assessment; • Market research, analysis, and strategy; • Competitor analysis; • Staffing plan; • Costs and pricing strategy; • Activity plan, with targets; • Financial forecast; • An exit strategy setting out the risk appetite and tolerances; and • Quality and safety standards with key performance indicators.	Head of Clinical Engineering & TriTech Institute	May-22	~~May-22~~ N/K	Red	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_002	High	R2. Management should establish and document the relationship structure in place between TriTech and other collaborative departments and groups to ensure responsibilities for items such as risk management, quality and safety, and managerial and professional arrangements have been identified and agreed by all parties.	1.2 The business plan will contain a governance section, so that the robust arrangements that have been put in place are clearly documented for future review. For assurance, it should be noted that several of the suggestions were already in place at the time of the audit: • There is a risk register which is incorporated in Hywel Dda University Health Board's risk management system and associated arrangements. Individual risk registers also exist for specific projects; • Quality and safety is of paramount importance to the initiative, with a clear governance route into the Research and Innovation Sub-Committee, which can then escalate the quality and safety arrangements as appropriate. Projects are only supported by TriTech when a sponsoring department has signed off that it is content with a project and this will often be done through their operational quality and safety arrangements.	Head of Clinical Engineering & TriTech Institute	May-22	~~May-22~~ N/K	Red	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_003	High	R3. Management should review the financial requirements for the TriTech Institute to ensure expenditure and income generation targets are appropriate and align with the business plan currently being developed.	2.1 Management agree that the financial assumptions originally proposed in the business case SBAR produced in 2020 have changed. Whereas the original business case projected the majority of income would be secured through grant and advisory work, the reality has seen a much greater demand for real world evaluations commissioned directly by commercial organisations. These income lines are reflected in the finance tracker, which has been established with finance business partners and provides a more accurate and real time overview of the position. Additional pay costs were evident from the appointment of a temporary 'Deputy Head of TriTech' post but these costs have been built into the finance tracker in order to provide a balanced and accurate position on pay and non-pay costs. It should be noted that, due to being fixed term, they do not reflect a change in the agreed establishment. The finance tracker is updated and presented to the Tritech management group in the monthly meetings by the finance business partner and the tracker is also included within the TriTech updates to R&I sub-committee for assurance. As detailed in Matter 4 below, the Head of Tritech job description has been developed and has been through the A4C matching panel. Funding has been secured and this will be reflected within the finance tracker pay costs going forwards. The Finance business partners are actively involved with the preparation of the business plan to ensure all assumptions are robust and sensitivity checked.	Senior Finance Business Partner	May-22	~~May-22~~ N/K	Red	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_004	High	R4. Management should ensure that the financial performance of individual projects are recorded and reported to the TriTech Management Group in order to ensure expenditure is in line with allocated grants.	2.2 The finance team already track the financial performance of individual projects on the finance tracker. The Tritech Finance Business partners will look to introduce a more detailed individual project breakdown as part of the Financial performance reporting presented to the Tritech Management Group.	Senior Finance Business Partner	May-22	~~May-22~~ N/K	Red	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation
HDUHB-2122-40	Mar-22	Internal Audit	TriTech Institute	Open	Limited	Medical	Central Operations	Chris Hopkins/Gareth Rees	Medical Director	HDUHB-2122-40_008	Medium	R8. Management should develop a standard operating procedure to document the grants bidding process for TriTech.	6.1 A new standard operating procedure to document the grants bidding process for TriTech is in development and will be complete by end of May 22.	Deputy Head of TriTech Institute	May-22	~~May-22~~ N/K	Red	10/06/2022 - service update sent to Directorate requesting update 08/07/2022 - advised by internal audit that follow up report due during 2022/23, to be presented at February 23 ARAC 27/07/2022 - progress updates received from Chris Hopkins, now forwarded to Internal Audit for confirmation
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.	Board Secretary / Director of Finance / Digital Director	Aug-22	Aug-22	Amber	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.
HDUHB-2122-31	Apr-22	Internal Audit	Workforce Planning	Open	Reasonable	Workforce & OD	Workforce & OD	Tracey Walmsley	Director of Workforce & OD	HDUHB-2122-31_001	Medium	R1. Management should ensure the terms of reference for the Workforce Planning & Conscience Group is updated and promptly approved.	Agreed - the Workforce Planning & Conscience Group and associated workforce planning groups have been reviewed and the attached outlines the approach going forward. Further work is underway to further integrate workforce planning with education planning and revised terms of reference will be developed shortly.	Director of Workforce & OD	Jul-22	Jul-22	Amber	
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.	Project Director	Sep-22	Sep-22	Amber	08/07/2022: Update received from Assistant Major Capital Development Managerthat progress is ongoing.
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.	Project Director	Jul-22	~~Jul-22~~ Sep-22	Amber	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." Assurance and Risk Officer has requested confirmation of the deadline extension.
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_001a	High	R1. The guidance document (and supporting audit tool) for assessing and managing ligature risk should be reviewed, updated where appropriate, formally approved and adopted.	Currently operational services are in the process of transitioning from paper risk registers to utilising the Datix system and this is being supported by corporate colleagues. This process of management was agreed at the directorate business performance and planning group on 24th March 2022. It is anticipated that the transition of operational services risk registers will be completed by 30th June 2022 at which point an audit of the risk registers to ensure compliance will be undertaken.	MH/LD Directorate Support Manager	Jul-22	Jul-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_001d	High	R1. The guidance document (and supporting audit tool) for assessing and managing ligature risk should be reviewed, updated where appropriate, formally approved and adopted.	Standard Operating Procedure for the management POL action plans to be developed and ratified through MH/LD WCDG, to include but not limited to monitoring, tracking and escalation process.	MH/LD Directorate Support Manager	Jul-22	Jul-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_003a	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.	POL audits will be completed in our inpatient areas once the procedure has been implemented and bespoke training completed. Once completed a rolling programme will be initiated to include immediate review of POL should function of a unit change.	Assistant Director of Nursing MH/LD	Jul-22	Jul-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_003b	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.	Assurance: Monitoring and tracking of subsequent action plans will be undertaken via the MH/LD Accommodation group, from which a report will be submitted to MH/LD QSEG	Deputy Director Support Manager	Aug-22	Aug-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/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.	Deputy Director Support Manager	Jul-22	Jul-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_005b	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.	Central oversight of Action plans will be facilitated through the MH/LD Accommodation Group to ensure monitoring and sharing of risks across all sites.	Director of MH/LD Chair of Accommodation Group	Aug-22	Aug-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/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.	Deputy Directorate Support Manager	Aug-22	Aug-22	Amber	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_001b	High	R1. The guidance document (and supporting audit tool) for assessing and managing ligature risk should be reviewed, updated where appropriate, formally approved and adopted.	Written Control Document – Assessment and Management of Environmental Ligature Risks within Mental Health and Learning Disability. Draft procedure has been produced and is currently out for comment. WCD is due to be presented to the MH/LD Written Control Document Group for ratification on Monday 16th May 2022.	Head of Health and Safety	May-22	~~May-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service

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HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_001c	High	R1. The guidance document (and supporting audit tool) for assessing and managing ligature risk should be reviewed, updated where appropriate, formally approved and adopted.	WCD Implementation plan – Each operational service to produce an implementation plan for the dissemination and implementation of the WCD which will include how compliance is reported through operational governance system to the MH/LD Quality Safety Experience Group.	Operational Heads of Service	Jun-22	~~Jun-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_002a	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.	The identification and management of ligature risks and completion of ligature audits in line with the guidance, will be included in the Health and safety training module provided by the Health and Safety Team.	Head of Health and Safety	Jun-22	~~Jun-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/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	Head of Health and Safety Assistant Director of Nursing MH/LD	Jun-22	~~Jun-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_004a	High	R4. Where ligature risks are identified the audit template should clearly document whether the risk is tolerable (e.g., mitigated via patient management, no action required) or requires remedial action.	As part of the development of the WCD the template will be amended to ensure that allow for the capture of rationale for toleration of risk associated with POL.	Head of Health and Safety	May-22	~~May-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_004b	High	R4. Where ligature risks are identified the audit template should clearly document whether the risk is tolerable (e.g., mitigated via patient management, no action required) or requires remedial action.	Mitigation of Risks will be captured via service level risk registers.	Head of Service	Jun-22	~~Jun-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carrole/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.	Head of Health and Safety	May-22	~~May-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service
HDUHB-2122-44	Apr-22	Internal Audit	Nurse Staffing Levels	Open	Reasonable	Nursing	Nursing	Chris Hayes	Director of Nursing, Quality and Patient Experience	HDUHB-2122-44_001a	Low	R1. The Nurse Staffing Level templates should be fully completed. If the overview document is the preferred method for capturing NSP Team and Designated Person review and approval, the template should be updated to remove these sections and instead refer to the overview document.	Ahead of the next (Autumn 2022) cycle, revise the Nurse Staffing Level review template and associated documents and design the process by which the revised nurse staffing level templates and associated documents are updated following thediscussion with the Designated Person	Nurse Staffing Programme Lead	Aug-22	Aug-22	Amber	
HDUHB-2122-44	Apr-22	Internal Audit	Nurse Staffing Levels	Open	Reasonable	Nursing	Nursing	Chris Hayes	Director of Nursing, Quality and Patient Experience	HDUHB-2122-44_002	Medium	R2. The Quality Safety & Experience Committee should receive regular assurance reports on the Health Board's ability to maintain agreed nurse staffing level, with escalation to the Board where appropriate.	Routinely provide a (minimum of a) 6 monthly (August and February) report to HB's Quality Safety & Experience Committee as part of the regular overarching assurance report to that committee. This report will include (quantitative) details of the extent to which the nurse staffing levels have been maintained across Section 25B wards during the previous 6 months; and (qualitative narrative) description of the steps that have been taken to maintain the planned rosters at their agreed levels and any notable patient outcomes associated with maintaining/not maintaining the staffing levels.	Nurse Staffing Programme Lead	Aug-22	Aug-22	Amber	
HDUHB-2122-44	Apr-22	Internal Audit	Nurse Staffing Levels	Open	Reasonable	Nursing	Nursing	Chris Hayes	Director of Nursing, Quality and Patient Experience	HDUHB-2122-44_001b	Medium	R1. Review and approval of the agreed nurse staffing levels by the Designated Person should be evidenced.	Design a process by which the Designated Person formally confirms the record of the agreed nurse staffing levels and test this process as part of the Spring 2022 nurse staffing level review cycle.	Nurse Staffing Programme Lead	May-22	~~May-22~~ N/K	Red	
HDUHB-2122-44	Apr-22	Internal Audit	Nurse Staffing Levels	Open	Reasonable	Nursing	Nursing	Chris Hayes	Director of Nursing, Quality and Patient Experience	HDUHB-2122-44_003	Low	R3. Ensure accurate reporting of nurse staffing levels to the Board.	Embed a process of checking/proofreading all the data incorporated into Board / QSEC reports to ensure accuracy	Nurse Staffing Programme Lead	May-22	~~May-22~~ N/K	Red	
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.	Assistant Director of Assurance & Risk	Dec-22	Dec-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_0012c	N/A	R12. Training for Project Director	Develop a PD Pocket Guide	Capital Planning Team	May-22	~~May-22~~ ~~Jul-22~~ Sept-22	red	07/01/2022- in progress. 03/05/22 - In development., revised date of July 2022 provided. 07/07/22 - Revised completion date September 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of 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	Capital Planning Team with feedback from CEIM&T	Jan-22	~~Jan-22~~ ~~Feb-22~~ ~~Mar-22~~ Sep-22	Red	07/01/2022- Completion date moved to align with sign off as part of IMTP. 02/03/2022- A Report is being prepared for Executive Team to consider in March 2022 prior to a WG submission by 31/03/2022. 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
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_007	N/A	R7. Setting up of an internal scrutiny process for business cases prior to them being finalised and presented to CEIM&T for approval	Develop a proposal and draft terms of reference for Executive Team discussion. This will cover how the process will be resourced and ensure upfront scrutiny and approval prior to CEIM&T submission	Capital Planning Team	Mar-22	~~Mar-22~~ Sep-22	Red	07/01/2022- In progress for discussion by Executive Team by March 2022. 29/03/2022- Update to Capital Sub Committee (CSC) reported that this will not be implemented by March and that an update on the action will be provided to the May CSC meeting. 03/05/2022 - In progress, revised date of September 2022 provided. 07/07/22 - On track for September 2022. Update being provided to July CSC.
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_008	N/A	R8. Consideration be given if CEIM&T and the Groups that sit underneath it should have delegated approval limit	Review the current capital approval framework documentation and delegated capital approval limits with the Governance Team. SBAR to May CEIM&T	Capital Planning Team with input from the Governance Team	May-22	~~May-22~~ Sept-22	Red	07/01/2022- in progress. 29/03/2022- Update to Capital Sub Committee (CSC) reported that this is in progress. 03/05/2022- SBAR to be presented to May CSC. 07/07/22 - Paper to ET for consideration and an update being provided to July CSC.Revised completion date is September 2022
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_012b	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.	Staff that attend training provided by OCD to cascade this training to other staff.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Sep-22	Red	
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.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Sep-22	Red	
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_002e	High	R2. Change control and validation were deficient in that the change record CC21-62 and VAL21-23, Application and Software Modification (MOD52) of the Ortho Vision analyser, did not follow change control and validation good practice principles evidenced by: The validation and change control data failed to demonstrate that the system was fit for purpose before it was introduced into routine use. For example, the validation data was a series of screenshots of patient records with no explanation of how the transfer of patient data was achieved.	Review the MOD52 validation protocol to ensure it captures and ensures validation of all the changes as detailed in the MOD52 application release notes. Where gaps are identified, further validation to be undertaken. Laboratory manager to ensure provision of sufficient staff in blood transfusion to allow BBM to complete this review.	Hannah Albery, Pathology Quality Manager	Aug-22	Aug-22	Amber	14/07/22- Validation protocol written and approved. Validations raised in Q-Pulse for further validation work to be completed
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_002e	High	R2. Change control and validation were deficient in that the change record CC21-62 and VAL21-23, Application and Software Modification (MOD52) of the Ortho Vision analyser, did not follow change control and validation good practice principles evidenced by: The validation and change control data failed to demonstrate that the system was fit for purpose before it was introduced into routine use. For example, the validation data was a series of screenshots of patient records with no explanation of how the transfer of patient data was achieved.	Perform a retrospective review of the MOD52 validation data and tabulate as per the example sign-off table in the validation policy so that the evidence is referenced, is clear and is appropriately signed-off. Laboratory manager to ensure provision of sufficient staff in blood transfusion to allow BBM to complete this review.	Hannah Albery, Pathology Quality Manager	Aug-22	Aug-22	Amber	14/07/22- validation protocol written

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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_003b	High	R3. Change control and validation were deficient in that the change record CC21-62 and VAL21-23, Application and Software Modification (MOD52) of the Ortho Vision analyser, did not follow change control and validation good practice principles evidenced by: •The validation data available showed no justification for the sample size used for validation testing.	Perform a retrospective review of the MOD52 validation data and justify the sample size used. If it is found that it cannot be justified or was insufficient further validation to be undertaken with a larger sample size. Validation protocol to be updated accordingly. Laboratory manager to ensure provision of sufficient staff in blood transfusion to allow BBM to complete this review.	Hannah Albery, Pathology Quality Manager	Aug-22	Aug-22	Amber	14/07/22- validation protocol written and includes justification of sample size
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_004b	High	R4. Change control and validation were deficient in that the change record CC21-62 and VAL21-23, Application and Software Modification (MOD52) of the Ortho Vision analyser, did not follow change control and validation good practice principles evidenced by: The samples used in the validation exercise did not accurately reflect the sites patient testing population.	Perform a retrospective review of the MOD52 validation and identify any gaps where the patient testing population hasn't been adequately reflected in the samples used for validation. Update validation protocol following this review and carry out further validation as necessary. Laboratory manager to ensure provision of sufficient staff in blood transfusion to allow BBM to complete this review.	Hannah Albery, Pathology Quality Manager	Aug-22	Aug-22	Amber	14/07/22- validation protocol written and includes requirement ot reflect the patient testing population
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_009c	High	R9. Laboratory practices were deficient in that: The out of hours issue fridge door code had no record of being changed and therefore controlled access could not be adequately guaranteed. The potential to restrict access of unauthorised staff had not been assessed.	Change the code to the blood issue fridge every 6 months to ensure only personnel assessed as competent have access (also change if there have been any security breaches, suspected security breaches or when notified that trained staff have left the employment of the HB).	Hannah Albery, Pathology Quality Manager	Jul-22	~~Jun-22~~ Jul-22	Amber	14/07/22 - memo written informing trained staff that the code will be changed on a set date.
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_010c	High	R10. Laboratory practices were deficient in that: There was no system in place to restrict access to the blood issue fridge after a prolonged period of not using the manual code system. The current process of identifying infrequent users via the two yearly training system was not based on an assessment of risk.	Change the code to the blood issue fridge every 6 months to ensure only personnel assessed as competent have access (also change if there have been any security breaches, suspected security breaches or when notified that trained staff have left the employment of the HB).	Hannah Albery, Pathology Quality Manager	Jul-22	~~Jun-22~~ Jul-22	Amber	14/07/22 - memo written infrmating trained staff that the code will be changed on a set date.
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_010e	High	R10. Laboratory practices were deficient in that: There was no system in place to restrict access to the blood issue fridge after a prolonged period of not using the manual code system. The current process of identifying infrequent users via the two yearly training system was not based on an assessment of risk.	Update training system so it only reflects staff who have within date competences for the collection of blood and archive old records.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Jul-22	Red	In progress- working through records and updating them 14/07/22- In progress: working through records and updating them
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_010f	High	R10. Laboratory practices were deficient in that: There was no system in place to restrict access to the blood issue fridge after a prolonged period of not using the manual code system. The current process of identifying infrequent users via the two yearly training system was not based on an assessment of risk.	Display list in issue room of staff that are trained and assessed as competent to collect blood and make it clear that it is a breach of HB policy and BS&QR if untrained staff collect blood.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Jul-22	Red	14/07/22- Dependant on completion of above action
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_010g	High	R10. Laboratory practices were deficient in that: There was no system in place to restrict access to the blood issue fridge after a prolonged period of not using the manual code system. The current process of identifying infrequent users via the two yearly training system was not based on an assessment of risk.	Update blood collection training documentation to emphasise the importance of blood stock security and to make it clear that the codes to the issue room must not be shared with any other personnel.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Jul-22	Red	14/7/22- Discussed with transfusion practitioner.
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_010h	High	R10. Laboratory practices were deficient in that: There was no system in place to restrict access to the blood issue fridge after a prolonged period of not using the manual code system. The current process of identifying infrequent users via the two yearly training system was not based on an assessment of risk.	Create a sign to place on the door to the issue room with contact details for on-duty BMS staff so that where personnel who do not have access are sent to collect blood they can contact the duty BMS to ensure there is no delay in the provision of blood.	Hannah Albery, Pathology Quality Manager	Jun-22	~~Jun-22~~ Jul-22	Red	14/07/22 - Will be completed when code is changed
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_011a	High	R11. Laboratory documentation was deficient in that there was no service level agreement or standard operating procedure in place for the provision of blood components to the Pembrokeshire Acute Response Team.	Implement a SLA with the Acute response team.	Hannah Albery, Pathology Quality Manager	Aug-22	Aug-22	Amber	14/07/22 - SLA written and approved. Ready to issue to ART
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.	N/K	~~Mar-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 27/06/2022- MWWFRS have already advised that they will be extending the completion date for this FEN to December 2022, which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. Recommendation will be turned back to amber once updated FEN letter has been received. 28/06/2022 – advised by the Director of Estates, Facilities and Capital Management that verbal updates have been received from MWWFRS that these actions have revised timescales, which will be formalised in written correspondence shortly and therefore RAG status amended from Red to Amber"
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.	N/K	~~Mar-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 27/06/2022- MWWFRS have already advised that they will be extending the completion date for this FEN to December 2022, which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. Recommendation will be turned back to amber once updated FEN letter has been received. 28/06/2022 – advised by the Director of Estates, Facilities and Capital Management that verbal updates have been received from MWWFRS that these actions have revised timescales, which will be formalised in written correspondence shortly and therefore RAG status amended from Red to Amber"
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.	N/K	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 27/06/2022- MWWFRS have already advised that they will be extending the completion date for this FEN to December 2022, which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. Recommendation will be turned back to amber once updated FEN letter has been received. 28/06/2022 – advised by the Director of Estates, Facilities and Capital Management that verbal updates have been received from MWWFRS that these actions have revised timescales, which will be formalised in written correspondence shortly and therefore RAG status amended from Red to Amber"
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.	N/K	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 27/06/2022- MWWFRS have already advised that they will be extending the completion date for this FEN to December 2022, which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. Recommendation will be turned back to amber once updated FEN letter has been received. 28/06/2022 – advised by the Director of Estates, Facilities and Capital Management that verbal updates have been received from MWWFRS that these actions have revised timescales, which will be formalised in written correspondence shortly and therefore RAG status amended from Red to 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	Recommendation Owner	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_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be the preferred safer option, it was explained to me that this was due to the residents being able to smoke within the premises before the smoking ban to reduce the false alarm calls. • It was noted that there was a detector being covered at time of inspection within the kitchen of the Pembroke county block (First floor flat F block). You must ensure that this practice is not repeated, information must be given to the occupants explaining the severity of this action. • Due to the Server within the Means of escape an additional detector within the area of the device is required (due to the lintel between the detector and the server) noted within the Pembroke county and St Thomas block (but this should include all blocks if server is on escape route in the same way). The changes should be carried out and commissioned by a competent person.	Full action plan held by Estates.	N/K	~~Jul-20~~ ~~Dec-21~~ Apr-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 27/06/2022- MWWFRS have already advised that they will be extending the completion date for this FEN to December 2022, which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. Recommendation will be turned back to amber once updated FEN letter has been received. 28/06/2022 – advised by the Director of Estates, Facilities and Capital Management that verbal updates have been received from MWWFRS that these actions have revised timescales, which will be formalised in written correspondence shortly and therefore RAG status amended from Red to Amber"
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.	N/K	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ Dec-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 21/03/2022- Head of Assurance and Risk awaiting copy of written confirmation from MWWFRS before adjusting the revised completion date for this recommendation. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 05/05/2022- MWWFRS have confirmed via email they are happy to extend KS/890/03 (Phase 1 works) as requested "due to your continuing efforts and commitment to complete the works, whilst on site at Withybush recently I witnessed first hand the good standard of works that is being carried out regarding phase 1". A formal extension letter will be issued in due course.
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_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	N/K	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ Dec-22	~~Dec-21~~ ~~Apr-22~~ Dec-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS. 02/03/2022- This programme now takes into account the additional complex work to undertake the "overboarding" as required by the MWWFRS. The completion date of works on site is December 2022 with a short period of contingency running into January 2023. The MWWFRS has been fully briefed on this programme adjustment, which is required to deliver the "overboarding" work. They are fully supportive of the adjustment and have provided written confirmation of their agreement. MWWFRS has advised that they will visit the site during 2022 and will formally update FEN dates when appropriate. 21/03/2022- Head of Assurance and Risk awaiting copy of written confirmation from MWWFRS before adjusting the revised completion date for this recommendation. 27/04/2022- MWWFRS have advised that they will be extending the completion date for this FEN to December 2022 which aligns with the current agreed programme for this work. It is anticipated that this updated FEN will be received within the next few weeks. 05/05/2022- MWWFRS have confirmed via email they are happy to extend KS/890/03 (Phase 1 works) as requested "due to your continuing efforts and commitment to complete the works, whilst on site at Withybush recently I witnessed first hand the good standard of works that is being carried out regarding phase 1". A formal extension letter will be issued in due course.
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.	N/K	~~Apr-23~~ 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. 05/01/2022- update being reported to Health & Safety Committee January 2022-At this point, confidence remains that the April 2025 date can be achieved, however this will be required to be reviewed when the Business Case work is completed. The matter has been discussed with MWWFRS and they appreciate that a revision may be required to this programme should the nature of the works dictate that an additional period becomes necessary. 27/04/2022- Update as above 05/01/2022 update, confidence remains that the April 2025 date can be achieved, however this will need to be reviewed when the Business Case work is completed. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025.
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.	N/K	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023. 02/03/2022- The current forecasted completion date is April 2023, however this will need to be closely monitored and reviewed as the project progresses. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. MWWFRS is fully aware of the above timescales and has advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension of time that may be required. 27/04/2022- as previous progress update, MWWFRS is fully aware of the above timescales and has advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension of time that may be required.
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_02	High	R2.Compartmentation – All Vertical Breaches and / or Penetrations. To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Glangwili Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 2nd Oct 2020). Fire resisting structures are to continue to slab/ upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	N/K	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023. 02/03/2022- The current forecasted completion date is April 2023, however this will need to be closely monitored and reviewed as the project progresses. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. MWWFRS is fully aware of the above timescales and has advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension of time that may be required. 27/04/2022- as previous progress update, MWWFRS is fully aware of the above timescales and has advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension of time that may be required.
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.	N/K	~~Oct-20~~ ~~Feb-21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 05/01/2022- update being reported to Health & Safety Committee January 2022- At this point, confidence remains that the April 2024 completion date is achievable, however this will be confirmed upon completion of the detailed Business Case work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme should the nature of the works dictate that an additional period becomes necessary. 02/03/2022- Phase 2 remains on programme to be completed by April 2024 (subject to the full due diligence work needed as part of the Business Case development). 27/04/2022-The delivery programme now indicates that the resource schedule will be submitted to WG circa May 2022 allowing the BJC to be commenced in July 2022. We would therefore expect the Phase 2 to mobilise on site circa April 2023. This will co-ordinate well with the completion of the Phase 1 programme. Phase 2 works will again be extremely complex given the delivery of these Fire Enforcement 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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113169	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edges and frames are to be no more than 3 mm	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113169	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113169	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.3. Fire doors should only be kept open by magnetic devices that releases when the fire alarm operate.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113169	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113169	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_002	High	2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
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Admin - General/00113166	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General/00113166	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113166_002	High	2.2. 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 bushed to at least 30-minute standard of fire resistance.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF BFS/KS/SJM/00115877	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_001	High	Item number 1 Alternative Escape Route (Distances). Provide an alternative means of escape as the overall travel distance from Lizzy's and Norma's Rooms is excessive. This new exit would need to be constructed within one of the rooms mentioned, the LABC and Planning department need to be contacted prior to any works undertaken (follow the recommendations within items 2 & 3 and this item will then no longer be required to be undertaken as we will accept item 2 and 3 as a compensatory feature for this situation).	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ N/K	External	24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed. 27/04/2022- UHB to liaise with Housing Association for confirmation the work has been completed. 27/06/2022- UHB has contacted MWWFRS to request a fire visit at the premises (date to be agreed) to ensure that ATEB have completed the works they are responsible for.
BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF BFS/KS/SJM/00115877	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_003	High	3.1 Item number 3 Fire Resisting Doors The fire doors in the following locations require : 1. Cold smoke seals to be repaired on a number of doors within the premises	Full action plan held by Estates.	N/K	Nov-21	~~Nov-21~~ N/K	External	24/08/2021- Action plan submitted to Health & Safety Committee shows timescale of November 2021. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed. 27/04/2022- UHB to liaise with Housing Association for confirmation the work has been completed. 27/06/2022- UHB has contacted MWWFRS to request a fire visit at the premises (date to be agreed) to ensure that ATEB have completed the works they are responsible for.

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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF BFS/KS/SJM/00115877	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_003	High	3.2 Item number 3 Fire Resisting Doors The fire doors in the following locations require : 2. The hinges are to be upgraded Twin Ball Bearing Fire Door Hinge BS EN Grade 14 or to an equivalent standard.	Full action plan held by Estates.	N/K	Nov-21	~~Nov-21~~ ~~Mar-22~~ N/K	External	24/08/2021- Action plan submitted to Health & Safety Committee shows timescale of November 2021. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022. 02/03/2022- Remaining items are fully the responsibility of ATEB (Housing Association). Awaiting a response from MWWFRS on whether any further inspection is planned. MWWFRS has already confirmed that all of the HDdUHB works are completed. 27/04/2022- UHB to liaise with Housing Association for confirmation the work has been completed. 27/06/2022- UHB has contacted MWWFRS to request a fire visit at the premises (date to be agreed) to ensure that ATEB have completed the works they are responsible for.
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Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General00295247	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER Admin - General00295247	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	N/K	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Jul-22~~ Aug-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 02/03/2022- The project is programmed to commence mid-April 2022 and for completion by the end of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. 27/04/2022- Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required. Current completion date is now the end of July following a short delay appointing the contractor for the work. 27/06/2022- It has been necessary to do some addional due diligence work with the contactors to confirm accredited status of installation staff. This has meant moving the competition date to end of Aug 22. 29/06/2022 – correspondence received from MWWFRS confirming the date extension to August 2022 08/07/2022- Recommendations remain on track
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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_018	High	R18. Further Recommendations We recommend that the evacuation strategy from the Ty Bryn Template is reviewed as at the time of the inspection it was noted that the external pathway wouldn't support evacuation of beds via this route, please refer to Chapter 3 WHTM 05-02 3.61 and 3.62.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	27/06/2022- The action plan to deliver these works is now nearing completion and we plan to have this finished by mid-July 2022. This will be subject to formal sign off from MWWFRS, so we are in full agreement with them as to the programming of work and the priorities established in different areas.
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_019	High	R19. Further Recommendations All external escape routes are clean and clear at the prince Phillip site, as at the time of the inspection the external escape route from the diabetic unit template was covered by leaves and garden waste.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	27/06/2022- The action plan to deliver these works is now nearing completion and we plan to have this finished by mid-July 2022. This will be subject to formal sign off from MWWFRS, so we are in full agreement with them as to the programming of work and the priorities established in different areas.
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_020	High	R20. Further Recommendations The laundry room within Bryngofal is subject to regular cleaning (tumble dryers).	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	27/06/2022- The action plan to deliver these works is now nearing completion and we plan to have this finished by mid-July 2022. This will be subject to formal sign off from MWWFRS, so we are in full agreement with them as to the programming of work and the priorities established in different areas.
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_021	High	R21. The no smoking policy is enforced to reduce the risk from fire, it was noted within the inspection that there was a build-up of spent smoking materials within the garden at Bryngofal.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions neccessery, if any.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions neccessery, if any.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions neccessery, if any.
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_004	High	R4. During the fire safety inspection evidence of tests carried out by a competent person on the emergency lighting system was not available. Evidence of such testing should be made available during a fire safety inspection to allow the responsible person to evidence that testing has taken place; the best evidence of testing being certificates of tests carried out by the said competent person.	Management response being prepared by the Estates & Facilities Directorate	N/K	Oct-22	Oct-22	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions neccessery, if any.
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).	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Full fire door survey to be undertaken by AFT on all doors.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week.
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week.
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_006	High	R6. The lounge/tv room in "Picu" was jamming on the floor and would not fully close into its rebate.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week.

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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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week.
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
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_008	High	R8. The automatic fire alarm system does not meet the current standard. The system is to be upgraded to meet a category L1 system., As specified in the British standard: Part 1 - "Fire Detection and Alarm Systems in Buildings", or the equivalent European Standard.	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
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_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: •Dampers •Roller shutter doors It is recommended the records are kept in a logbook	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Dec-22	Dec-22	Amber	

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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	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-23	Jan-23	Amber	
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-22	Amber	
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Puple 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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-23	Jan-23	Amber	
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-25	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
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Sep-22	Sep-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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Jan-23	Jan-23	Amber	
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	
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_002	High	R2. An assessment should be able to take him to ensure that all areas have suitable and sufficient Firefighting equipment installed and in suitable location. The appropriate type, number and size of extinguisher should be provided. Further information is available in BS 5306-8.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	
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.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	
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	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	Amber	
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_006	High	R6. Effective systems of communication must be established with those who are responsible for all departments to ensure all relevant persons are provided with suitable and sufficient information in respect of the fire safety measures implemented. The cooperation must ensure that the shared fire safety measures protect you all.	Management response being prepared by the Estates & Facilities Directorate	N/K	Nov-22	Nov-22	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.	Anna Thomas	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 world wide. 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_CYPDMDT1116	Nov-16	Peer Review	Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016	Open (external rec)	N/A	Women and Children's Services	Women and Children's Services	Margaret Devonald-Morris	Director of Operations	PR_CYPDMDT1116_001	N/A	R1. Absence of a 24 hour on-call advice system	Discuss development of a regional / All Wales 24/7 helpline with other UHBs as a more cost effective alternative to UHB specific arrangements.	Tracey Bucknell	Mar-16	Dec-22	External	The new 24/7 system is to be developed and implemented at an All Wales Level. 5/10/2020 Response received. There is currently no progress on this recommendation as it is being taken forward at an All Wales level by the All Wales Network. 04/12/2020 No progress awaiting All Wales response. 27/01/2021 No progress requires an All Wales solution. 07/04/2021 SDM to establish who the links are. 12/07/2021 No progress awaiting an All Wales Network response. 14/12/2021 Awaiting All Wales solution. 02/02/2022 - as per previous update. Is this recommendation still relevant as at Feb 2022? 08/07/2022 - update received from the service confirming that the All Wales 24 Hour on call did not happend, but CYP have 24 hour open access to the children's ward at both GGH and BGH. SDM seeking approval as to whether this recommendation can be closed, or if it should remain open.
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.	David Richards	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.
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.	David Richards	Mar-20	~~Dec-21~~ Oct-22	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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	David Richards	Dec-19	~~Dec-21~~ Oct-22	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.
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.	David Richards	Jan-20	~~Mar-20~~ ~~Oct-20~~ ~~Dec-21~~ Oct-22	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.
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	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
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_001 b	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.	Head of Information Services	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 inputing. Project is more significant and labour intesive than initially predicted - this is reflected in the amended completion date
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	Clinical Director and Service Delivery Manager	Mar-22	~~Mar-22~~ Oct-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- cardiac clinical teamhave improved engagement with tertiary education program and clincial 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.
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	N/K	Mar-22	~~Mar-22~~ Oct-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- all clinicans actively engaging as per descriptor- yet to be formulated in job planning but this is to be addressed following appointment of new clinical lead
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.	Service Delivery Manager, Head of Nursing and Senior Nurse Manager	Jun-22	~~Jun-22~~ Oct-22	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 developemnt and will be reviewd as a part of the HB recruitment processes.
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	Clinical Director and Service Delivery Manager	Mar-22	~~Mar-22~~ Oct-22	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 clarificaiton 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 developement of formalised honorary contracts.
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]	Service Delivery Manager, Head of Nursing and Senior Nurse Manager	Mar-22	~~Mar-22~~ ~~Jun-22~~ Aug-22	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 No funding forthcoming form IMTP submission to support county- based nurse support, Nurse leads to revisit possible develpments within nursing establishment
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.	Service Delivery Manager, Head of Nursing and Senior Nurse Manager	Jun-22	~~Jun-22~~ Aug-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 No funding forthcoming form IMTP submission to support county- based nurse support, Nurse leads to revisit possible develpments within nursing establishment
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.	Senior Nurse Manager	Jun-22	~~Jun-22~~ Aug-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 SDM in discussion with Cardiac services to support additional resourcing for paeds workload
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.	Clinical Director	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.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Service Delivery Manager, Head of Nursing and Senior Nurse Manager	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.
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	Clinical Director	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.
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_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	Head of Information services & Service Delivery Manager	Jun-22	~~Jun-22~~ Oct-22	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/2022- The HB system in developemnt will support this - and in collaboration with "cardiobase" this situation will improve
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)	Service Delivery Manager, Head of Nursing and Senior Nurse Manager	Jun-22	~~Jun-22~~ Oct-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- New role in development
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_020 a	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	Paediatrician with Expertise Cardiology and Senior Nurse Manager	N/K	Oct-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- 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 Sepcialist nurse will be tasked to devlop when in post
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_020 b	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)	N/K	Mar-22	~~Mar-22~~ Oct-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- CNS post in development- UHW cardiologists already provide info as required.
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	Service Delivery Manager	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.	Head of Nursing and Service Delivery Manage	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.	Head of Nursing and Service Delivery Manage	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.	Service Delivery Manage	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
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.	Jegadish Mathias	Mar-22	~~Mar-22~~ Jul-22	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.
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.	Debra Bennett	Mar-22	~~Mar-22~~ Jul-22	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 ti understand the bottlenecks in the pathway. To explore installation of another CT Scanner in WGH.	Debra Bennett	Mar-22	~~Mar-22~~ Jul-22	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	Mr Pawan Rao	Mar-22	~~Mar-22~~ Jul-22	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 ooptimized use of diagnostic resources. This should potentially significantly improve pathway time compliance.
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_008a	N/A	R8. Holistic Needs Assessment not offered throughout the pathway. HNAs are only undertaken at the start of the patient pathway and not at key points along the way.	Need to ensure that patients receive HNA throughout their pathway.	Sarah Owen/Nerys Thomas	Mar-22	~~Mar-22~~ Jul-22	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. Looking to implement HNA clinics across H Dda. Booklets being given in clinic and patients are being followed up.
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_008b	N/A	R8. Holistic Needs Assessment not offered throughout the pathway. HNAs are only undertaken at the start of the patient pathway and not at key points along the way.	Nurseled pathways are under review as they haven't been updated since 2013. Proposal is to include HNA & PROM data collection as part NLFU. An electronic solution to generate letters from NLFU is also being assessed to free up time for HNA/PROM data collection. The amended Protocol will be reviewd in MDT prior to implementation.	Mr Pawan Rao/Debra Lewis	Mar-22	~~Mar-22~~ Jul-22	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. Draft proposal for consultation with nurses – review in Jan 2022. IT logistics to facilitate contemporaneous data collection/recording being sought prior to pilot of the proposed changes. Quality Assurance Team is looking into solutions.
PSOW_202002558	Sep-21	Public Service Ombudsman (Wales)	202002558	Open	N/A	Nursing	Mental Health & Learning Disabilities	Olivia Barker	Director of Operations	PSOW_202002558_004	N/A	Commissions and completes its planned review of the Health Board's child psychology services and reports the findings back to the Ombudsman.	Action plans held with Ombudsman Liaison Manager. The Clinical Lead for Community Paediatrics and a Health Board Psychologist are undertaking a review of Child psychology services across the Health Board. A representative from Swansea University is supporting this work. The review will be reported to the executive led Children and Young Persons Working Group.	Lisa Humphrey & Tracey Bucknell	Mar-22	~~Mar-22~~ N/K	Red	11/03/2022 - The Children and Young Persons Working Group was due to meet 28.02.22 and the initial findings of the review of Child Psychology services across the Health Board was to be reported at this meeting. I have emailed Lisa Humphrey and Tracy Bucknell for an update 01.03.22. This is the only outstanding action for this case. 03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - The initial findings of the psychology review were shared with the CYP Working group verbally on 28/02/2022. The agenda for this meeting was provided to the PSOW as evidence. The outcome following the meeting of 28/02/2022 - was for the presenters to undertake further work which falls into the wider work being undertaken by the CYP Working Group. The next meeting is 27/05/2022, asked PSOW if I can update after this date. 12/07/2022 Update provided to PSOW, further CYP meeting scheduled for 22.07.22.
PSOW_202005624	Mar-22	Public Service Ombudsman (Wales)	202005624	Open	N/A	Scheduled Care	Unscheduled Care (BGH)	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202005624_003	N/A	46c) Undertake a review of the mechanisms in place to ensure that patients admitted to an emergency hospital setting have timely access to specialist pain reviews where necessary, prior to discharge. The Health Board should provide the Ombudsman with its findings and any subsequent action plan or procedural changes.	Action plans held with Ombudsman Liaison Manager.	James Sheldon Lydia Davies	Sep-22	Sep-22	Amber	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - Reminder due to service 23/05/22 12/07/2022 - Discussion with Senior Nurse Manager who is the lead on this recommendation on 30/05/22. This is on track.
PSOW_202004139	Mar-22	Public Service Ombudsman (Wales)	202004139	Open	N/A	Scheduled Care	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202004139_003	N/A	36C Report sharing - Share this report with all relevant clinical staff and highlight key learning points when doing so.	Action plans held with Ombudsman Liaison Manager. Report emailed to relevant staff. Report to be presented and key learning points discussed at the next T&O Dept meeting on 25/05/22.	Lydia Davies Lianne Corcoran Owain Ennis	Apr-22	~~Apr-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - Evidence part submitted to PSOW 19/04/22. The report was shared with clinicians by email, it was also due to be presented at the T&O meeting in April but the agenda was full. It will be discussed at the next meeting on 25/05/22. PSOW aware. 12/07/2022 - Presented at meeting on 25/05/22, evidenced to PSOW on same day. Awaiting cpnfirmation of compliance from PSOW.
PSOW_202004139	Mar-22	Public Service Ombudsman (Wales)	202004139	Open	N/A	Scheduled Care	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202004139_004	N/A	37D Hand injury referrals - Take action to ensure that hand injury referrals are made to the Other Health Body, or another health agency, for specialist hand trauma-related input, promptly and efficiently.	Action plans held with Ombudsman Liaison Manager	Lydia Davies Lianne Corcoran Owain Ennis	Jun-22	~~Jun-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - Reminder to service due 23/05/22. 12/07/2022 - Evidence sent to PSOW on 14/06/22, awaiting confirmation of compliance from PSOW
PSOW_202004139	Mar-22	Public Service Ombudsman (Wales)	202004139	Open	N/A	Scheduled Care	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202004139_005	N/A	37E Update - Formally update the Ombudsman regarding its redress-related consideration of the patients clinical care concerns.	Action plans held with Ombudsman Liaison Manager. Update from Redress Team.	Olivia Barker Kirsty Harrington-Butcher	Jun-22	~~Jun-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - update will be sought in June 22. 12/07/2022 - Evidence sent to PSOW on 14/06/22, awaiting confirmation of compliance from PSOW
PSOW_202100189	Mar-22	Public Service Ombudsman (Wales)	202100189	Open	N/A	Nursing	Nursing	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100189_002	N/A	63 c) Review the availability of nutritional supplements across all relevant wards, to ensure that commonly used supplements (including alternatives to milk-based options) are readily available and remind relevant staff of the mechanisms by which they can order and obtain supplements that may be less common.	Action plans held with Ombudsman Liaison Manager. Action Plan completed – to be shared for wider learning at Health Board level. To be fed into Quality, safety & Assurance Meeting as well as Nutrition & Hydration Group Meeting.	Olwen Morgan Iona Evans Karen Thomas	Jun-22	~~Jun-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - This action is with Olwen Morgan, Iona Evans and Karen Thomas (Dietetics), update provided on 28/04/22 12/07/2022 - Evidence sent to PSOW 29.06.22, awaiting confirmation of compliance from PSOW
PSOW_202100189	Mar-22	Public Service Ombudsman (Wales)	202100189	Open	N/A	Nursing	Nursing	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100189_003	N/A	63 d) Compare a set of at least 3 months of the monthly checks noted in the Health Board's action plan, to confirm that the actions taken have improved care practices and provision on the ward and take remedial action if further issues are identified.	Action plans held with Ombudsman Liaison Manager. Monthly monitoring and recording of Care Indicators relating to Percentage of Nutrition Score Completed and Appropriate Action Taken within 24 hours of admission through Health & Care monitoring System. Audit results discussed in monthly Assurance Meeting.	Olwen Morgan Iona Evans	Jun-22	~~Jun-22~~ N/K	Red	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - This action is with Olwen Morgan and Iona Evans, update provided on 28/04/22. 12/07/2022 - Evidence sent to PSOW 29.06.22, awaiting confirmation of compliance from PSOW
PSOW_202004109	Apr-22	Public Service Ombudsman (Wales)	202004109	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202004109_003	N/A	69 c) Confirms that the report has been shared with the Health Board's Mental Health Directorate and that its findings are relayed to and discussed with the relevant CMHT, CRHT team and AMHPs.	Action plans held with Ombudsman Liaison Manager	Sara Rees/Kay Isaacs/Amanda Davies	Jul-22	Jul-22	Amber	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - discussed with Sara Rees 07/04/22. 12/07/2022 - Evidence of partial compliance submitted to PSOW 12/07/22. The report has been shared appropriately but also needs to be discussed in MH/LD QSEG meeting and individual team meetings.

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	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
PSOW_202004109	Apr-22	Public Service Ombudsman (Wales)	202004109	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202004109_004	N/A	69 d) Provides the Ombudsman with evidence of the measures, initiatives and improvements to services (as referred to in its correspondence) that have been implemented (or which are being developed) in respect of: • Identifying appropriate environments for patients with mental health conditions waiting for admission. • Implementing strategies to address the issue of shortages of trained psychiatrists, Section 12 approved doctors, psychotherapists and other mental health clinicians.	Action plans held with Ombudsman Liaison Manager	Sara Rees/Kay Isaacs/Amanda Davies	Jul-22	Jul-22	Amber	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - discussed with Sara Rees 07/04/22. 12/07/2022 - Evidence submitted to PSOW 12/07/22, awaiting confirmation of 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 Nursing, Quality and Patient Experience	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	Sara Rees/Kay Isaacs/Amanda Davies	Oct-22	Oct-22	Amber	03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - discussed with Sara Rees 07/04/22.
PSOW_202100351	May-22	Public Service Ombudsman (Wales)	202100351	Open	N/A	Unscheduled Care (GGH)	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100351_001	N/A	R1. 32a) Apologises to the complainant for the identified failings.	Reflect on the findings of the report and issue an appropriate apology letter	Olivia Barker	Jun-22	~~Jun-22~~ N/K	Red	12/07/2022 - Evidenced 01.06.22, awaiting confirmation of compliance from PSOW
PSOW_202100351	May-22	Public Service Ombudsman (Wales)	202100351	Open	N/A	Unscheduled Care (GGH)	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100351_002	N/A	R2. 32b) Makes a redress payment of £4,000 for the upset, uncertainty, and distress that the failings identified caused to the complainant and her family.	Include offer of the payment in the apology letter	Olivia Barker	Jun-22	~~Jun-22~~ N/K	Red	12/07/2022 - Evidenced 01.06.22, awaiting confirmation of compliance from PSOW
PSOW_202100351	May-22	Public Service Ombudsman (Wales)	202100351	Open	N/A	Unscheduled Care (GGH)	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100351_003	N/A	R3. 33c) Reviews guidelines and links with primary carers to ensure good awareness of liver disease, when to refer and pathways for referral.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Nov-22	Nov-22	Amber	
PSOW_202100351	May-22	Public Service Ombudsman (Wales)	202100351	Open	N/A	Unscheduled Care (GGH)	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100351_004	N/A	R4. 33d) Reminds staff at the Hospital that it is their responsibility to arrange further patient referral.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Nov-22	Nov-22	Amber	
PSOW_202100351	May-22	Public Service Ombudsman (Wales)	202100351	Open	N/A	Unscheduled Care (GGH)	Scheduled Care	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202100351_005	N/A	R5. 33e) Outlines to the Ombudsman the steps taken, or are intended to take, to potentially prevent a recurrence of what happened to this patient.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Nov-22	Nov-22	Amber	
PSOW_202102801	May-22	Public Service Ombudsman (Wales)	202102801	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Nursing, Quality and Patient Experience	PSOW_202102801_001	N/A	R1. apologise to complainant for the failings in complaint handling.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Jun-22	~~Jun-22~~ N/K	Red	12/07/2022 - Evidenced 01.06.22, awaiting confirmation of complaince from PSOW
PSOW_202102801	May-22	Public Service Ombudsman (Wales)	202102801	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Nursing, Quality and Patient Experience	PSOW_202102801_002	N/A	R2. Remind the Orthopaedic Team of the importance of record -keeping, particularly when it comes to documenting key assessments carried out.	Action plans held with Ombudsman Liaison Manager	Olivia Barker Lianne Corcoran Lydia Davies	Jun-22	~~Jun-22~~ N/K	Red	12/07/2022 - Evidenced 01.06.22, awaiting confirmation of complaince from PSOW
PSOW_202102801	May-22	Public Service Ombudsman (Wales)	202102801	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Nursing, Quality and Patient Experience	PSOW_202102801_003	N/A	R3. Provide evidence of the measures it says it has taken to address the shortcomings identified.	Action plans held with Ombudsman Liaison Manager	Olivia Barker Lianne Corcoran Lydia Davies	Jun-22	~~Jun-22~~ N/K	Red	12/07/2022 - Evidenced 01.06.22, awaiting confirmation of complaince from PSOW
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	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202003517_001	N/A	R1. I recommend that within 1 month of this report, the GP Practice should apologise to Mr X, Mr Y and their family for the failings identified in this report.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Aug-22	Aug-22	Amber	
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	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202003517_002	N/A	R2. I recommend that within 2 months of this report, the GP Practice obtains written agreement from the GP to discuss this case at his next annual appraisal.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Sep-22	Sep-22	Amber	
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	Olivia Barker	Director of Nursing, Quality and Patient Experience	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	Olivia Barker	Jan-23	Jan-23	Amber	
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	Olivia Barker	Director of Nursing, Quality and Patient Experience	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	Olivia Barker	Jan-23	Jan-23	Amber	
PSOW_202003517	Jul-22	Public Service Ombudsman (Wales)	202003517	Open	N/A	Primary Care, Community and Long Term Care	Nursing	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202003517_005	N/A	R5. I recommend that within 1 month of this report, the First and Second Health Boards should apologise to Mr X, Mr Y and their family for the failings identified in this report.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Aug-22	Aug-22	Amber	
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 Nursing, Quality and Patient Experience	PSOW_202003517_006	N/A	R6. I recommend that within 4 months of this report the First Health Board should provide the Acute Oncology Nurse, and the Upper Gastrointestinal and Sarcoma MDTs with training on the NICE Guidance for Management of Cancer of Unknown Primary.	Action plans held with Ombudsman Liaison Manager	Olivia Barker	Nov-22	Nov-22	Amber	
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 Nursing, Quality and Patient Experience	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	Olivia Barker	Jan-23	Jan-23	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_01 1a	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.	Paediatric & Adult Clinical	N/K	~~Dec-21~~ ~~Jun-22~~ N/K	Amber	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_01 1b	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.	Tracey Bucknell	Aug-21	~~Aug-21~~ ~~Mar-22~~ Sep-22	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.	Matthew Willis	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.
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.	Exec and Site Senior Team	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	Matthew Willis	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

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	Recommendation Owner	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_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.	Graham Boswell, Educational Lead	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	5.1 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.	Hilary Edwards / John Evans	Sep-22	~~Sep-22~~ Mar-25	Amber	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	5.2 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.	Hilary Edwards / John Evans	Sep-22	Sep-22	Amber	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training.
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.	County Director, HoN & GM	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.	Graham Boswell, Educational Lead	Mar-23	Mar-23	Amber	23/03/2022- This has been started, GM will check for update with relevant colleagues.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Workforce & OD	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	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 a All Wales Level.	Heledd Kirkbride	Mar-20	~~Mar-20~~ N/K	External	Language skills data from Primary Care contractors is not collected. Staff in the four Managed Practices however have to log their Language skills on ESR. Over summer 2019, the Primary Care team administered a questionnaire, on behalf of Welsh Government, with all four Primary Care contractor areas to assess compliance with the six Welsh Language Duties for Primary Care contractors. In response to the Duty to encourage the wearing of a badge, provided by the Local Health Board, by Welsh speakers, to convey that they are able to speak Welsh, 63% of Primary Care contractors who responded to the questionnaire reported that they were meeting this (although this isn't an audit of language skills). 18/09/20: This recommendation is being taken forward at a national level, led by Welsh Government, to enable the collection of Welsh language skills of GPs and Practice staff through the National Workforce Reporting System, as part of the data collection. The intention is that the system will be able to log Welsh language skills next year. Recommendation outside the gift of the Health Board to implement, no change to comments in Jan 2021. 21/12/2020 - rec is being taken forward by the Welsh Government.

Reports closed on the Audit Tracker since ARAC June 2022

Report name	Lead Executive/Director
Delivery Unit: All Wales Assurance Review of Crisis & Liaison Psychiatry Services (CAMHS), issued March 2022	Director of Operations
Health Inspectorate Wales: Unannounced Hospital Visit - Unscheduled Care Directorate & Surgical Assessment Unit - 11 & 12 August 2015 (Publication date 4 December 2015)	Director of Operations
Internal Audit: Field Hospital Decommissioning (Advisory Report)	Director of Operations
MWWFRS: Letter of Fire Safety Matters Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations
MWWFRS: Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations
MWWFRS: Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations
MWWFRS: Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations
Public Service Ombudsman (Wales): 202100857	Director of Nursing, Quality and Patient Experience

Reports opened on the Audit Tracker since ARAC June 2022

Report name	Lead Executive/Director	Final report received at
Internal Audit: Glangwili Hospital Women & Children's Development (*report omitted in error from appendix 2 of the previous ARAC Audit tracker report in June 2022)*	Director of Operations	Audit and Risk Assurance Committee
MHRA: Insp BLCA 28172/119309-0018 - Withybush General Hospital	Director of Operations	To be confirmed
MWWFRS: Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Health & Safety Committee
MWWFRS: Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Health & Safety Committee
MWWFRS: Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Health & Safety Committee

MWWFRS: Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Health & Safety Committee
MWWFRS: Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Health & Safety Committee
Public Service Ombudsman (Wales): 202100857	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 202102801	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 202003517	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee

Report	Number of Recommendations	Service Area	Progress Update
Audit Wales – Taking Care of the Carers	3	Workforce & OD	Awaiting revised timescales from the service.
Community Health Council – Eye Care Services in Wales	2	Scheduled Care	Clarification has been received since 19th July (date the tracker was run off for this report) and will be reflected in the next Audit Tracker paper to ARAC.
Community Health Council – Maternity Care in Hywel Dda	1	Women and Childrens	Maternity services to liaise with Public Health colleagues as recommendation relates to health visiting. Recommendation now lists Public Health as a supporting service, and updates will be obtained for this recommendation from the Public Health team directly as part of the service update process going forward.
Delivery Unit - Review of progress towards delivery of Eye Care Measures	2	Scheduled Care	Service Delivery Manager (SDM) unable to provide revised timescale as no decision received on priorities or if detail included in IMTP will be supported.
Delivery Unit – Focus on Ophthalmology: Assurance Reviews	1	Scheduled Care	Clarification of timescale has been requested from the Dental and Optometry service.
Health Inspectorate Wales – St Caradog Ward, Withybush Hospital	2	Mental Health & Learning Disabilities	The Patient Safety and Assurance Team are awaiting a response from both Estates and Capital Planning, who are the supporting services for these recommendations to confirm if these can be closed.
Health Inspectorate Wales – Ty Bryn	7	Mental Health & Learning Disabilities	Whilst updates have been provided via the Patient Safety and Assurance Team, recommendations are unable to be confirmed as implemented as the unit remains closed to admissions.
Health Inspectorate Wales IRMER Quality Check – Remote Inspection Visit of Prince Philip Hospital	1	Radiology	No revised timescale was provided by the Patient Safety and Assurance Team with the progress update, therefore the recommendation is currently classified as “Not Known”. Assurance and Risk Team to obtain clarification on these timescales for reporting to the next ARAC meeting in October 2022.

Health Inspectorate Wales – Wales Ambulance Service Trust (WAST)	6	Acute Services	The Patient Safety and Assurance Team are awaiting a response from the service.
Health Inspectorate Wales – Quality Check: Morlais Ward, Glangwili Hospital	2	Mental Health & Learning Disabilities	The Patient Safety and Assurance Team are awaiting a response from Estates, who are the supporting service for these recommendations to confirm if these can be closed.
Health Inspectorate Wales - National Review of Mental Health Crisis Prevention in the Community	5	Mental Health & Learning Disabilities	The Patient Safety and Assurance Team have confirmed the management responses drafted for this review since the previous ARAC, however no revised timescales were provided for those recommendations where the original completion date was noted as June 2022. Assurance and Risk Team to obtain clarification on these timescales for reporting to the next ARAC meeting in October 2022.
Internal Audit – Partnership Governance	2	Primary Care, Community and Long Term Care	Clarification has been received since 19th July (date the tracker was run off for this report) and will be reflected in the next Audit Tracker paper to ARAC.
Internal Audit - Financial Planning, Monitoring and Reporting	1	Finance	Discussion with Internal Audit confirmed that a Financial Management Review is due this financial year, where any outstanding recommendations will be reviewed.
Internal Audit – Discharge Processes	5	Primary Care, Community and Long Term Care	USC Lead is meeting with Assistant Director of Nursing in late July to discuss work to be taken forward under the Transforming Urgent & Emergency Care Program. Updates will be reflected in the next Audit Tracker paper to ARAC.
Internal Audit – Medical Staff Recruitment	1	Workforce & OD	Awaiting clarification from service if action can be closed. Another action requires a response from the Digital Director which the service is chasing.
Internal Audit - TriTech Institute	5	Central Operations	Recommendations had original completion dates of June 2022, and due to the timing of the Assurance and Risk Teams' service update process, it is expected that

			revised completion dates will be obtained in readiness for the next ARAC meeting.
Internal Audit - Nurse Staffing Levels	2	Nursing	Clarification has been received since 19th July (date the tracker was run off for this report) and will be reflected in the next Audit Tracker paper to ARAC.
Internal Audit - Prevention of Self Harm	4	Mental Health & Learning Disabilities	Recommendations had original completion dates of June 2022, and due to the timing of the Assurance and Risk Teams' service update process, it is expected that revised completion dates will be obtained in readiness for the next ARAC meeting.
Peer Review – Respiratory Cancer	1	Respiratory	Awaiting revised timescale from the new SDM, who is currently reviewing this recommendation with the Clinical Lead.
Public Service Ombudsman for Wales - 202002558	1	Nursing	Ombudsman Case Manager confirmed a further CYP Working Group meeting is scheduled for 22/07/2022. Updates will be reflected in the next Audit Tracker paper to ARAC.
Public Service Ombudsman for Wales - 202004139	3	Scheduled Care	Evidence has been sent to PSOW. Ombudsman Manager awaiting confirmation of compliance from PSOW.
Public Service Ombudsman for Wales - 202100189	2	Nursing	Evidence has been sent to PSOW. Ombudsman Manager awaiting confirmation of compliance from PSOW.
Public Service Ombudsman for Wales - 202100351	2	Unscheduled Care (GGH)	The Ombudsman Manager is currently awaiting confirmation from PSOW that these recommendations can be closed.
Public Service Ombudsman for Wales - 202102801	3	Scheduled Care	Evidence has been sent to PSOW. Ombudsman Manager awaiting confirmation of compliance from PSOW.
Royal College of Paediatrics and Child Health – National Diabetes Quality Programme	1	Women and Childrens	Awaiting progress update from the service.

Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report	1	Unscheduled Care (BGH)	Awaiting revised timescale from service.