Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 April 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Asesiad / Assessment

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

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

Improving Together sessions with directorates commenced in January 2023, which include reviewing progress against audit and inspection recommendations with Directorate leads. The previous process of bi-monthly e-mails to services to collate progress updates have ceased to reduce duplication of requests and pressures on operational services. Updates are provided by way of table of actions generated from Improving Together sessions and via existing governance arrangements within Directorates.

HIW inspection activity, and the corresponding follow up to determine progress of recommendations raised, is undertaken and managed by the Quality Assurance and Safety Team with progress provided to the Assurance and Risk team for the Audit and Inspection Tracker.

Since the previous report, 14 reports have been closed or superseded on the Audit Tracker, and 16 new reports have been received by the Health Board, as detailed in Appendix 2.

As of 20 March 2023, the number of open reports has increased slightly from 88 to 89. 33 of these reports have recommendations that have exceeded their original completion date, which has decreased from the 39 reports previously reported in February 2023. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is a slight decrease in the number of recommendations where the original implementation date has passed, from 128 to 115. Detail on this decrease can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR. The number of recommendations that have gone beyond six months of their original completion date has decreased slightly from 58 to 56, as reported in February 2023. The table below provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC February 23	New reports since February 23	Closed reports since February 23	Open reports at ARAC April 23	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	5	0	1	4	3	4	3
CHC	2	2	0	4	2	6	2
CHC / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
Counter Fraud Authority	0	2	1	1	0	1	0
DU	5	1	0	6	3	7	6
HEIW	0	0	0	0	0	0	0
HSE	0	0	0	0	0	0	0
HIW	9	3	0	12	6	28	9
HTA	0	0	0	0	0	0	0
Independent Review	0	1	0	1	0	13	0
IA	27	5	9	23	11	0	0
Internal Review	1	0	1	0	0	25	18
MHRA	1	0	0	1	1	1	1
MWWFRS	23	0	0	23	1	4	0
NHS Wales Cyber Resilience Unit	1	0	0	1	0	5	0
Peer Reviews	4	1	0	5	3	17	14
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	7	0	2	5	1	1	0
PHW	0	1	0	1	0	0	0
Royal Colleges	2	0	1	1	1	3	3
Other (External Consultant)	0	0	0	0	0	0	0
WLC	1	0	0	1	1	0	0
TOTAL	**88**	**16**	**15**	**89**	**33**	**115**	**56**

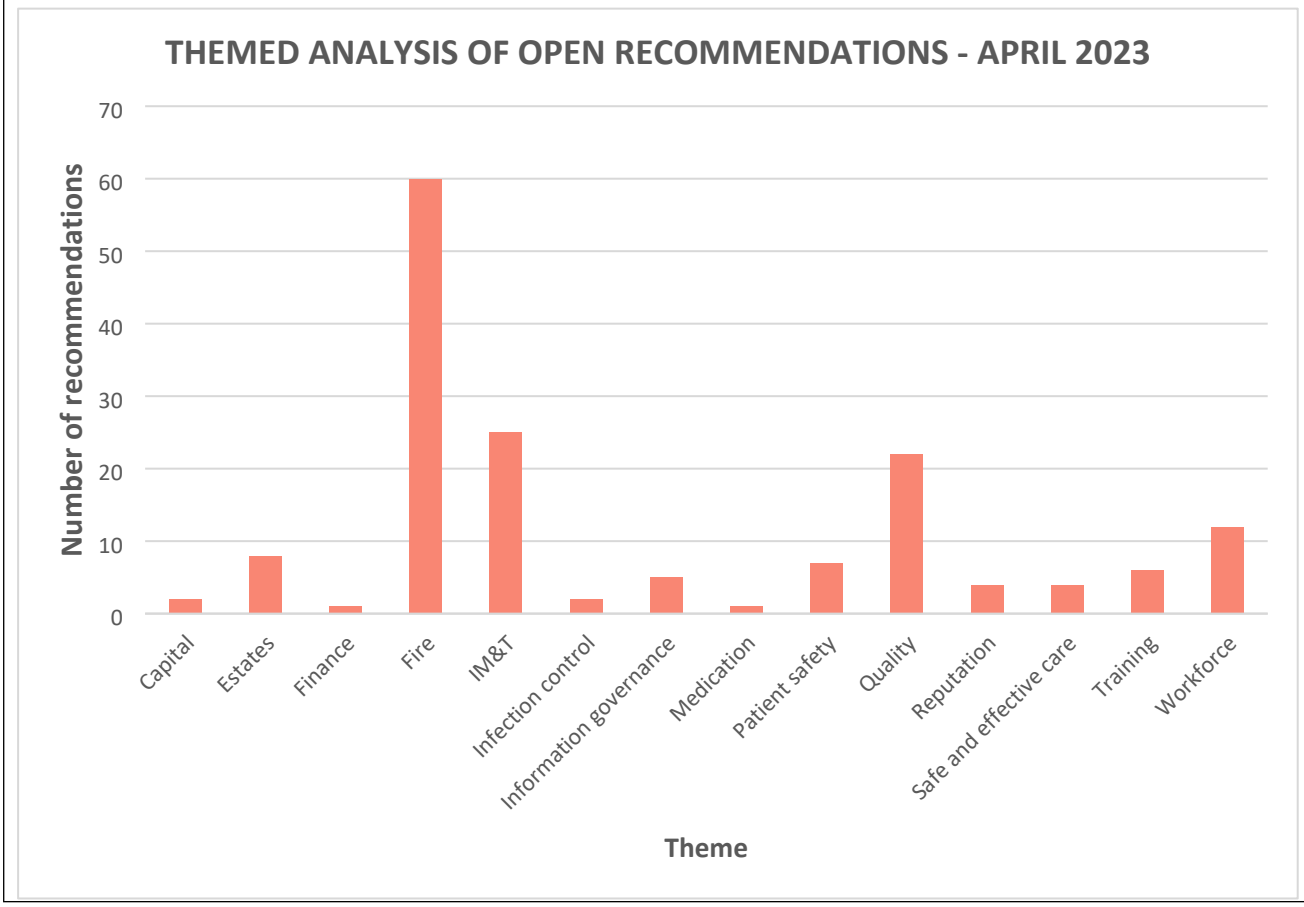
**Reports which have passed their original implementation date*
***Original implementation date noted for the recommendation has passed, or will not be met*

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

There are currently **327 open recommendations** (an increase from 262 reported in February 2023) on the audit tracker. Appendix 2 details reports which have been added to the Audit and Inspection tracker since February 2023. Appendix 1 includes the 24 recommendations that are considered to be outside the gift of the UHB to currently implement, for example reliant on an external organisation to implement. These recommendations are marked as 'External' in the RAG status column.

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

There are 47 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported), a slight decrease from the 49 previously reported. The individual recommendations are included in Appendix 3, which details the date at which point the recommendation became N/K. The current number of recommendations assigned a N/K status comprises of a combination of recommendations which have recently lapsed to N/K status, and those which have been for a longstanding period of time that are dependent on additional funding or resources in order to implement.
Below is a chart providing a thematic analysis for all open recommendations on the Audit and Inspection Tracker as at April 2023:



Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 20 March 2023, including trends since the last report to ARAC in February 2023. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager.

The arrows included in the table below are as follows:

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

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

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

Service	Open reports as at March 23	Overdue reports As at March 23	Total number open recs March 23*	Total overdue (red) recs March 23	Of which overdue by more than 6 months	Comments
Acute Services	1 →	1 →	10 ↓	4 ↓	3 ↓	• 1 HIW National Review on WAST - 4 overdue recommendations, 3 of which are overdue by more than 6 months. The Quality Safety and Assurance Team have received revised dates from the service to April 2023. 6 recommendations with an 'External' status.
Cancer Services	1 →	1 →	3 →	3 →	3 →	• 1 Peer Review on Colorectal Cancer - 3 recommendations which are overdue by more than 6 months, with revised completion dates ranging between April 2023 and March 2024.
Cardiology	1 →	1 →	1 →	1 →	1 →	• 1 DU report on All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review – 1 recommendation overdue by more than 6 months. The Assurance and Risk team to discuss with Director of Operations to obtain approval for closure in April 2023.
CEO Office (Welsh Language)	1 ↓	1 ↓	2 ↓	2 ↓	2 →	• 1 follow-up IA report on Welsh Language Standards - 2 recommendations overdue by more than 6 months with revised completion dates of March 2023 and April 2023. • 1 IA closed on Welsh Language Standards Implementation
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	0 ↓	0 ↓	0 ↓	0 →	0 →	• 1 AW report with 1 'external recommendation' closed since previous meeting.
Community - Pembrokeshire *(N/A)*	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Central Ops	2 →	2 →	7 →	7 →	7 →	• 1 IA report on Records Management – 3 recommendations overdue by more than 6 months with revised completion dates of March 2023. A further IA review is due to take place for Records Management in 2023/24. This will be confirmed in the IA Plan 2023/24. • 1 Peer Review – 4 recommendations overdue by more than 6 months. A new peer review undertaken in July 2022, with management responses drafted and due to be presented to OQSEC in May 2023. Once approved, recommendations from the new review will supersede existing recommendations.

Service	Open reports as at March 23	Overdue reports As at March 23	Total number open recs March 23*	Total overdue (red) recs March 23	Of which overdue by more than 6 months	Comments
Digital and Performance	3 ↓	1 ↓	29 ↓	6 →	0 ↓	• 1 report by NHS Wales Cyber Resilience Unit on Cyber Assessment Framework with 23 recommendations - 5 of these are overdue, 1 with a revised completion date of April 2023 remaining 4 with no revised completion dates. • 1 IA report on IT Infrastructure with 6 recommendations – completion dates range from March 2023 to March 2024 and 1 recommendation is overdue, with no revised completion date. • 1 IA on Cyber Security all recommendations completed. Awaiting confirmation from IA to close the report. • 2 IA reports closed: ○ IM&T Assurance – Follow Up ○ Network and Information Systems (NIS) Directive
Director of Operations	1 →	1 →	2 →	1 →	0 →	• 1 AW Review of Quality Governance Arrangements – This has been reassigned to Director of Operations due to nature of outstanding recommendations and their ownership - 2 recommendations remain outstanding, 1 of which has an 'External' status.
Estates	27 →	3 ↓	75 ↑	8 ↓	4 ↑	• The number of recommendations has increased slightly from 73 to 75 (16 of these recommendations are from 4 IA reports, with remainder from the 5 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)). • The number of overdue recommendations has reduced from 24 to 8, due to the MWWFRS letter dated 20 January 2023 confirming they have accepted the revised timescales provided by the UHB. A progress update has been obtained from the service since the data was run for this report which has resulted in the number of overdue recommendations reducing further from 8 to 4, which will be reflected in the Audit Tracker report to ARAC in June 2023. • 1 new IA report on Glangwili General Hospital Fire Precautions Works: Phase 1 with 11 recommendations with varying timescales from May to July 2023. • 3 IA reports (Fire Governance, Waste Management and WGH Fire Precautions Works: Phase 1) with 1 recommendation within original agreed timescales, and 4 which have passed their implementation date. IA are undertaking a follow up on the WGH Fire Precautions Works which is planned to be reported to ARAC June 2023 meeting. • 1 IA report closed on Backlog Maintenance. • All MWWFRS recommendations overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting.

Service	Open reports as at March 23	Overdue reports As at March 23	Total number open recs March 23*	Total overdue (red) recs March 23	Of which overdue by more than 6 months	Comments
Finance	1 →	0 ↓	1 ↓	1 ↓	0 ↓	1 new Counter Fraud Authority report on Covid-19 Post Event Assurance Report - 1 outstanding recommendation which currently does not have a timescale. • 1 new Counter Fraud Authority report on Covid-19 Post Event Assurance Report - 1 outstanding recommendation which currently does not have a timescale. • 1 new Counter Fraud Authority report on Purchase Order vs non-Purchase Order report on findings for Hywel Dda University Health Board – all 6 recommendations have been completed and the report has been closed. • 1 IA report closed on Financial Planning, Monitoring and Reporting.
Governance	2 ↑	0 →	8 ↑	0 →	0 →	• 1 new Independent Review on Governance and Decision Making in relation to Bluestone Field Hospital – 4 recommendations with completion dates ranging from March to May 2023. • 1 AW report on Structured Assessment 2022 - 4 recommendations with completion dates ranging from March to December 2023.
Medical	2 ↑	0 →	7 ↑	0 →	0 →	• 1 new report on Llwynhendy Tuberculosis Outbreak External Review – 7 recommendations, 1 of which is owned by the UHB and has a completion date of June 2023 and 6 of which are 'external' recommendations being led by PHW • 1 IA report on Individual Patient Funding Requests - all recommendations completed. Awaiting confirmation from IA to close the report .
Medicines Management	1 →	1 →	2 →	1 →	1 →	• 1 AW report on Medicines Management in Acute Hospitals - 1 recommendation overdue by more than 6 months with revised date of March 2023, and 1 'external' recommendation.

Service	Open reports as at March 23	Overdue reports As at March 23	Total number open recs March 23*	Total overdue (red) recs March 23	Of which overdue by more than 6 months	Comments
MH&LD	11 ↑	5 ↑	43 ↑	19 ↓	9 ↑	• 1 new CHC report on S-CAMHS - 7 recommendations with varying completion dates up to December 2023. • 1 new DU report on All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults- 4 recommendations, 2 of which timescales are being clarified with the service. • 1 new IA Follow up report on Prevention of Self Harm- highlighted 4 recommendations which are overdue by more than 6 months, and due for completion by the end of March 2023. • Total number of recommendations which have passed their original completion date has slightly reduced from 20 to 19. • Total number of recommendations overdue by more than 6 months has increased from 6 to 9. • The details of recommendations that have passed their original completion dates are below: ○ IA on Prevention of Self Harm (new Follow up report) – details mentioned above. ○ HIW Quality check: Morlais Ward - 1 recommendation overdue by more than 6 months. ○ HIW National Review of Mental Health Crisis Prevention in the Community - 5 recommendations have passed their original completion dates, of which 2 are overdue by more than 6 months. ○ HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months. ○ HIW Bryngofal Ward – Prince Phillip Hospital, Issued October 2022 - 6 recommendations have passed their original completion dates. ○ 1 DU report on All Wales Assurance Review of Crisis and Liaison Psychiatry Services for Adults – 1 recommendation with revised completion date of May 2023. • 1 HIW report (Ty Bryn 1 November 2021) - all 14 recommendations have been implemented, however report will not be formally closed on the Audit &Inspection tracker until formal approval received at Public Board in March 2023. • 1 PSOW - all evidence submitted to PSOW, awaiting confirmation of compliance from PSOW to close the 5 recommendations from this report. • 1 DU report - 7 recommendations with completion dates ranging from July to December 2023. • 1 IA report closed (superseded by Follow up report noted above).

Service	Open reports as at March 23	Overdue reports As at March 23	Total number open recs March 23*	Total overdue (red) recs March 23	Of which overdue by more than 6 months	Comments

NQPE	5 ↓	1 →	13 ↓	7 ↓	0 →	• 1 CHC report on Accident & Emergency Departments - 5 recommendations, of which 2 are overdue, one with a March 2023 revised completion date and one with no revised completion date.
						• 1 IA report on Falls Management – 6 recommendations, 4 of which are overdue with revised completion dates ranging from June to July 2023.
						• 2 PSOW reports:
						  • 202002558 – 4 complete recommendations. Evidence has been submitted to PSOW and currently awaiting confirmation to close.
						  • 202003189 - 1 overdue recommendation whereby the service is awaiting confirmation from PSOW on an extension request and 1 recommendation within its original agreed timescale.
						• 1 IA report on Quality and Safety Governance, with all recommendations confirmed by the service as implemented, and currently awaiting IA approval for closure of the report.
						• 1 PSOW report - 202003339 closed since previous ARAC meeting.

Pathology	1 →	1 →	1 →	1 →	1 →	• 1 MHRA report for WGH - 1 outstanding recommendation overdue by more than 6 months, with a revised completion of September 2023.
Primary Care, Community and Long Term Care	3 →	3 ↑	9 ↓	6 ↑	5 →	• 1 IA report on Continuing Healthcare and Funded Nursing Care - 1 overdue recommendation with a revised completion date of June 2023. • 1 IA Discharge Processes report has 7 recommendations. 2 are 'external' and 5 are overdue by more than 6 months. The Assurance and Risk team will be meeting with the new Integrated System Director to establish if any of the recommendations can be closed. • 1 WLC report – 1 'external' recommendation.
Public Health (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present*
Radiology	2 ↑	1 →	18 ↑	3 ↑	0 →	• 1 new HIW IRMER report GGH – 2 overdue recommendations with no revised completion date. • 1 HIW IRMER report WGH - 1 overdue recommendation with a revised completion date of March 2023.
Service	**Open reports as at March 23**	**Overdue reports As at March 23**	**Total number open recs March 23***	**Total overdue (red) recs March 23**	**Of which overdue by more than 6 months**	**Comments**

Scheduled Care	6 ↑	2 ↓	22 ↑	21 ↑	8 →	• 1 new Peer Review on Getting It Right First Time (GIRFT) Orthopaedic Review – 13 recommendations with timescales currently pending (not known). • 1 CHC report – 3 recommendations overdue by more than 6 months, 2 of which have revised timescales of June 2023 and 1 with an unknown timescale due to awaiting the rollout of a national workstream for digital communication, noted as "external". • 2 DU reports – 4 recommendations overdue by more than 6 months, with no revised completion dates. • 1 HIW report - 1 recommendation which is overdue by more than 6 months with a revised completion date of June 2023. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report.
Strategic Development & Operational Planning	4 →	2 ↓	24 ↑	2 ↑	2 ↑	• 1 new IA report on A Healthier Mid & West Wales Programme - 16 recommendations, with timescales ranging from May 2023 to January 2024. • 1 IA report on Decarbonisation - 2 recommendations on schedule with dates of January and March 2025, and 3 'external' recommendations. • 1 IA report on Glangwili Hospital Women & Children's Development - 1 recommendation with July 2023 timescale. • 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangements - 2 recommendations overdue by more than 6 months (reopened in December 2022 following AW Structured Assessment 2022). • 1 Internal review report closed since previous ARAC report.
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 →	3 →	3 →	3 →	• 1 RCP report - 3 recommendations overdue by more than 6 months. 1 recommendation with revised completion date of March 2024 and 2 with no revised completion dates. • Assurance and Risk Team met with BGH management team in March 2023, with recommendations to be presented to Director of Operations in April 2023 for closure as contingency plans in place mitigating the lack of funding and recruitment issues which are noted as main reasons for inability to fully complete recommendations.
USC GGH	2 ↑	1 →	16 ↑	1 →	0 →	• 1 new HIW report on the Emergency Unit at GGH - 15 recommendations with timescales ranging from March to June 2023. • 1 IA report on GGH Directorate Governance review - 1 overdue recommendation that has a revised completion date of March 2023.
Service	**Open reports as at March 23**	**Overdue reports As at March 23**	**Total number open recs March 23***	**Total overdue (red) recs March 23**	**Of which overdue by more than 6 months**	**Comments**

USC PPH	1 ↓	0 →	1 →	1 →	1 →	• 1 Peer Review on Respiratory Cancer report - 1 recommendation overdue by more than 6 months. The Assurance and Risk team are to clarify with Director of Operations if this recommendation can be closed in light of the review that has been undertaken by the service. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report. • 1 HIW report closed.
USC WGH	0 ↓	0 ↓	0 ↓	0 ↓	0 →	• 1 IA on Directorate Governance – WGH Unscheduled Care closed.
Women & Children	7 ↑	4 ↑	30 ↑	17 ↓	6 ↓	• 1 new CHC report on Babies and Births in Hywel Dda – 5 recommendations, 2 of which overdue with revised completion dates of April 2023. • 1 new IA report on Glangwili Hospital - Women & Children's Development, issued February 2023 – 4 recommendations on schedule. • 1 new HIW report on Glangwili – Maternity Services – 7 recommendations, 5 with no revised completion dates. • 1 HIW report on Angharad Ward, Bronglais Hospital – 3 recommendations, with 1 overdue with no revised completion date. • 1 IA report -1 recommendation classified as 'external' with a revised completion date of March 2023. • 1 Peer Review – 10 recommendations, with 1 'external' recommendation, and 9 recommendations overdue, 6 of which by more than 6 months. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report. • 1 RCPCH report closed
Workforce & OD	3 →	0 →	0 →	0 →	0 →	• 3 IA reports on Medical Staff Recruitment, Non-Clinical Temporary Staffing and Overpayment of Salaries – all recommendations confirmed by the service as implemented, and currently awaiting IA approval for closure of the report.
Total	**89**	**33**	**327**	**115**	**56**	

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

Services with a Concerning Trend

The services below have been identified as ones with a concerning trend based on current performance metrics, but are not being suggested as at April 2023 to be brought to ARAC. The Assurance and Risk Team continue to work alongside these service to address the areas of concern as detailed below.

Mental Health and Learning Disabilities

Whilst the number of recommendations overdue has reduced slightly from 20 to 19, the number of those overdue by more than 6 months has increased from 6 to 9. This increase is due to the outstanding actions raised in the Internal Audit Follow up Prevention of Self Harm Final Internal Audit Report which have revised completion dates of March 2023. Of the 19 recommendations overdue, 16 have revised timescales of March 2023; therefore, an improved position should be reported to ARAC in June 2023.

Scheduled Care

The number of overdue recommendations for the Directorate has increased from 8 to 21 since the previous meeting, which is a result of the addition of the Getting It Right First Time Orthopaedic Review which has recently been added to the tracker. Initial management responses to the recommendations did not include completion dates; therefore, these are

currently being reported as 'not known' and have been categorised as red on the Tracker. The Assurance and Risk Team continue to work closely with the service, and a meeting is scheduled for April 2023 in order to obtain progress updates and revised completion dates where applicable. The outcomes of these discussions will be reflected in the report to be presented to ARAC in June 2023.

Women and Children

The total number of overdue recommendations has decreased from 20 to 17 due to the closure of the Royal College of Paediatrics & Child Health (RCPCH) National Diabetes Quality Programme (NDQP) report. The total number of recommendations overdue by more than 6 months since February 2023 has also decreased from 12 to 6. Progress updates have been obtained confirming the closure of 6 recommendations previously reported as open to ARAC in February 2023 in relation to the Peer Review on Congenital Heart Defects. However, 10 recommendations remain open against this report, 9 of which are overdue and 6 are without revised completion dates. The Assurance and Risk Team continue to work with the service to obtain progress updates and revised completion dates.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital BPPAG – Business Planning and Performance Assurance Group CHC – Community Health Council DCP – Discretionary Capital Programme DU – Delivery Unit EWTD – European Working Time Directive GGH – Glangwili General Hospital HEIW – Health Education and Improvement Wales HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IGSC – Information Governance Sub Committee IRMER – Ionising Radiation (Medical Exposure) Regulations Management & Technology Sub Committee MH&LD – Mental Health & Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience NWIS – NHS Wales Informatics Service PAMOVA – Prevention, Assessment & Management Of Violence & Aggression QSEC – Quality and Safety Experience Committee SDEC – Same Day Emergency Care PHW – Public Health Wales PPE – Post Project Evaluation PPH – Prince Philip Hospital PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SBUHB – Swansea Bay University Health Board SDM – Service Delivery Manager SIFT – Service Increment For Teaching SSU – Specialist Services Unit UEC- Urgent and Emergency Care UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance/Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
Gweithlu: Workforce:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: Risk:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and identified risks are not being managed.
Cyfreithiol: Legal:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: Reputational:	As above.
Gyfrinachedd: Privacy:	No direct impacts from this report
Cydraddoldeb: Equality:	No direct impacts from this report

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Medicines Management	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_001	High	R1b: Refresh its Medicines Management Strategy to provide an integrated vision across primary and secondary care that is developed in full partnership between pharmacy, medical and nursing staff.	One of the key roles for the newly appointed Head of Medicines Management will be to update and refresh the strategy for the service. Employing the County Leads, who all have busy operational and managerial roles, as rotating interim Heads of Medicines Management has not allowed strategic aims to be tackled.	Apr-16	~~Sep-22~~ ~~Nov-22~~ Mar-23	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. 29/11/2022- Draft strategy currently with local teams for comment, followed by sharing with wider teams/exec level for feedback. The draft strategy will then be brought back to MMOG in January 2023 followed by formal consultation. Revised date March 2023. 31/01/2023- on track. MMOG on 31/01/2023 supported the draft strategy going out for UHB consultation with the aim of bringing it back to MMOG in March 2023 for final approval.
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	N/K	External	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales. 30/12/2022- WG have provided some funding for a small pre-implementation team that is now in place to develop local business case to secure funding for Electronic Prescribing and Medicines Administration (ePMA). Nationally there are currently 3 systems that have been approved on the framework and once funding approved then a mini-procurement process will be undertaken to secure most appropriate system for the UHB.
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	Director of Strategy and Planning	Director of Strategy and Planning	AW_2360A2021-22_001	High	R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked.	As part of Targeted Intervention, the Health Board is undertaking an assessment of its planning maturity, incorporating the alignment of plans. In addition, an Independent Review is being conducted by Sally Attwood on behalf of Welsh Government. Once complete the Health Board will develop action plans to respond to both of these pieces of work. The capacity and role of the planning function will be important considerations within this, see below for an update on capacity.	Sep-21	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report.
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	Director of Strategy and Planning	Director of Strategy and 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.	The Health Board has recently (January 2023) transferred the commissioning function in to the Planning Directorate. The alignment and amalgamation of the Planning and Commissioning team has provided additional resilience within the Directorate. However, it is worth noting the commissioning team only consisted of 2.0 WTEs (with 1.0 WTE split between Planning and Commissioning) and are responsible for a budget of circa £170m. As part of Targeted Intervention, there is an Independent Review being conducted by Sally Attwood on behalf of Welsh Government. It is anticipated this will consider the capacity and capabilities within the team, which the Health Board will then consider how best to respond.	Mar-22	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as as the original completion dates are based on the timescales provided in the original report.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b3	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	Dec-23	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- update to ARAC provides revised date of December 2022 for the implementation of the new risk management system. This is an All Wales system therefore the implementation date is outside the gift of the Health Board. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b4	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	~~Jul-22~~ N/K	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 21/11/2022 - Assistant Director of Assurance and Risk with the Deputy Director of Operations to establish a revised process and timescale for implementation for the recommendation. 24/11/2022 - Recommendation changed from red to external as implementation will be dependent on the implementation of the new Datix system
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_004	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_002	High	While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associatedgovernance arrangements progresses as a matter of urgency.	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Dec-23	Dec-23	Amber	
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_004	High	The Health Board has not set out expected outcomes for all its planning objectives set out in its Annual Plan. In revising its planning objectives for 2023-26, the Health Board needs to clearly articulate the expected outcomes for its streamlined set of planning objectives.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Mar-23	Mar-23	Amber	
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_005	High	Implementation plans to support corporate enabling strategies did not always exist or include clear milestones, targets, and outcomes. The Health Board needs to ensure: • existing implementation plans include clear milestones, targets, and outcomes; and • implementation plans are developed for enabling strategies that currently do not have one. Alongside the monitoring of relevant individual planning objectives, this will enable periodic review of overall progress of delivery of the enabling strategies.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Mar-23	Mar-23	Amber	
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_006	High	The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	The 2023/24 planning cycle is underway which will, with Board approval, reflect the challenges that have been experienced during 2022/23. Opportunities have been clearly articulated, and the planning cycle will be the vehicle for teams across the Health Board to deliver sustainable plans in the areas highlighted as opportunities, as well as undertaking their delegated financial responsibilities to review and deliver all efficiency and benchmarking opportunities. With the unprecedented demand challenges that have been experienced, the financial overspends have resulted in a significant deterioration to our deficit. The recovery plan will need to be cognisant of the impact which these demand challenges are having across our system.	Mar-23	Mar-23	Amber	

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CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open (external rec)	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ ~~Apr-22~~ ~~Jun-22~~ N/K	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 25/08/2020 update- still awaiting national roll out as part of national work stream. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 08/10/21- further national delays to the roll out of EPR due to network concerns. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update when HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found. 14/10/2022 - Update from Joao Martin: LHBs have not yet received the OpenEyes UAT for testing. Believed to be pending on CRNs duplicates issues and last Monday's test was unsuccessful. Unknown when this will be resolved nationally. We do meet with the National Team every Monday and I expect clarification on some of the issues next week. Further guidance may be provided at the National Programme Board at the end of month.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Aug-23~~ ~~Mar-23~~ June-23	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Positive progress being achieved in the delivery of Ministerial measures for the 52/104 week waiters. Further work underway to deliver additional weekend clinics to reduce the backlog of people awaiting appointments. This will continue until approximately June 2023 at present.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ Jun-23	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service.
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_003c	N/A	R3. The Health Board to look at the waiting areas and to provide comfortable seating for patients who have to wait hours. To provide water coolers, cups and vending machines.	WG have provided capital funds to enhance the experience in A&E. Progress on this is to be through Capital Monitoring Group	Mar-23	Mar-23	Amber	28/11/2022 - Capital finds have been agreed actions being taken forward through General Managers through each site. All General Managers aware of bids will oversee progress against actions.
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_004b	N/A	R4. Toilet cleanliness needs addressing with regular cleaning schedules	Spot check audits of schedules and time cleaned	Dec-22	~~Dec-22~~ ~~N/K~~ Mar-23	Red	28/11/2022 - To be considered as part of core audits. 10/03/23 - Ad Hoc assurance check to be undertaken led by the IPC team and reported back by 31/03/23
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_005a	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	GGH is working with Gwili railway to provide an additional 140 spaces for staff to release space in the hospital site.	Jun-23	Jun-23	Amber	28/11/2022 - Parking on all hospital sites remains a challenge. Alternative ways to support patients access is being continually considered by Director of estates and Facilities
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_005b	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	There are patient designated parking areas which are patrolled by car parking attendants. Staff parking in these areas are issued with a parking fine.	Jun-23	Jun-23	Amber	28/11/2022 - Parking on all hospital sites remains a challenge. Alternative ways to support patients access is being continually considered by Director of estates and Facilities
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_006b	N/A	R6. Ensure patients are made aware at reception they can discuss their need in private and not in front of a waiting room of people.	WG funding has been agreed and booths are being considered in reception area on the BGH site.	May-23	May-23	Amber	28/11/2022 - This work will be overseen by the capital monitoring group.
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_007b	N/A	R7. The Health Board to have better communication by keeping patients regularly informed of waiting times.	Funding agreed via WG for digital communication screens in waiting area, once purchased will have information on waiting times.	Mar-23	Mar-23	Amber	28/11/2022 - Funding agreed awaiting screens.
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_007c	N/A	R7. The Health Board to have better communication by keeping patients regularly informed of waiting times.	Benchmarking with other organisations to understand any further better approaches.	Jan-23	~~Jan-23~~ N/K	Red	28/11/2022 - SDM for scheduled care GGH benchmarking across HB's. 10/03/23 - Plan in place based on communication formats availabe.
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_001d	N/A	R1. Provide much more post-natal support for mums on the ward. Whilst mums who have had babies before or who have had normal deliveries may feel well supported, other mums with different kinds of births want more help to recover from their delivery. This includes managing to care for their new-born and in establishing breastfeeding. Aparticular focus needs to be given to first time mums, those with caesarean or unexpected types of deliveries.	We have recruited additional Health Care Support workers to provide additional support to mums on the postnatal Ward	Apr-23	Apr-23	Amber	
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_001f	N/A	R1. Provide much more post-natal support for mums on the ward. Whilst mums who have had babies before or who have had normal deliveries may feel well supported, other mums with different kinds of births want more help to recover from their delivery. This includes managing to care for their new-born and in establishing breastfeeding. Aparticular focus needs to be given to first time mums, those with caesarean or unexpected types of deliveries.	Birth rate Plus Ward acuity tool to be commenced in January 2023 – one month bedding in phase to support understanding levels of acuity to ensure appropriately staffed to the level of activity.	Jan-23	~~Jan-23~~ ~~N/K~~ Apr-23	Red	15/03/2023 - Delay start for the tool due to training requirements of staff new date April 30th if Birthrate plus can deliver the training in the agreed timescales. We are dependent on the external company for this.
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_001g	N/A	R1. Provide much more post-natal support for mums on the ward. Whilst mums who have had babies before or who have had normal deliveries may feel well supported, other mums with different kinds of births want more help to recover from their delivery. This includes managing to care for their new-born and in establishing breastfeeding. Aparticular focus needs to be given to first time mums, those with caesarean or unexpected types of deliveries.	Public Health Care Assistants have been recruited to support care in the community and are anticipated to commence work in the Spring 2023.	Apr-23	Apr-23	Amber	
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_002b	N/A	R2. Use feedback from mums and families in discussions with staff, as these provide specific instances of good and bad communication. There were many examples of good communication on CHC's findings but also times when there was a lack of empathy and compassion.	We actively seek our women and families feedback through the use of surveys to inform and improve services. We publish and you said we heard response to these.	Apr-23	Apr-23	Amber	Surveys – Antenatal, Labour, Postnatal and Induction of Labour have been completed – 2 have been shared with the public the final 2 anticipated Spring 2023
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_002c	N/A	R2. Use feedback from mums and families in discussions with staff, as these provide specific instances of good and bad communication. There were many examples of good communication on CHC's findings but also times when there was a lack of empathy and compassion.	Scope the availability of Emotional Intelligence training and education.	Jun-23	Jun-23	Amber	HB Culture and People Team are scoping this for our service.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_003a	N/A	R3. Review the communication and advice given to mums during their pregnancy, delivery and after delivery, to provide better consistency. Whilst written information may be available on the wards and should continue to be available, potentially an 'app' that mums can access on their phones or devices will avoid the need to look for information on the wards, when staff appear to be busy. Information on an app can also be updated quickly and added to as women share their experiences about using maternity services. Alternatively, being able to access short videos, explaining what to expect on the ward could be helpful and might reduce the need to read lots of paper based information.	Public Health Wales are reviewing the Baby Bump and Beyond Book issued in pregnancy in conjunction with the 7 Health Boards in Wales. This is anticipated to be available in the Summer of 2023.	Aug-23	Aug-23	Amber	
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_003b	N/A	R3. Review the communication and advice given to mums during their pregnancy, delivery and after delivery, to provide better consistency. Whilst written information may be available on the wards and should continue to be available, potentially an 'app' that mums can access on their phones or devices will avoid the need to look for information on the wards, when staff appear to be busy. Information on an app can also be updated quickly and added to as women share their experiences about using maternity services. Alternatively, being able to access short videos, explaining what to expect on the ward could be helpful and might reduce the need to read lots of paper based information.	Short information videos have been developed, filmed and translated and will be available to support mothers care of the new-born.	Mar-23	Mar-23	Amber	Currently with Communications team for approval
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_004c	N/A	R4. Many mums want to breastfeed their babies but need more help on the ward and after discharge home. A further investment in breastfeeding support could help mums establish breastfeeding, continue with breastfeeding when they go home and receive support that could allow them to extend the length of time that they breastfeed.	Recruitment of 3 community based Public Health Care Assistants	Aug-23	Mar-24	Amber	In progress, compliance expected March 2024 – rolling programme throughout 2023 – 2024.Compliant with annual mandatory Infant Feeding updates for all maternity staff. Options to employ Band 4 NNEB (5.69wte) for the postnatal ward considered
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_005a	N/A	R5. To share our 2021 report, the Health Board's action plan and this current report with all staff. To ensure that mums are clearly told about the actions being taken so that people can see what has improved.	CSfM's to share the report via the Lunch and Learn sessions with staff	Feb-23	~~Feb-23~~ N/K Apr-23	Red	Lunch and Learn to share findings with staff. 15/03/2023 - Deferred to April 2023 due to prioritisation of the HIW and MatneoSSP reports.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001a	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	The S-CAMHS service has established a waiting list monitoring group which meets monthly to provide Governance of demand and capacity across the service , identify any key areas for improvement and reduce long waits. Managers review any waiting lists periodically to review any risk and also to ascertain if S-CAMHS remains the most appropriate service	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001b	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	Robust recruitment is ongoing to recruit into vacant posts and ensure retention of key staff	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001c	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	S-CAMHS has undertaken demand and capacity planning provided by the Welsh Government Delivery Unit	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001d	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	S-CAMHS will continue to ensure "Keep in Touch" letters are sent to all clients waiting for an appointment every 12 weeks to reassure them they await an appointment.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001e	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	S-CAMHS will advise all clients & families in this letter to contact the service should their concerns escalate whilst waiting an appointment to expediate appointments.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001f	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	All clients / families will be provided with information on local support, websites and Digital help available .	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_001g	N/A	R1. Long waits for assessment and treatment to be improved and systems developed to better maintain contact with service users and their families, parents or carers.	S-CAMHS has commissioned Kooth -On line Digital Counselling Service to provide ADDITIONAL support when waiting for appointments / treatment .	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_002a	N/A	R2. Any application for help should be responded to in a timely manner	All referral agencies will be provided with the S-CAMHS Service Specification which outlines both the Operational and Governance framework for the Specialist Child and Adolescent Mental Health Service (S-CAMHS) provided by Hywel Dda Health University Board .	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_002b	N/A	R2. Any application for help should be responded to in a timely manner	S-CAMHS will introduce a response time standard of a return call within 3 days for non urgent ,or same day for urgent calls.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_002c	N/A	R2. Any application for help should be responded to in a timely manner	The service has a Single Point of Contact (SPOC) for all referrals and this is operational 5 day a week and will ensure the service responds to referrals withn the Welsh Government performance targets of 48 hours for emergency and 28 days for routine referrals.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_002d	N/A	R2. Any application for help should be responded to in a timely manner	S-CAMHS will ensure there is a clear referral pathway for the NHS 111 Ring 2 service into S-CAMHS and the Crisis Assessment Team outside working hours and weekends.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_002e	N/A	R2. Any application for help should be responded to in a timely manner	The SCAMHS Crisis Assessment and Treatment team will be available 24/7 to provide urgent assessments and support out of hours .	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_003a	N/A	R3. Enhancement in support and information for service users if they are deemed not suitable for CAMHS services.	S-CAMHS will ensure all service users/ referrals not accepted by the Single Point of Contact team are contacted and informed of the reason why the referral is not accepted.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_003b	N/A	R3. Enhancement in support and information for service users if they are deemed not suitable for CAMHS services.	Where the criteria for a mental health service is not met, we will endeavour to provide an alternative means of support and sign post to key agencies such as School Counselling, Area 43, Third Sector services and also inform referrers and service users of the wide range of On line support and Apps that maybe helpful.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_003c	N/A	R3. Enhancement in support and information for service users if they are deemed not suitable for CAMHS services.	S-CAMHS will ensure information is provided on how to access Kooth : On Line Counselling Service for all CYP.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_003d	N/A	R3. Enhancement in support and information for service users if they are deemed not suitable for CAMHS services.	S-CAMHS will explore with partner agencies if a proposal for multi agency early help panels can be developed in order to ensure better coordinated response to all mental health and wellbeing referrals.(No Wrong Door approach)	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004a	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	S-CAMHS will ensure all GP Clusters are provided with the S-CAMHS Service Specification to ensure awareness of service function and referral pathways.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004b	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	The S-CAMHS website will be updated and available to provide additional information and advise.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004c	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	The PMH Service Manager will attend monthly GP Cluster meetings where service developments and any key issues can be raised and addressed. We have shared new innovations and service developments via these meetings and will consider developing new literature to share information.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005a	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will ensure Implementation of the Code of Practice for Autism.	Jun-23	Jun-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005b	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will contribute and implement further service support ,interventions and developments in line with the Welsh Government Neurodivergence Improvement Plan	Jun-23	Jun-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005c	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will continue to support the Regional Partnership Board in the delivery of improved services.	Jun-23	Jun-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005d	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will ensure the workforce receives specific training on ASD and related Neurodevelopmental disorders.	Jun-23	Jun-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_006a	N/A	R6. Ending of any support (or an individual giving support) must be clearly communicated to the service user	S-CAMHS will ensure that discharge planning / treatment endings is undertaken as preparation for discharge.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_006b	N/A	R6. Ending of any support (or an individual giving support) must be clearly communicated to the service user	S-CAMHS will provide information on community support etc on discharge and advise on re referral pathways as appropriate.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_007a	N/A	R7. Development of a CAMHS specialist at Primary Care (or at cluster level)	S-CAMHS has a dedicated Primary Mental Health Team for Children and Young People whose remit is to provide emotional and mental health support for mild to moderate presentations.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_007b	N/A	R7. Development of a CAMHS specialist at Primary Care (or at cluster level)	S-CAMHS will ensure the full implementation of the School in Reach Service across the health board footprint	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_007c	N/A	R7. Development of a CAMHS specialist at Primary Care (or at cluster level)	S-CAMHS Managers will explore with GP Clusters the possibility of additional services within the community ie expand the Pilot Family Support Service in Pembrokeshire	Mar-23	Mar-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_008a	N/A	R8. All medications to be explained to parents /carers	S-CAMHS will ensure use of the Medication Consent forms is in place for all CYP who are prescribed medication.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_008b	N/A	R8. All medications to be explained to parents /carers	S-CAMHS will ensure medication information leaflets are routinely provided and medication plans are discussed with client/ parent/carer when consent is provided. Explanations / information will be provided on any investigations needed to be undertaken , such as blood tests etc.	Mar-23	Mar-23	Amber	
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_008c	N/A	R8. All medications to be explained to parents /carers	S-CAMHS will also explore alternatives to medication if parents/carers and their child are not in agreement.	Mar-23	Mar-23	Amber	
C19PEAR_0922	Sep-22	Counter Fraud Authority	Covid-19 Post Event Assurance Report of findings for HYWEL DDA UNIVERSITY LHB	Open	N/A	Finance	Finance	Head of Counter Fraud	Director of Finance	C19PEAR_0922_001	High	R1. Health Sector CFB to review the effectiveness of centralised support / coordination for NHS organisations in sourcing and procuring essential equipment during the onset of Covid-19. An enhanced understanding of overseas markets and use of intermediaries should form the core support mechanisms provided in future emergency management scenarios.	Hywel Dda UHB Counter Fraud – This recommendation was made by the Counter Fraud Authority, who have been asked to comment how this will be actioned across Wales. Their response was received, stating that discussions will be taking place with the Head of CFS Wales to review existing controls. A further update will be requested regarding any developments.	N/K	N/K	Red	29/03/2023 - Further update requested from NWSSP.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_007	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	N/K	~~Apr-22~~ ~~Oct-22~~ ~~Nov-22~~ 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 setup plans is being led by the Primary Care Optometric Leads. 23/02/2022- update from Head of Dental and Optometry- The first stage was to develop ODTs in Primary care to deliver The Glaucoma pathway and this has been delayed because of the appointment process for a lead consultant with a sub specialist interest in glaucoma and the installing of IT systems to support the pathway. Plans are in place to start the pathway providing there is a recurrent source of funding available from the 01/04/2022. 13/07/2022- Funding provided through the approved ARCH Business Case for the delivery of Glaucoma Services. The longer term IT solutions for working and sharing data across Primary and Secondary Care is a work in progress at an all Wales level. The Health Board has appointed a Consultant through a Honorary Contract and currently in an open Procurement tender process for the establishment of ODTC's in Hywel Dda. 30/09/2022- The tendering process is now closed and is waiting for review by Primary Care and lead consultant for Glaucoma (check with Head of Dental and Optometry & Low Vision Services Manager). There is hope this may progress (i.e. awarding contracts) by October. 13/10/2022 - Update from Primary Care: ODTC contracts have been awarded to two Providers, one in Haverfordwest and the other in Llanelli. The internal process is being finalised between PC and secondary care colleagues and it is anticipated that clinics will start in November 2022. 10/01/2023 - Update from Primary Care: The internal processes have been agreed. ODTCs to use Consultant Connect to save and be able to share the findings with colleagues in HES. Prior to setting this up, the HB Information Governance (IG) team must agree/sign off a Data Processor Data Protection Impact Assessment (DPIA). HES submitted the DPIA to IG in October and despite them requesting an update on multiple occasions, they still do not have a timescale from IG. Unable to provide revised timescale. 16/01/2023 - Update from Rachel Absalom: We are awaiting confirmation from IG that we can progress and, despite repeated emails, have not received this as yet. Revised timescale is therefore unknown. Will continue to chase/raise as an issue. 22/02/2023 - Update from Rachel Absalom: Informed by IG that they would be meeting to discuss on 06/02/2023 but no response received to their requested for an update. Until IG respond, no timescale can be given.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	~~Mar-23~~ Apr-23	Red	22/02/2022- SDM confirmed recommendation to remain open until we're in a position to review the progress of the Glaucoma patients in March 2022 - then we'll have an idea of when the work will be completed by. 21/03/2022- Recommendation added back to the main audit tracker. 13/05/2022- SDM provided revised date of March 2024. This will be depending on the regionalisation with Swansea Bay (ARCH), in principle this should cover the whole of UHB. Ceredigion discussions on Mid Wales Collaborative with Powys and Betsi- discussions taking place on Mid Wales lead for Ophthalmology to be advertised, difficulties in recruiting in Ceredigion area. 07/07/2022- Risk stratification of Glaucoma patients now complete. Work continues on outpatient templates to ensure capacity to review patient backlog. Current difficulties with staff capacity March 2023, as per Ministerial measures for addressing backlog. Meeting to take place with WG which will hopefully provide clarity on targets. 30/09/2022- Revised completion date to be kept as March 2023. A discussion has taken place with WG, they want eye care measures and MD to be implemented; the service are micro-managing capacity and booking to ensure both targets are prioritised. 9/1/2023- Meeting with team planned this month (capacity, model for delivery etc). 02/03/2023 - Planned expansion of the glaucoma service is expected to improve review response times throughout 2023. Clinical job plans to be completed by April 2023 to maximise clinic capacity.
DU_AWCCSTPAR0519	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Open	N/A	Cardiology	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DU_AWCCSTPAR0519_003	N/A	R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.	HDUHB was in the process of working with IT to setup another SharePoint system to move towards the electronic referral of patients between Cardiology and Cardiac Surgery. However, this hasn't been progressed due to the All Wales Accelerating Cardiac Informatics work being progressed on Hospital to Hospital Referrals. Cardiology Service Delivery Manager currently in discussion with HDUHB Informatics and AWACI.	May-19	~~Dec-20~~ ~~Jun-21~~ ~~Mar-22~~ Mar-23	Red	"Unable to progress due to COVID review date December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- Update from reporting officer- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. Clinical Lead/SDM plan to review the possibility of developing a more reliable SharePoint system to support referrals and discuss this with SBUHB counterparts with respect to have we might progress this. 24/05/2021- Requested update if this rec will be completed by end of June 2021, no response as of 28/05/2021. 11/06/2021 update -The Cardiology Service is currently undertaking a Pathway Transformation Project which will review the tertiary care element and processes of all pathways – it is anticipated that this work will provide an updated perspective of the needed digital/electronic component of future cardiology pathways. This project runs to the end of March '22 at which point it will report its findings and recommendations relevant to this action. 10/08/2021 – Cardiology Pathway Transformation Project in progress and will report its recommendation re development of an electronic referral system by March 2022. 16/03/2021 – Discussions continuing between HDUHB and SBUHB Cardiology Management Teams concerning need/feasibility of developing SharePoint system. 11/07/2022 - discussion with the SDM and Service Manager confirmed that the recommendation has to date been implemented with regards to inpatients, however further work needed with regards to outpatients. Discussions are also ongoing with SBUHB in order to further the implementation of this recommendation, and a revised timescale has been given of March 2023 in relation to this recommendation. 16/01/2023- Requested update via service email on 22/12/2022 for update by 13/01/2023, chaser sent 13/01/2023. 30/01/2023- SDM confirmed that the Cardiology Service undertakes monthly compliance audits of provision of 'pathway start dates' to Morriston Tertiary Cardiology Service. Compliance is consistently at 100% which fully mitigates the risk / issue highlighted by the DU. As a result of this status and assurance, the Cardiology Service does not feel it necessary to pursue the recommendation to develop a SharePoint system for referrals from HDUHB secondary care cardiology to SBUHB tertiary care cardiology. Assurance and Risk team to discuss with Director of Operations if he is happy for this recommendation to be closed.
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_002	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ N/K	Red	22/02/2022- Plans submitted as part of IMTP and ARCH plan for Glaucoma now in place. Meeting arranged with Shrewsbury & Telford in Feb 2022 to scope provisions for the North of the Health Board and the patients in Ceredigion. 21/03/2022- Recommendation re-opened on the audit tracker. 13/05/2022- SDM updated that IMTP submitted, no decision received on priorities and if IMTP is supported therefore unable to provide further update on this. 07/07/2022- No feedback as yet on plans submitted to IMTP. Awaiting clarity on IMTP response before timescales can be provided. 30/09/2022- No official response from IMTP. The UHB has a funded Glaucoma plan and diabetic retinopathy plan, which are both in place. The overarching plan for the whole service is outlined in the IMTP. To clarify with Director of Operations if this recommendation to be closed. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm that this recommendation can now be closed. 9/1/2023 - Dependent on outcome of IMTP - no response yet. 02/03/2023 - Outcome of regional clinical workshop (being held early 2023) will influence long-term model.
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_004	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	~~Jul-20~~ ~~Aug-20~~ ~~Oct-20~~ N/K	Red	22/02/2022- If this will be addressed via the IMTP, then once the IMTP is approved the Director of Operations will be happy for this to be closed. 21/03/2022- Recommendation re-opened on the audit tracker. 13/05/2022- IMTP submitted, no decision received on priorities/ if IMTP is supported. Until the decision on the IMTP and regional are made this recommendation cannot be fully implemented. 07/07/2022- No feedback as yet on plans submitted to IMTP. Awaiting clarity on IMTP response before timescales can be provided. 30/09/2022- No official response from IMTP. Sustainable monies have been invested into Glaucoma plan and cataracts, however there are still other areas of the service (such as AMD, plastics, paeds, VR, etc.) that require investment. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm current position of this recommendation and revised date. 9/1/2023 - Dependent on outcome of IMTP - no response yet. 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service.
DU_AWRPTDECM0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM0919_006	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Mar-23~~ N/K	Red	22/10/22- update from SDM: Successful regional recruitment of Consultant Ophthalmologist with an interest in Glaucoma. Honorary Contract in place with Swansea Bay for Consultant. Interviews arranged for Feb 2022 for substantive Consultant Ophthalmologist - potential candidate able to commence March 2023. Meeting arranged with Shrewsbury & Telford in Feb 2022 to scope opportunities for the North of the HB and patients in Ceredigion. 21/03/2022- Recommendation re-opened on the audit tracker. 13/05/2022- Honorary contract in plan, and substantive Consultant Ophthalmologist to start in March 2023 (from New Zealand) . No further progression on the collaboration with Shrewsbury & Telford . Mid Wales clinical lead to be readvertised. 07/07/2022- Interviews taking place week commencing 11/07/22 for 6 speciality doctors (3 vacancies to fill). In addition, a locum consultant advert has just closed with 5 applicants (clinical lead currently shortlisting). Also, Swansea Bay HB have successfully recruited 2 locum consultants for Glaucoma which will support the regional ARCH plan (Timescale = End of August). 30/09/2022- We have successfully recruited 2 speciality doctors and 2 locum consultants. A second honorary annual contract with Swansea Bay glaucoma consultants is in progress via ARCH. The midwales (Powys and Betsi) clinical lead was readvertised with no applicants. SDM to meet with the County Director Ceredigion for next course of action. 09/1/2023 - Position still the same. Exploring regional posts with Swansea Bay. 02/03/2023 - Regional clinical view is that without central prioritised investment, it would be difficult to attract appropriately qualified skilled individuals who are able to be recruited into centres of excellent elsewhere across the UK.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
DU_AWARCLPSA0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0322_005a	N/A	RSa. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	The Health Board is currently developing a new assessment form, which will incorporate a section on risk, and safety, to ensure this, is completed at point of assessment.	Dec-22	~~Mar-23~~ May-23	Red	03/05/2022 - PAS team are assisting the Directorate with providing management responses to these recommendations, and corresponding timescales. Tracker to be updated on receipt of information 20/05/2022 - confirmation received from the PAS team that they are continuing to support the directorate in formulating responses and they are currently in draft and awaiting sign off. 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- Patient Safety and Assurance Team confirmed revised completion date of 30/05/2023.The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 16/02/2023- Lead Officer confirmed the introduction and implementation of the new assessment document has been delayed. Revised date of May 2023 provided.
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	RSb. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clear process to be identified in both Liaison and CMHC SOP about recording of risk and safety plan.	Dec-22	May-23	Red	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. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023.
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	RSc. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	6 Monthly audit of patient risk assessments to be completed by team managers to review quality.	Dec-22	May-23	Red	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. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023.
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	RSd. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clinician to attend WARN and Storm training	Dec-22	May-23	Red	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. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023.
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	RSe. 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 managers to ensure a consistent and timely approach with the sharing of information with refers.	Dec-22	May-23	Red	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. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_001a	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	HDUHB will undertake a review of the Health Board Part 1 Scheme in collaboration with partner agencies (LA) and commissioned services to ensure the service is aligned to the MH Measure.	Dec-23	Dec-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_001b	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	S-CAMHS will contribute to the update ensuring all the new service developments are aligned to the Measure, including the new SIR Service.	Dec-23	Dec-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_002a	N/A	R2. The service should consider reviewing eligibility criteria to ensure clarity relating to the scope of the different CAMHS functions	S-CAMHS will ensure the current eligibility criteria is as outlined in the NHS Wales S-CAMHS Service Framework.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_002b	N/A	R2. The service should consider reviewing eligibility criteria to ensure clarity relating to the scope of the different CAMHS functions	S-CAMHS will ensure clarity for the different service functions are outlined in the Service Specification	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_003a	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	S-CAMHS will undertake a review of the terminology used in all S-CAMHS documents and ensure clarity and consistency.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_003b	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	S-CAMHS Service Specification will be updated to ensure consistency.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_003c	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	A glossary of terminology will be developed, included in the Service Specification, service literature and shared with all staff.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004a	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	S-CAMHS will establish a Steering Group with specific terms of reference, to develop and monitor a recovery plan.	Oct-23	Oct-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004b	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	An improvement trajectory will be developed to monitor the numbers of clients waiting for clinical interventions following assessment under Secondary CAMHS.	Oct-23	Oct-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004c	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Workforce capacity will be reviewed to address demand imbalance in each locality team and increase recruitment into vacant posts.	Oct-23	Oct-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004d	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A review of clinicians' Job Plans overseen by locality team leads in conjunction with professional clinical leads will be undertaken.	Oct-23	Oct-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004e	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Further monitoring of DNA's or was not brought (as lost capacity needs to be minimised) discharge and transfer information (to help ensure flow through services and avoid blockages e.g. access to specialist therapies) and actions to improve engagement and letting go if needed.	Oct-23	Oct-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004f	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A workforce training analysis will be completed and training plan including CAPA Core competencies developed to ensure all staff have the core competencies required to meet service need.	Oct-23	Oct-23	Amber	

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DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_005a	N/A	R5. The HB should review its arrangements for care coordination to ensure it fulfils its statutory obligations under the MHM.	A CTP Monitoring group will be established with clear terms of reference to ensure : -A CTP Register is developed and all eligible clients are placed on a CTP -Admin staff will have a clear pathway for ensuring the CTP review and exploration are monitored and communicated to the team to ensure review takes place. -A CTP Pathway will be developed to ensure all staff are aware of their responsibility under Part 2 of the MH Measure -A CTP Training Plan will be established to provide training for new staff, and also provide refresher training -All clients not placed on CTP will be reported under Part 1 MH Measure to ensure accurate data is reported.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_005b	N/A	R5. The HB should review its arrangements for care coordination to ensure it fulfils its statutory obligations under the MHM.	CTP audit pathway for line managers will be developed in line with Health Board Policy.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_005c	N/A	R5. The HB should review its arrangements for care coordination to ensure it fulfils its statutory obligations under the MHM.	S-CAMHS will ensure the S-CAMHS management reviews the workforce capacity within the service to undertake role of Care Coordination and highlight service need where there is an imbalance.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006a	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	A service wide review/audit of adherence to the CAPA model and principles will be undertaken and recommendations implemented.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006b	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	Key staff will undertake a review of CAPA outcomes and delivery in other HB and apply such learning where appropriate to HDUHB to improve compliance.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006c	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	A service user evaluation will be undertaken to evaluate effectiveness	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_007a	N/A	R7. The service may wish to access further capacity and demand training from the NHS Delivery Unit or other training providers.	LPMHSS S-CAMHS will undertake Demand & Capacity Training.	Jul-23	Jul-23	Amber	
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_007b	N/A	R7. The service may wish to access further capacity and demand training from the NHS Delivery Unit or other training providers.	Secondary S-CAMHS will undertake Demand and Capacity Training.	Jul-23	Jul-23	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_001a	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Assign a Clinical Lead.	Mar-23	Mar-23	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_001b	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Review a representative number of case studies (inclusive of near-miss incidents) of functional ill health [possibly mild cognitive impairment] Service users from Older Adult Mental Health Services with a presenting need to access Crisis Resolution and Home Treatment, Out of Hours, Liaison Psychiatry, NHS 111+2 Services. Bench-mark against the level of service 'age-through' Adult Mental Health Service Users benefit.	Jul-23	Jul-23	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_001c	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Produce a report for QS&EG with any required pathway improvement/equality recommendations.	Aug-23	Aug-23	Amber	16/03/2023- To be submitted for QS&EG Meeting 21/08/23 at the latest.
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_002a	N/A	R2. The Health Board and partner agencies should explore additional opportunities to developholistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventionsin order to reduce crisis and provide alternatives to admission.	Meet with Health and Social Care Leads (each county) to share and test potential for collaboration for a same-day 'holistic multi-agency multidisciplinary pathways for people living with dementia requiring support in crisis' care pathway.	Jul-23	Jul-23	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_002d	N/A	R2. The Health Board and partner agencies should explore additional opportunities to developholistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventionsin order to reduce crisis and provide alternatives to admission.	Identify and visit representative health led initiatives (each county) that could align as a foundation for collaboration on pathway development.	Mar-24	Mar-24	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_002e	N/A	R2. The Health Board and partner agencies should explore additional opportunities to developholistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventionsin order to reduce crisis and provide alternatives to admission.	Attempt to reach agreement (not necessarily implementation) for at least one health led initiative to pilot/test the concept.	Mar-24	Mar-24	Amber	
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_003	N/A	R3. The Health Board should further consider how the "what matters to me/most" conversations can be incorporated and evidenced within the mental health liaison assessments.	HDUHB current development of the 'Mental Health Service Comprehensive Assessment'. This assessment will include and evidence "what matters to me/most" conversations.	N/K	N/K	Amber	16/03/2023- Management response has been provided by Interim Senior Nurse Mental Health Liaison & In-patient, however these responses and corresponding timescales are to be confirmed with the Head of Adult Mental Health Inpatient Wards and Learning Disabilities Service when they return from leave.
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_004	N/A	R4. The Health Board should review accommodation within the Emergency Department to provide an environment where a mental health assessment can be provided to ensure privacy, low stimuli and safety for patients and staff.	Review undertaken. Appropriate areas in place Bronglais, Withybush and Prince Phillip. Layout change in Glangwili ED has led to identified area no longer available for mental health assessment. On-going discussions needed with ED management across HDUHB to resolve and ensure the provisions of appropriate assessment areas.	N/K	N/K	Amber	
HIW_TRO0116	Jan-16	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	HIW_TRO0116_001	N/A	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	N/K	~~Mar-22~~ ~~Mar-23~~ Jun-23	Red	22/02/2022- SDM confirmed actions a & c completed. Action B will be addressed with the implementation of the Glaucoma clinics and the risk stratification work. 21/03/2022- Recommendation and action B re-opened on the main audit tracker. 13/05/2022- SDM provided revised date of March 2024. Glaucoma clinics and the risk stratification work has started, will be completed by October 2022. Following this the remaining follow up patients (outside of glaucoma) will then need to be addressed, using clinics and See on Symptom (SOS) and Patient Initiated Follow Ups (PIFU). 30/09/2022- No longer doing the See on Symptom (SOS) and Patient Initiated Follow Ups (PIFU) as this is not a viable option, as discussed by clinical lead. Anybody who remains on the waiting list needs a face-to-face follow up with clinician, which needs to be managed (service micro-managing capacity and booking to ensure both targets are prioritised). 9/1/2023 - Prioritisation still happening (e.g. longest waits). Still don't have capacity to deliver (outweighed by demand). 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. 02/03/2023 - Improvements in follow-up waiting times will be based mainly around extended roles for optometrists which will be possible through contract reform (no date agreed as yet). Planned extension of the glaucoma service is expected to improve response times throughout 2023.
HIW_20136_GGHMW	May-21	HIW	Quality Check: Morlais Ward, GGH 4 March 2021 (Publication date 5 May 2021)	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	HIW_20136_GGHMW_002a	High	The health board must review the training data and provide assurance that staff have up to date skills and knowledge to provide safe and effective care as well as reviewing the training data to ensure the reports provide an accurate and current compliance figure.	As a result of the Covid-19 pandemic, all face to face L2 fire safety training has been suspended until further notice. This position is being reviewed regularly as to when L2 face to face sessions can resume.	N/K	~~Dec-22~~ ~~N/K~~ Mar-23	Red	19/05/2021 Awaiting WG relaxation of current of social distancing rules to be approved prior to face to face training being recommenced. 07/09/2021 - Fire training has recently commenced via Microsoft Teams and members of staff are booking on and attending 29/11/2021 - 21 staff of the 30 on the ward have now undertaken the fire training and a further session has been agreed with the Ward Sister and Head of Fire Safety Management scheduled for the week of 29th November 2021 to complete the training for the remaining 9 members of staff. 23/02/22 Significant percentage increase of compliance since return of training via Microsoft teams. 18/05/2022 - chased, no update received. QAST update 11/07/22 27/05/22 - All staff have resumed L2 fire training. The fire officer has since completed f2f on the ward for the team and there are also Microsoft teams sessions all can attend by booking on via learning and development. QAST update 07/09/22 update requested 18/07. QAST update 01/11/22 requested update Sept / Oct, none received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST Update 23/02/22 Significant percentage increase of compliance since return of training via microsoft teams.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	~~June 22~~ ~~Oct 22~~ ~~N/K~~ ~~Jan 23~~ ~~N/K~~ Mar-23	Red	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date. QAST Awaiting an update chased Dec 22, Jan 23, Feb 23.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_001b	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Point of Ligature, Major works to be completed. Plans currently out to tender. Construction Phase 1 on target to be commenced 15/11/21. Phase 2+3 to be commenced 03/01/22, completion expected April 2022.	Apr-22	~~Apr 22~~ ~~Jul 22~~ ~~N/K~~ ~~Jan 23~~ ~~N/K~~ Mar-23	Red	16/11/21 - MHLD PoL Capital Works Meeting - Edmunds & Webster have been assigned the contract, and waiting for Finance to approve. Construction Stage to start on the 22/11/21. 22/10/21 - Fire Stopping Meeting - Fire Stopping works are to start on the 08/11/21 and the PoL works to start on the 22/11/21 working parallel with each other, as majority of work is outside with minimal work on the ward. 09/11/21 - Pre-Contract Meeting with Contractors 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in April 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 PO work is currently being undertaken with a provisional completion date of end of July 2022. QAST update 07/09/2022 requested update 18/07/22, none received to date. QAST 01/11/22 QAST chased for update Sept / Oct none received. QAST Awaiting an update chased Dec 22, Jan 23, Feb 23.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ May-23	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response. 20/12/2022- All IPC issues with furniture have been addressed as all communal dining and lounge furniture has been replaced. Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed. QAST update Feb 23 Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ Apr-23	Red	23/02/2022 (BGH) - The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. Doctors' rotas reviewed every day to ensure appropriate cover. The Executive Director of Patient Experience and Quality agreed that if ED have to surge into minors, then one additional RN to be put on duty for nights. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E / AMAU have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST Update 01/11/22 - 27/10/22 (BGH) Free access to kitchen beverages and sandwiches stocked in fridge . Excellent rapport between WAST and Emergency staff regarding fundamentals of care (WGH) Confirmation from WGH that hot food and drinks provided to all patients waiting in department or awaiting handover. QAST Update 27/10/22 update (BGH) Staffing levels reviewed using BEST audit tool which requires need for uplift in staffing levels. Recruitment remains challenging so Dept focusing on retention . Staffing deficit impacting on offload delays . Exec team asked to consider implementation of financial incentives for all permanent staff to improve consistency in care . WGH The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap.
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/A	N/A	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/A	N/A	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/A	N/A	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/A	N/A	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/A	N/A	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/A	N/A	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_03d	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Health Board would look at other organisations practices and roles, which are not embedded into our current service delivery models and would welcome further discussion with WAST, other HB's and HIW in relation to this.	Dec-22	~~Dec-22~~ ~~Mar-22~~ ~~Dec-22~~ ~~N/K~~ Mar-23	Red	No update received from QSE team on progress against this recommendation as at March 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - not yet due no update received. QAST update 11/07/22 due December 2022, no update therefore requested. QAST update 11/07/22 & 07/09/22 due December 2022, no update requested. QAST update 01/11/22 chased all sites, no further update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 20/03/2023 Chased all sites for a response, awaiting response.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ Apr-23	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been setup chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation. 23/02/2022 (BGH) - Ambulance offload policy arrangements are ongoing. Meetings due to be held in February. Acute stroke pathway has been in place long standing and the crews can handover immediately to teams in the CT scanner area. 18/05/2022 - position in WGH same as BGH (above). QAST update 11/07/22, no update from PPH & GGH to date. 07/09/22 GGH & PPH Ambulance offload policy being updated currently with WAST representatives on group, individual department handover processes are in appendices within this policy. QAST update 01/11/22 chased sites , no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds . Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ Apr-23	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Ambulance offload policy, embedded in which is the Care of the patient in the ambulance policy. Actions are awaiting to be agreed by the Health Board with a meeting due in early March to discuss, led by Unscheduled care HoN with Task and Finish Group. 18/05/2022 - requested, none received. QAST update 11/07/22 requested update from PPH & GHH Feb, March, April and May 2022, none received. QAST update 07/09/22 for GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. QAST update 01/11/22 chased all sites, no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds .Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified. Patients able to use facilities within the main ED department. Rapid assessment area available to support appropriate care delivery when patients are awaiting offload.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001c	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will develop a consistent format for documentation that is meaningful for patients.	Jan-23	~~Jan-23~~ ~~N/K~~ Mar-23	Red	QAST update 07/09/22 T&F group developed. QAST update 20/03/2023 - Awaiting update.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001d	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will co-produce with service users a leaflet to support the documentation	Jan-23	~~Jan-23~~ ~~N/K~~ Mar-23	Red	QAST update 07/09/22 T&F group developed. QAST update 20/03/2023 - Awaiting update.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_003	N/A	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	All CMHT's have identified practitioners who will ensure the annual health checks are undertaken. Each CMHT operates a link worker system with GP practices to promote physical wellbeing for patients.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Jan-23~~ May-23	Red	18/05/2022 -Current evaluation of the team areas is being conducted –being led by Senior Nurse SC. QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning. QAST update 02/12/22 IDs for roles drafted, to be shared with GOP colleagues w/c 05/12/22. LMHPSS and GP Cluster colleagues to collaborate on where the Well-being Practitioners will be based and how the services link up to ensure smooth referrals.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_004b	N/A	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	Mar-23	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_005b	N/A	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	Mar-23	Amber	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_014b	N/A	Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.	To review the information and wellbeing advice held on the IAWN App (developed by the service).	Dec-22	~~N/K~~ Mar-23	Red	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 no update yet received from service. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_015b	N/A	Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	To discuss the findings with the WWAMH and identifying further actions as required.	Dec-22	~~N/K~~ Mar-23	Red	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 no update yet received from service. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_017	N/A	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	To complete the work that is already underway to outline the steps regarding the development and recruitment of the MH practitioner role.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Dec-22~~ ~~N/K~~ Mar-23	Red	18/05/2022 - PAS team to liaise with SDM of Psychological Therapies to develop a response and obtain updates QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no service update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_001	N/A	Patients are assessed in a timely manner if they have physical health problems and for doctors on the ward to feel supported by their colleagues on the general wards	Senior medical staff from Mental Health Services and General Acute Services in Prince Philip Hospital to liaise and discuss how communication to support timely assessments and support can be improved upon for doctors.	Nov-22	~~Nov-22~~ ~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_002	N/A	Work must be undertaken to improve the appearance of the garden.	Estates will review the garden and identity work plan to improve appearance.	Nov-22	~~Nov-22~~ ~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST Update Feb 23 review completed costing awaited.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_003	N/A	Appropriate and safe curtains are to be placed in patient bedrooms	Estates to review the environment in bedrooms and identity work plan to replace curtains.	Nov-22	~~Nov-22~~ ~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. Update Feb 23 Review completed, awaiting suitable alternative.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_007	N/A	Invest in appropriate observation mirrors to enable staff to see concealed areas in section 136 suite.	Estates to review environment and work plan formulated to ensure appropriate observation mirrors are in use.	Dec-22	~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_009	N/A	Staff offices and communal areas require refresh and repainting	Estates to review and build in regular maintenance of surroundings into work plan.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022. QAST Update Feb 23 reviewed by estates and costed. Awaiting completion of works.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_010	N/A	Carpets need replacing with proper flooring to prevent hazards and risks of infection	Estates work to be carried out and regular maintenance of flooring and surroundings to be arranged.	Dec-22	~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST Update Feb 23 Reviewed by estates and costed, awaiting completion of works.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_011	N/A	Tea bay needs a complete refurbishment, and a fridge must be made available for the patients	Estates to review to be carried out including the provision of a fridge and regular maintenance of tea bay and surroundings to be arranged.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022. QAST Update Feb 23 reviewed by estates and costed. Awaiting completion of works.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_012	N/A	A designated office space is made available on the ward for Dr and medical staff	Senior Nurse and Ward Manager have identified area. Estates work required to modify area.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022. QAST Update feb 23 reviewed by estates and costed. Awaiting completion of works.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_015	N/A	Shelving in clinical room is replaced and reorganised.	Estates work to be carried out and regular maintenance of shelves and surroundings to be arranged. Shelves to be reorganised once Estates work has been completed.	Dec-22	~~N/K~~ Mar-23	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST Update Feb 23 Reviewed by estates and costed, awaiting completion of works.
HIW_03148_BGHAW	Jan-23	HIW	Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Open	N/A	Women and Children's Services	Estates	Senior Nurse Paediatrics	Director of Operations	HIW_03148_BGHAW_003	N/A	The health board should ensure that any outstanding actions stemming from IPC (and related audits) are completed in a timely manner.	All actions from IPC and other related audits are monitored through the Directorate Q&S Committee. In relation to recommendation from the recent IP&C audit funding for the new flooring has been sourced, and the service area is in communication with estates to identify a date for required works to be approved and completed.	Mar-23	Mar-23	Amber	
HIW_03148_BGHAW	Jan-23	HIW	Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Open	N/A	Women and Children's Services	Estates	Senior Nurse Paediatrics	Director of Operations	HIW_03148_BGHAW_004	N/A	The health board must ensure that a review of paediatric menus is completed and implemented in a timely manner to ensure that nutritional needs are more appropriately met.	A Task and Finish group has been set up to review and oversee the development of menus to ensure the nutritional needs are met. The group will engage with patients and families as part of this process to seek their views.	Jun-23	Jun-23	Amber	
HIW_03148_BGHAW	Jan-23	HIW	Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Open	N/A	Women and Children's Services	Estates	Senior Nurse Paediatrics	Director of Operations	HIW_03148_BGHAW_008	N/A	The health board may wish to reflect upon the comments provided in the staff feedback to identify good practice and whether any additional areas require strengthening.	The service is reviewing the comments received. The comments and service response will be shared with staff, and if required, can also be shared with HIW.	Feb-23	~~Feb-23~~ N/K	Red	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_001	High	R1. The health board should consider displaying a designated health promotion board, so relevant information is accessible.	Public Health Midwife and Postnatal Ward Manager to identify a public health promotion board and co-ordinate all activities to this one central board.	Feb-23	Feb-23	Red	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_002	High	R2. The health board must ensure that signage at the hospital is reviewed to ensure that it is easy for patients to locate all the maternity wards	To improve signage. Estates to cost and provide a timescale for works to be completed.	Mar-23	Mar-23	Amber	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_003	High	R3. The health board must ensure that pain relief is provided in a timely manner on the post-natal ward	POM (Patient's Own Medication) secure box to be installed on each ward to reduce any delays for patient obtaining medication.	Jan-23	Jan-23	Red	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_006a	High	R6. The health board must ensure that all staff signatures are identifiable and contain GMC and NMC pin numbers.	To provide Doctors and Midwives with name stamps.	Mar-23	Mar-23	Amber	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_006b	High	R6. The health board must ensure that all staff signatures are identifiable and contain GMC and NMC pin numbers.	Communication to be released to all staff that if they do not have their name stamp the expectation is that the staff will print and sign their name	Dec-22	Dec-22	Red	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_010	High	R10. The health board must ensure that mandatory training compliance figures are improved.	Communication to be released to all staff to ensure dedication of time to complete training	Mar-23	Mar-23	Amber	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_011a	High	R11. The health board must ensure that junior doctors are supported with their training and ongoing personal development	Process introduced by College Tutor and Clinical lead to ensure that a programme is in place to support Junior Doctors with timeframes to achieve and progress individual learning needs assessment has been undertaken and monitor individual progress	Jan-23	Jan-23	Red	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_012a	High	R12. The health board should review the feedback from community staff and aim to improve staff welfare and staff relationships.	The Health Board and Head of Midwifery have reconfirmed their commitment to the Royal College of Midwives Caring for You charter. This will be communicated to all staff.	Mar-23	Mar-23	Amber	
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_012b	High	R12. The health board should review the feedback from community staff and aim to improve staff welfare and staff relationships.	Staff are to be given the option of participating and attending in the staff Wellbeing committee, to ensure it is representative of all areas of the service.	Mar-23	Mar-23	Red	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007a	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To seek advice from the Health Promotion Team and source suitable promotional material for the department.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007b	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure that the health promotion materials are bilingual (English and Welsh)	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007c	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure staff are aware how to access to materials in other languages as required by the local population.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_009a	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To agree a schedule for audit of current practice and compliance to identify key areas of improvement relating to assessment, prescribing, action, monitoring and escalation of pain needs. An initial baseline audit will be undertaken which is then followed up with further audits.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_009b	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To create and arrange provision of a schedule of training from the Pain Team for ED staff, which includes information on how staff can ensure the patients' pain is adequately assessed and managed.	Jun-23	Jun-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_009c	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	Link nurses to act as point of resource for staff within the unit to work alongside the pain team in ED.	Mar-23	Mar-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_009d	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To lead and engage with clinical colleagues and specialist teams to ensure timely patient assessment and prescribing of medication.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010a	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To obtain a baseline Information Governance e-learning figure for ED staff and remind all staff to maintain training levels.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010b	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To monitor compliance of IG training on a bi-monthly basis.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010c	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To obtain and ensure Information Governance posters are clearly displayed in the department as a reminder to staff and patients to maintain confidentiality.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010d	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To offer patients a private space to discuss any confidential matters, a poster advertising this to be displayed in the waiting area.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010e	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To issue a reminder to Nurses onthe NMC Code of Conduct in relation to the patient's right to confidentiality.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010f	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To issue a reminder to all departmental doctors and attending specialities on the patient's right to confidentiality.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010g	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	Bring the all-Wales Information Governance Policy to theattention of all ED staff through team brief sessions and written reminder.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_011a	N/A	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To arrange provision of new information screens for the department.	May-23	May-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_011b	N/A	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To remind all multidisciplinary staff within the department of the importance of updating patients and carers regarding their care and treatment.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_012i	N/A	R12. The health board is required to provide HIW with an update on the action taken and the processes in place to improve patient flow	TUEC and Improving Together work in progress to stream patients appropriately from ED.	Jun-23	Jun-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_012j	N/A	R12. The health board is required to provide HIW with an update on the action taken and the processes in place to improve patient flow	Implementation of SAFER – Phase 1 Pilot (Policy Goal 5) to support and improve discharge process/length of stay/improve patient experience.	Apr-23	Apr-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_014b	N/A	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To remind all staff that the viewing room should not be utilised for storage of items	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_014c	N/A	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To facilitate working with '2 Wish' charity regarding the refurbishment of relatives/viewing room	Sep-23	Sep-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_016a	N/A	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	To engage with the estates and the Mental Health Teams regarding creating a safe space to review Mental Health patients in the department	Jun-23	Jun-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_016c	N/A	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	A reminder to be issued to staff to promote the new way of accessing Mental Health and wellbeing support by dialling 111, option 2 for a MH practitioner	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_017a	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	To ensure work alongside estates to review refurbishing staff changing rooms, shower facilities and toilets	Sep-23	Sep-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_017b	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	Reviewing the opportunity to utilise charitable funds to facilitate improvements to the area in the ED Performance meeting	May-23	May-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018a	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To liaise with the IPC team to facilitate a schedule of refresher training on hand hygiene	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018b	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To ensure sister reviews audit results and implement improvement actions required regarding hand hygiene	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018c	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	Utilise hand wash training UV light box in the department to re-iterate the importance of effective hand washing techniques	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018d	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To obtain additional hand hygiene posters for the department	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018e	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To liaise with estates regarding the need for additional storage space in the department to ensure that the decontamination room is readily available	Mar-23	Mar-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_018f	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To arrange Fire audits reminder for staff of the need to keep areas clutter free	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_020a	N/A	R20. The health board is required to provide details to HIW of the action taken to ensure oxygen therapy is prescribed and staff record when this is administered.	To issue communication reminder to all ED Doctors and specialities the importance of prescribing oxygen therapy	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_020b	N/A	R20. The health board is required to provide details to HIW of the action taken to ensure oxygen therapy is prescribed and staff record when this is administered.	Oxygen Audit compliance to be undertaken to review current practice and identify key learning.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_021b	N/A	R21. The health board is required to provide HIW with details of the action taken to improve staff confidence regarding their concerns about unsafe practice being addressed.	Arrange weekly reviews and monitoring of Safeguarding referrals, ensuring correct referral method and compliance	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_021d	N/A	R21. The health board is required to provide HIW with details of the action taken to improve staff confidence regarding their concerns about unsafe practice being addressed.	Enable staff to attend / undertake Safeguarding training and monitor compliance	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_023b	N/A	R23. The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	SNM monthly audits currently under review.	Apr-23	Apr-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_023c	N/A	R23. The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	To ensure that medical staff within the department are supported to and undertake regular clinical audit.	Apr-23	Apr-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_024a	N/A	R24. The health board is required to provide HIW with details of the action taken to ensure unit staff: • are aware of the Bronze, Silver and Gold on call structure arrangements • are provided with updates, as appropriate, during periods of escalation.	The Bronze, Silver and Gold details of escalation and patient flow and on call arrangements to be shared with all department staff.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_024c	N/A	R24. The health board is required to provide HIW with details of the action taken to ensure unit staff: • are aware of the Bronze, Silver and Gold on call structure arrangements • are provided with updates, as appropriate, during periods of escalation.	All Senior Staff to receive training / refresher training on responding to and managing incidents in line with the Major Incident Plan.	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_025a	N/A	R25. The health board is required to provide HIW with details of the action taken to improve unit staff compliance with mandatory training.	To remind all multidisciplinary staff and arrange for protected time for staff to undertake refresher / mandatory training	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_026a	N/A	R26. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report. This must include the action taken in relation to communication between senior management and staff and senior managers acting on feedback.	Senior Nurse Manager to link with Organisation Development Relationship Managers for ED to arrange regular checks-in with ED staff regarding any staff concerns	Mar-23	Mar-23	Amber	
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_026c	N/A	R26. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report. This must include the action taken in relation to communication between senior management and staff and senior managers acting on feedback.	To facilitate weekly ED performance meetings where concerns/issues can be discussed.	Mar-23	Mar-23	Amber	
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	Oct-22	Mar-23	Red	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. 23/01/2023 - Confirmation received from QAST that this recommendation has reopened. 23/01/2023 - We need to establish a robust procedure for reviewing NMR/med physics competency requirements. This is a role which ideally needs to fall within the scope of a Quality Lead Radiographer and has been identified as a need, was included in our IMTP and also is on our risk register. QAST update - 28/10/22 The electronic version via Teams needs to be via a generic account in the clinical areas - we are working on this as there are some difficulties from IT. We really require a dedicated document control system, which was included in our IMTP and is also on our risk register and is designed for the specific purpose. We need to establish a robust procedure for reviewing NMR/med physics competency requirements. This is a role which ideally needs to fall within the scope of a Quality Lead Radiographer and has been identified as a need, was included in our IMTP and also is on our risk register. New date March 2023.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_001	High	R1. The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion information within the Diagnostic Imaging Dept.	shared with our communities via our social media channels to ensure formal recognition for the time women and	Feb-23	~~Feb-23~~ N/K	Red	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_002b	High	R2. The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients.	Create a working group to standardise the letter format for radiology using the HB guidelines.	Sep-23	Sep-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_004	High	R4. The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	A review of the procedure for patient identify checks will be undertaken to update the Employer's Procedure (EP).Introduce an audit to be performed on compliance with identity checks.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_005a	High	R5. The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of the enquiries of individuals of child bearing potential Employer's Procedure will be undertaken and updated with any gender specific reference to be removed.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_005b	High	R5. The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of all service documentation including letters and posters will be undertaken with any gender specific reference to be removed.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_006	High	R6. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for non-medical imaging exposures so that it includes reference to Tuberculosis (TB) screening.	Introduce a process whereby all Employer's Procedures will be reviewed in February 23 and updated to include all examinations currently performed.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_007	High	R7. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedures providing guidance on making a referral so that they reflect the need to avoid using acronyms and include reference to current guidance where applicable.	All Employer's Procedures will be reviewed in February 23 and updated to include that we do not accept referral forms with acronyms. We will also ensure that all referrers receive a copy of the Employers Procedures for referrers.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_009	High	R9. The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	Apr-23	Apr-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_010a	High	R10. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks.	Introduction of a procedure to review EP's to include the logbook checking frequency.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_010b	High	R10. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks.	Instigate an audit to check compliance as part of the audit schedule.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_011	High	R11. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedurefor the assessment of patient dose and administered activity so that it includes details of the procedure for exposures performed in surgical theatres and interventional radiography.	Introduction of a procedure to review all Employer's Procedures to include theatre procedures and interventional radiography.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_012	High	R12. The employer is required to provide HIW with details of the action taken to promote a consistent approach for the process and presentation of clinical audits.	Instigate a procedure to promote a consistent approach for process and presentation of clinical audits.	Mar-23	Mar-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_013	High	R13. The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to identify individuals entitled to act as referrer, practitioner or operator so that it clearly sets out the position in relation to anaesthesia associates.	Introduce a procedure to review all Employer's Procedures to include the position on anaesthesia associate. The policy will be clearly reworded to reflect that only registered professionals are able to refer.	Mar-23	Mar-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_014	High	R14. The employer is required to provide HIW with details of the action taken to maintain a complete and up to date record of the training, entitlement and scope of practice for entitled duty holders, including non-medical referrers	A review of the entitled duty holder matrix will be undertaken with the suggested change being made to provide a more thorough record.	Jun-23	Jun-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015a	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These competencies will be added to matrix.	May-23	May-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015b	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	The Employer's Procedure will be updated to include the justification process.	May-23	May-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015c	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Introduce a process to establish dose constraints and add to Employer Procedures.	May-23	May-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_016	High	R16. The employer is required to provide HIW with details of the action taken to develop and implement written protocols, where appropriate, for paediatric patients.	A process has been introduced to review all adult protocols. The review will inform the development and implementation of paediatric protocols.	Jun-23	Jun-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_017a	High	R17. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	A process has been introduced whereby the Lead Radiographer coordinates all written documentation to ensure no conflict with the employers written procedures.	Apr-23	Apr-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_017b	High	R17. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Sep-23	Sep-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_018a	High	R18. The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Hard copies of the protocols are available at all times in the department. A process will be undertaken to ensure any remaining old copies of protocols are removed and that the author is identified.	Mar-23	Mar-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_018c	High	R18. The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Written examination protocols will be made available to all staff in electronic and paper formats for all areas.	Feb-23	~~Feb-23~~ N/K	Red	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019a	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	The management team have approached the Health Board's values and culture team for expert advice on how to ensure the staff's voices are heard and action taken.	May-23	May-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019b	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	A series of staff engagement events are planned to instigate 'culture change' within the department and empower staff's confidence in the management.	May-23	May-23	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019c	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	Staff meetings are being strengthened and a regular schedule of meetings are being arranged in advance and circulated to staff.	May-23	May-23	Amber	
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_001	N/A	R1. To ensure that senior staff undertaking responsibilities on behalf of the Executive Team understood their roles and the need for good documentation to support any decision-making.	The scheme of delegation will be reissued to all Executive Directors and their direct reports alongside the Board and Committee revised Standard Operating Procedure.	Mar-23	Mar-23	Amber	
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_002	N/A	R2. To consider developing 'Decision Making whilst in emergency response' Guide for Health Board staff.	The importance of making safe decisions during emergency responses will be reiterated in the revised Board and Committee Standard Operating Procedure. This will indicate that any deviation from business-as-usual decision making processes must be communicated to and approved by the Executive Team.	Mar-23	Mar-23	Amber	
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_003	N/A	R3. To review the governance processes in relation to decision making groups between the Health Board and Pembrokeshire County Council (PCC) to ensure that decisions are clearly recorded in the minutes.	A review will be undertaken of the joint groups established between the Health Board and PCC. Furthermore, a review will be undertaken of the governance and reporting arrangements of the Integrated Executive Group which reports into the West Wales Care Partnership.	May-23	May-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_004	N/A	R4. To ensure that the Board Secretary is fully engaged in decision making and their advice on the appropriate governance is taken at an early stage of the process. A reminder will be issued to all Executive Directors advising of the importance of seeking governance advice for all key programmes of work. Command Structure – The Director of Corporate Governance is required to attend all GOLD command meetings. The Assistant Director of Assurance and Risk is required to attend all SILVER (tactical) meetings in all health emergency scenarios.	The Director of Corporate Governance/Board Secretary is a valued member of the Executive Team and is responsible for advising on the appropriateness of governance during business-as-usual and emergency response situations. A reminder will be issued to all Executive Directors advising of the importance of seeking governance advice for all key programmes of work. Command Structure – The Director of Corporate Governance is required to attend all GOLD command meetings. The Assistant Director of Assurance and Risk is required to attend all SILVER (tactical) meetings in all health emergency scenarios.	Mar-23	Mar-23	Amber	
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_004	Medium	R4. Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.	As identified in the recommendation above following a report reviewed by the non pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of the scoping working the groups will be required to identify any records outside of retention guidance and the relevant costs of destruction. As clarified above this work will be progressed early in the new year.	Mar-19	~~Jul-21~~ ~~Nov-22~~ Mar-23	Red	19/04/2022 - update provided to ARAC stated that the following works remain in order to complete the recommendation: 1) Develop a proposal for unifying all patient records management accountabilities under one executive lead (May 2022). 2) Following on from (1) relocation of records to Llangennech and Unit 3 Dafen ahead of scanning (November 2022, subject to review - dependent on freeing up space and notice periods for present arrangements). 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The Health Board continues to operate with the imposed UK government destruction embargo in situ, meaning no patient records can be destroyed. The relevant inquires could be completed early in 2023 and destruction processes can immediately go back into operation. The review of the offsite and private storage facilities, continues as part of the IG work programme and is identifying various records held at the localities. Work has also commenced in terms of returning Hywel Dda records to the central health records storage facilities, from private storage. Relocating records to one central management team will ensure retention and destruction schedules are followed diligently.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	Mar-23	Red	19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The IG work programme to review storage facilities is ongoing and to date 4 locations have been reviewed, including 2 private providers (Lloyd & Pawlett and Logic Document) and the health records storage facilities based at Dafen and Llangennech in Llanelli. Concerns remain in regards the private storage providers and an SBAR was presented to the Executive Team in October 2022 proposing that the management and storage of all Hywel Dda records be streamlined to one Executive lead. Clearly this is a considerable project to undertake and complete and it will require significant support from a wide range of services and identified IAO's. Work has commenced in terms of developing a project plan and schedule of work, but initial progress has been made by relocating A&E and pharmacy records, with other services to follow. Once all records are relocated to the Health Board storage facilities this will negate any concerns.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section2. Management should establish what information is stored with the third party storage providers and that the retention and destruction of information is being undertaken in line with the Welsh Government arrangements.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	Mar-23	Red	19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – Please see update provided for recommendations R4 and R6 section 1. The SBAR presented to the Executive Team in October 2022 proposing to move the management, handling, scanning and destruction of all Hywel Dda records to one Executive lead and retained within the health records storage facilities will ensure all storage, governance, destruction issues are fully resolved.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_007	Medium	R7: Management should establish refresher sessions to ensure existing staff receive records management training.	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.	Feb-19	~~Jun-21~~ ~~Nov-22~~ Mar-23	Red	19/04/2022 - update provided to ARAC with the following work remaining to be undertaken in order to close the recommendation 1) Identify shortfalls in records management processes and non-compliance with appropriate standards, within relevant services (November 2022). 2) Following on from (1) develop a plan for records management training within those areas (November 2022). 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile. 17/11/2022 – Health Records training remains part of the agenda for the Welsh Health Records Management Group, however no further progress has been made to date due to a prioritisation of work to the development and implementation of eth Records Management Code of Practice, Transgender procedures and adoption protocols.
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development, issued April 2021	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lisa Humphrey/Project Director	Director of Strategic Development and Operational Planning	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP:SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ Jul-23	Amber	26/05/2021 no update. 09/06/2021 in progress. Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract. 02/03/2022 & 03/05/2022- Expected to remain open until July 2023. 03/05/2022- outstanding rec expected to remain open until July 2023. Exec Lead amended from Director of Operations to Director of Strategic Development and Operational Planning as remaining recommendation is for Strategic Development and Operational Planning Directorate to implement. 12/08/22-Date remains July 2023 30/08/2022 - Director of Strategic Developments and Operational Planning confirmed no change. 10/11/2022 - Head of Captial Planning confirms no change. 10/01/2023 & 01/02/2023-Head of Captial Planning confirms no change - ongoing monitoring of contractor performance which will continue until completion of the contract planned for July 2023. 16/03/2023- update remains as above
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001a	N/A	R1a. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	~~Mar-22~~ Mar-23	External	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 31/10/2022- agreed by Director of Primary Care, Community and Long Term Care that this recommendation is changed to 'external'. Discharge requirements are being reviewed at an All Wales basis, in light of developments following Covid-19.Once these are reissued (the All Wales review is expecting to be completed imminently), the UHB discharge policy will be refreshed. The current discharge policy will be requested to be extended for three months, whilst the UHB awaits guidance from WG following the All Wales review, as well as awaiting ministerial advice on the Delayed Transfer of Care (DTOC), which will also feed into the amended policy. Revised date of March 2023 timescale provided, and the recommendation changed from red (overdue) to external (outside the gift of the UHB to implement) whilst the outcome of All Wales review is awaited. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002a	N/A	R2a. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. The importance across the Region is that the key principles and standards within the discharge policy are met and considered within the partnership boards. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	Sep-22	~~Sep-22~~ Aug-23	Red	31/10/2022- Discharge to Recover then Assess (D2RA) pathways are being reviewed as part of the All Wales level work which feeds into the Policy Goal 6 work. Local Authority representatives are advising this national work. The Policy Goal 6 work is reviewing the processes and looking at a consistent approach. This is linked to the Programme delivery group structure now in place, as noted in the recommendation above. We recognise there is more work to do and therefore the work of this recommendation will be added into the relevant workstreams. Work is continuing however the UHB is mindful of the All Wales guidance which is expected imminently. Assurance and Risk Officer awaiting confirmation this recommendation has been added to the relevant workstream. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss these recommendations and if it has been added to the relevant UEC workstream. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002b	N/A	R2b. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level.	Apr-22	~~Sep-22~~ N/K	Red	31/10/2022- Focusing on the ask of the original recommendation, across the Regional UEC Programme Delivery Group undertakes a monthly review of the agreed high level 3Cs outcome measures (Conveyance, Conversion and Complexity) and, to highlight any worsening trends, and focus through the delivery groups the expectation will be that focused outcome measures will be agreed by each Policy Goal Delivery Group, with exception reporting feeding up to the programme delivery board. This will develop equitable outcomes across the Hywel Dda patch, even if separate models across the counties is required and regardless if a dashboard is in place. Through the Policy Goals 5 & 6, the outcome measures that have been identified will be shared with all the Policy Goals Delivery Groups as required. Recommendation to be requested to be closed once the above is being reported through the Delivery Groups and explicit within the workplans, approximate date not yet known, this will be a long term recommendation to fully implement with the date currently not known. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this is now being reported through the UEC Delivery Groups and explicit within the workplans. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002c	N/A	R2c. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PG5 & 6 workstream.	Jul-22	~~Jul-22~~ N/K	External	31/10/2022-This recommendation is being driven through the delivery groups of the UEC programme, as described above. These recommendations are to be included in the workstream workplan, along with the WG guidance once received. Timescale not yet known as awaiting WG guidance. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003a	N/A	R3a. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Following a recent staff survey one of the key recommendations is to develop better, very practical and locally delivered discharge planning training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days	Apr-22	N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003b	N/A	R3b. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Important to note that there is still work to be done on data quality,, which is being considered via performance teams and UEC board. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can commence on admission and information can be provided to facilitate a conversation.	Apr-22	~~Sep-22~~ N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_006	N/A	R6. Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	~~Jun-22~~ Aug-23	Red	31/10/2022- There are processes in place through the weekly panels, where process issues are identified, however as a UHB we are aware the learning is not routinely fed back. As part of the Policy Goal 5 Delivery Group work Safer review, learning will be considered and processes identified to support embedding this learning. As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by Improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the PG5 workplan, approximate timescale August 2023 for this process to be embedded. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-23~~ Mar-23	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_008	N/A	R8. Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	Apr-22	~~Jun-22~~ Aug-23	Red	31/10/2022- Related to the Policy Goal 5 Delivery Group Safer review and outcome measures. Approximate timescale of August 2023. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request progress of this recommendation. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_009	N/A	R9. A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	~~Jun-22~~ N/K	Red	31/10/2022- Director of Primary Care, Community & Long-Term Care confirmed this recommendation is to remain open- even if it is picked up under UEC as it is clear from recent reviews across all sites that in the main the discharge planning process commences at too late a stage following admission. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request approximate completion date for this recommendation. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting.
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001b	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	Oct-23	Amber	11/11/2022-Progress to be requested in early 2023 to ensure this is on track.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU_WHSSC_2122-02	Apr-22	Internal Audit	Glangwili Hospital Women & Children's Development, issued April 2022	Open	Reasonable	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	SSU_WHSSC_2122-02_005	Medium	R5. The Health Board should confirm provision of a Parent Company Guarantee in respect of Phase II of the Women and Childrens project at Glangwili.	5.1 Agreed. A new Parent Company Guarantee which includes changes to registered head office for both contractor and parent company, and the rebranding of the contractor, are in the process of being completed. The SCP is currently actioning, and has advised that this could take a further two months to complete.	Jul-22	~~Jul-22~~ ~~Sep-22~~ Mar-23	External	08/07/2022: Update received from Assistant Major Capital Development Manager as follows - "Extension of time agreed. The SCP has announced that it is becoming an independent company. Framework Managers to confirm new company status, and whether PCG or other form of guarantee is required." Revised extension of September 2022 provided, this is outside of our control to action and could take longer. 12/08/22-No changes, Interim General Manager Women & Children needs to respond. 09/11/2022 - Internal audit to request progress updates and revised timescales. 11/11/2022- Welsh Government has issued revised Parent Company Guarantees to Tilbury Douglas (external company) and are awaiting their response/sign off. Should be received by end November 2022. Revised timescale March 2023. This is not a scheme specific problem, but a framework problem across the whole of Wales re. Tilbury Douglas contracts. 09/01/2023- Tilbury Douglas when reviewing, modified and added a clause so now this sits with TD and the framework manager (shared services) for discussion. Awaiting response from Tilbury Douglas. Sitting outside the UHB to currently implement, recommendation changed from red to external, as agreed with Internal Audit. 01/02/23 - Framework manager continues to gain a response from TD. If a response is not recieved by end Feb 23 TD will be issued with a revised PCG. 16/03/2023- Updates remains as above.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004a	Medium	R4. Future Contracts - The timely completion of all contract documentation for respective parties involved at the project.	Agreed	Aug-22	~~N/K~~ Mar-23	Amber	12/08/22-evidence will be provided via a future action- for all approved contracts all are in place. Internal Audit to check on the background on the recommendation to establish when this can be closed. 07/09/22- IA to obtain clarification of what is required for this recommendation to be closed, or may need to remain open as a future action. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- RAG status changed from red to amber as this is a future action. Internal Audit to check if anything can be evidenced to close this recommendation.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004b	Low	R4. The Project Manager's report should be updated to reflect an accurate assessment of the status of project contract documentation	Agreed	Aug-22	Mar-23	Red	12/08/22- Completed- Capital Development Manager to send evidence to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_004c	Low	R4. The supervisor's contract should also be included within the Project Managers reports in the NEC contract status schedule (until completion)	Agreed	Aug-22	Mar-23	Red	12/08/22 Completed- evidence to be sent to Internal Audit. 07/09/22- Estates to send evidence to IA to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007a	Medium	R7a. Identity checks should be undertaken to ensure correct labour rates are being applied.	Agreed	Aug-22	Mar-23	Red	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007b	Medium	R7b. Additional labour rates should be contractually agreed by the UHB.	Agreed	Aug-22	Mar-23	Red	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007c	Low	R7c. Additional information should be supplied differentiation disallowed and unsubstantiated costs.	Agreed	Aug-22	Mar-23	Red	12/08/22-Internal Audit to check what is required to sign off recommendation. 07/09/22- IA to obtain clarification of what is required for this recommendation to be closed, or may need to remain open as a future action. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_009	Medium	R9. The UHB should ensure the interim cost benchmarking exercise is completed, providing assurance on the ongoing affordability (or otherwise) of the project.	Agreed – A draft affordability exercise has been undertaken and will be presented to the Project Group for discussion.	Sep-22	~~N/K~~ Mar-23	Red	12/08/22-on track 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- Still on track for March 2023 deadline, paper to Capital Sub Committee followed by SDODC highlighting the financial challenges of the project outturn. Internal Audit to check evidence submitted by the Estates team and if this can now be closed.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_010	Medium	R10. Further efforts are required to resolve the performance issue within the design team; and an effective audit trail of evidence needs to be maintained that supports the performance issues raised.	Agreed Whilst issues have been consistently raised locally, a meeting has been planned with the Directors/Senior Team of the Supply Chain Partner to further highlight performance issues.	Sep-22	Mar-23	Red	12/08/22-on track 07/09/2022- PA to Director of Estates & Facilities to send minutes/actions from WGH FEPG Meetings as evidence to close this recommendation. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 10/01/2023- improving trend is being reported through the project team meetings. Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided.
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_005	Medium	R4. The directorate should target areas with low compliance rates and set a deadline for achieving the Health Board target compliance rate of 85%.	Statutory and Mandatory Training Compliance being reviewed within Sister/Charge Nurse & SNM 1:1 on a monthly basis. Plans to be devised to work towards compliance rate of 85% by November 2022. To monitor compliance through monthly Budget & Management meeting – and target areas of non-compliance (also looking at allocated staff time/flexible working to support). Review individual statutory & mandatory compliance through PADR (especially with implementation of pay progression PDR).	Nov-22	Mar-23	Red	16/01/2023- still to be achieved, delayed due to vacancies, operational pressures, etc. Revised target date of end March 2023. 72.39% compliance rate for Unscheduled Care as of January 2023.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_001	Medium	R1. Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	In-patient falls group set up and Task & Finish group established to update Falls Policy.	Dec-22	~~Dec-23~~ ~~N/K~~ Jun-23	Red	20/01/2023 - Extended period of bereavement/sickness leave for Head of Nursing (Scheduled Care) resulting in meetings being postponed. Meetings now re-established and policy review in progress. Request has been made for final extension; date to be confirmed. 10/03/23 - The work that has been progressed so far was received at SNMT (09/03/23). Current Policy has been extended to June 2023 to ensure that all updates have been incorporated.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_002	Medium	R1. Consider re-launching the updated policy with an awareness campaign to ensure all clinical staff are au fait with the requirements	Falls policy following completion to be ratified through relevant Governance committees. Relaunch following approval	Feb-23	~~Feb-23~~ ~~N/K~~ Jul-23	Red	10/03/23- Once ratified further awareness raising of the revised policy and tools will be undertaken-Jul23
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_005	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	Apr-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_006	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	Apr-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_007	Medium	R5. Monitoring/review of falls incidents to identify those not investigated in a timely manner and noncompliance with the requirement for focused review. Issues identified should be addressed with the responsible individual(s), with action taken for repeated non-compliance where appropriate.	Scrutiny meetings to be reviewed and Terms of reference will be updated to include monitoring of falls incidents and quality of the investigation. Action identified to be reviewed at each meeting.	Jan-23	~~Jan-23~~ ~~N/K~~ Jun-23	Red	10/03/23- Further work is required through UHB falls Inpatient group to drive consistency and timeliness of investigations. This matter will be picked up at Improving Together sessions with Directorates.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_008	Medium	R6. Review existing governance arrangements for falls prevention and management and identify an appropriate forum for Health Board-wide sharing of lessons learned.	The Governance arrangements will be considered via the In-patient falls group and discussed with Assistant Director of Assurance and Risk.	Dec-22	~~Dec-22~~ ~~N/K~~ Jun-23	Red	20/01/2023 - Discussed at inpatient falls group and included in draft terms of reference; confirmation discussion with Assistant Director of Nursing scheduled for 2 February 2023. 10/03/23 - PNF in place, Inpatient falls group and Listening and Learning Subcommittee in place. DoN to review scrutiny arrangements.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_001	Low	R1. The entire catalogue of documentation must be reviewed and updated. All documents must have a date reviewed, and a due date for the next review to assist with confirming its relevance. We note that this could be partially or wholly addressed by the cyber security programme Policies and Procedures workstream.	We will add this recommendation to the policies and procedures workstream of the cyber programme to undertake a documentation review and ensure they are updated.	Mar-23	Mar-23	Amber	16/01/2023 - One policy updated and approved. 5 going to next IGSC.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_002	Medium	R2. The Health Board should have one asset management system that contains all necessary data for its identification and remote monitoring. It should contain enough information on each asset so that its make/model/os/SNo./location, assigned user etc is recorded.	The Health Board has procured the FreshService Asset Management module which is part of our Service Management tool. This will be integrated with our various management platforms to provide a single asset register for the Health Board. This work forms part of the Asset Management Workstream of the cyber programme.	Aug-23	Aug-23	Amber	16/01/2023 - Project is commencing and the kick-off meeting is 25th January 2023 to implement system.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_003	Medium	R3. Suppliers should be monitored regularly, at annual review points, to ensure all contractual obligations, including claimed standards and accreditations for themselves and their staff are being maintained.	This recommendation is being picked up as part of the supply chain security workstream of our cyber programme where assurances will be sought at contract award and annual renewal of their standards and accreditations.	Jul-23	Jul-23	Amber	16/01/2023 - Work in progress. On track.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_004a	Medium	R4a. All network management tools should be correctly configured so as to be able to identify and categorise alerts by importance/severity, and to assist with capacity management.	The Asset Management workstream will be integrating the Solarwinds Network Management tool with FreshService. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur.	Feb-23	~~Feb-23~~ N/K	Red	16/01/2023 - Work in progress. On track.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_004b	Low	R4b. A procedure for reviewing alerts and ensuring corrective actions are applied correctly and in a timely fashion should be created and documented so all existing and new staff can follow it and complete the review process within the required timescale.	We will add this recommendation to the policies and procedures workstream of the cyber programme to undertake a documentation review and ensure they are updated.	Mar-23	Mar-23	Amber	16/01/2023 - Work in progress. On track.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_005a	High	R5a. A process for patching of unpatched switches or other network components should be established. A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	A change process has now been developed for upgrading switch firmware and is being tested in Elizabeth Williams Clinic and Ty Elwyn This process will be documented as a standard change once successful and a programme of deployment across the organisation as part of "Securing the Boundary" cyber workstream will be created. It should be noted it is envisaged this programme would take many months as would need to be carefully planned to ensure minimum disruption for clinical areas.	Mar-23	Mar-23	Amber	16/01/2023 - Upgrades completed. Awaiting update.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_005b	High	R5b. All equipment that utilises obsolete/unsupported, or insecure operating systems should be located, updated, removed, replaced, or isolated as a matter of urgency. An asset management process should be created, documented, and implemented to ensure the obsolescence of all equipment is monitored so that this situation cannot recur.	This work is already underway, and the latest dashboard is shows that over 99% of the desktop estate has been updated and the last devices remaining are a challenge due to legacy systems in use. The "securing the servers" workstream is improving patching compliance, deploying new anti-virus platform, and removing legacy objects and a dashboard is under development. Monitoring is now undertaken through NESSUS and Windows Defender which highlight old items.	Sep-23	Sep-23	Amber	16/01/2023 - Upgrades completed. Awaiting update.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_006	Low	R6. All data held, and that is about to be created by the digitisation project, should be reviewed and its data-quality dimensions established as per the HMG data quality framework. An assessment of the likely required network capacity should be undertaken to ensure that the network can handle the increased traffic.	The review of scanned images is a component of the Digitalisation of Health Records Project and CITO (our supplier) complies with the relevant ISO certification for health records scanning. The scanning communications take place between the scanning providers and our Azure platform therefore this process sits outside our network. However, network upgrade projects are underway at WGH and PPH hospitals and this will include capacity assessment.	Mar-24	Mar-24	Amber	08/03/2023 - Update from Carolyn: Preferred solution is cloud-based and therefore not on prem which means it should not impact our network. Expecting report some time in March 2023 (Auditor not raised this question yet).
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_003	N/A	R3. DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	This is agreed and linked to above development of the DAP costings and investment strategy development.	Mar-25	Mar-25	Amber	20/12/22- Internal Audit report states deadline to be aligned to meet targets for 2025 and 2030. 23/01/2023- to be clarified with Director of Strategic Development & Operational Planning if there is secured funding or outline where the funding will be sourced from.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_004	N/A	R4. NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	This is agreed. There is a requirement for Welsh Government to establish a fixed baseline that will better supports HBs to target set and reduce risk of reporting inaccuracies.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_008	N/A	R8. Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	This is agreed.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_009	N/A	R9. In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	This is agreed. The HB to utilise to the WG / PHW Carbon Awareness documentation once this is established.	N/A	N/A	External	20/12/22- Internal Audit report states Subject to external timescales, but this will continued to be monitored. 23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_015	N/A	R15. The Health Board should, as a matter of priority, ensure the following from the Decarbonisation Action Plan is fully realised: Delivery Plan to be developed into detailed and costed departmental actions plans, in areas of transport, procurement, buildings and wider healthcare; and build responsibility for delivery across the organisation through divisional action plans and workstreams aligned with mapped objectives– assigning specific projects as required.	Submitted the Delivery Plan to Board for approval – Board approval provided 29th September. The HB DAP was the few plans to identify early funding need to enable us to deliver early win projects, develop design feasibility that will inform the DAP funding costs and investment strategy going forward. The HB to continue to explore opportunities to secure funding to support this work.	Jan-25	Jan-25	Amber	20/12/22- Internal Audit report states AP plan to align to funding opportunities and be targeted to meet targets for 2025 and 2030.
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_003a	High	R3.1 The WLS Team should chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director	The WLS Team to chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director, and support directorates and services, who request it, in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	~~Sep-22~~ Mar-23	Red	05/12/2022 - This report superseded HDUHB-2122-12. 05/12/2022 - The action required in response to the recommendation has yet to be fully implemented. Whilst the majority of directorates and services have submitted a completed self-assessment tool to the Welsh Language Team, returns have not been received from the Nursing and Operations Directorates. A revised timescale for obtaining these has been set as the end of December 2022, which has been noted within Risk No.1232 on the Health Board risk register. A revised target completion date has been set for March 2023. Conclusion: Action Ongoing – Further Action Required. 20/02/2023 - Nursing have now completed their self-assessment. Operations Directorate still in the process of completing theirs. Service to chase up whether this will be completed by March 2023. 15/03/2023 - As of yet, still no response from Ops Directorate on this - they are going to check in with them this week to see how far they have progressed.
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_003b	High	R3.2 The WLS Team should support directorates and services in their development of action plans to address areas of non-compliance with the Standards.	The WLS Team will support directorates and services that engage with them in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	~~Sep-22~~ Mar-23	Red	05/12/2022 - This report superseeded HDUHB-2122-12. 05/12/2022 - The action required in response to the recommendation has yet to be fully implemented. Whilst the majority of directorates and services have submitted a completed self-assessment tool to the Welsh Language Team, returns have not been received from the Nursing and Operations Directorates. A revised timescale for obtaining these has been set as the end of December 2022, which has been noted within Risk No.1232 on the Health Board risk register. A revised target completion date has been set for March 2023. Conclusion: Action Ongoing – Further Action Required. 20/02/2023 - Nursing have now completed their self-assessment. Operations Directorate still in the process of completing theirs. Service to chase up whether this will be completed by March 2023. 15/03/2023 - As of yet, still no response from Ops Directorate on this - they are going to check in with them this week to see how far they have progressed.
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_004	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	~~Mar-23~~ ~~Mar-23~~ Apr-23	Red	05/12/2022 - This report superseded HDUHB-2122-12. 05/12/2022 - The Welsh Services Manager confirmed that the Steering Group will be formed once the Welsh Language and Culture Discovery report has been completed. The target date for this is by the end of March 2023. Conclusion: Not Implemented – Further Action Required 15/03/2023 - Aiming to establish the Steering Group in April 2023.
HDUHB-2223-10	Jan-23	Internal Audit	Continuing Healthcare and Funded Nursing Care	Open	Reasonable	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Head of Long-Term Care	Director of Primary Care, Community and Long Term Care	HDUHB-2223-10_003	Medium	R3. A formalised reporting structure should be introduced that allows for appropriate monitoring and assurance reporting to the Health Board or appropriate sub-committee.	There has been some work to try to develop a reporting template with the Corporate Team to align reporting with IPAR, however due the CHC sitting in 3 separate directorates it was difficult to combine these into a single format. Following discussion with the Director of Primary, Community and LTC an agreed format for scrutiny and performance monitoring will be in place going forward with the monthly service reports: Community & Care Home Report, LTC Pathway Report & Summary, Community Packages, LTC & DoLS staff Report, Monthly Performance, and Corporate Report. These are scrutinised monthly and challenged in a quarterly Key Performance meeting with the Head of Service and Team Leads. These reports will be sent to the Director of Primary Community and LTC for further Scrutiny on a quarterly basis prior to the planned dates for the Strategic Development & Operational Delivery Committee (SDODC). The Reports will then be summarised and submitted to SDODC for Executive oversight.	Feb-23	Jun-23	Red	22/02/2023- Senior Nurse Manager (Long Term Care) confirmed this has been delayed due to current workforce changes in the LTC team (performance manager role starting in April 2023, and Head of Long Term Care retiring in March 2023 with replacement to start in May 2023), with a revised date of June 2023 has been provided.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_001	N/A	R1. Develop/Approve Programme governance and management framework – defined within a Project Initiation Document.	The existing Project Execution Plan proforma utilised for capital projects will be developed for the overall programme.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_002	N/A	R2. Consideration should be given to establishing the Programme Group as a formal Committee of the Board.	To be considered as part of the overall governance requirements of the programme.	Jan-24	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'To be considered in advance of the Outline Business Case stage'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_003	N/A	R3. The terms of reference of the Programme Groupshould clearly defined activities within and outside of scope.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_004	N/A	R4. When linkage is required to the Executive Team/ Executive Steering Group, the accountability arrangements should be clearly defined.	Agreed.	Jan-24	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'As required'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_005	N/A	R5. Linkage to the Major Infrastructure PBC will be defined.	To be considered as part of the overall governance requirements of the programme.	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_006	N/A	R6. Terms of reference should be updated to confirm those members with and without delegated authority.	Only Health Board employees will have decision making responsibility and this will be confirmed with in respective terms of reference.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_007	N/A	R7. Project Initiation Documents should be produced for all workstreams.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_008	N/A	R8. Programme Team to set master programme targets to inform workstream targets.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_009	N/A	R9. The master programme should be activity/ task based.	Agreed.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_010	N/A	R10. The existing slide pack reporting to the Programme Groupshould be enhanced to include performance monitoring.	A full review will be undertaken of the slide pack to incorporate changes suggested at the audit and other best practice observed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_011	N/A	R11. The changes outlined should be extended to the Programme Team monitoring of the workstreams.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_012	N/A	R12. A concise and standardised method of workstream monitoring and reporting should be introduced.	The terms of reference will clearly state whether workstreams should produce action orientated or full minutes. A consistent format will be applied across all workstreams.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_013	N/A	R13. An activity-based resource schedule will be produced for the Outline Business Case stage.	A resource plan has been agreed for the current stage, however a full exercise is required for the next stage.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_014	N/A	R14. Existing Health Board staff (including the SRO and Executive Team) will be advised of the expected level of commitment anticipated for the production of the Outline Business Case.	Agreed.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_015	N/A	R15. Adequate representation will be secured from all key functions e.g workforce, clinical, finance, IT, hotel services etc.	Agreed.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_016	N/A	R16. Having identified the resource requirement to prepare each aspect of the Outline Business Case, the Health Board should seek to build its own internal resource/ expertise.	Agreed.	Sep-23	Sep-23	Amber	
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-002	Medium	R2.1 Ensure POL audits are completed as soon as possible for the remaining MH&LD sites and risk scores are correctly calculated in line with procedure.	We will complete POL audits for the outstanding Older Adult, Primary Care and Older Learning Disability Community Teams	Aug-22	Mar-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 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. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-003	Medium	R2.2 For the POL audits already completed, review and update the overall risk scores in line with procedure.	Risk scores will be rectified and the Risk Assessment Document will be amended.	Aug-22	Mar-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 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. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-004	Medium	R3.1a Update the POL action plan template to identify deadlines for completion of actions to address identified ligature hazards.	Actions arising from POL audits will be monitored through to implementation by the MH&LD Accommodation Group, with assurance reporting to the directorate Quality, Safety & Experience Group (QSEG).	Aug-22	Mar-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 3.1b 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.Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-005	Medium	R3.1b Actions to be monitored through to implementation by the MH&LD Accommodation Group, with assurance reporting to the directorate Quality, Safety & Experience Group (QSEG).	All training completed by Team Leaders (who are responsible for undertaking the audits) for each clinical area or community site.	Aug-22	Mar-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 3.1c Actions should be monitored through to implementation, with assurance reported to an appropriate forum/sub-committee. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_001	Low	R1. The Terms of Reference should be reviewed for appropriateness and subsequently re-approved.	The Terms of Reference were circulated at the January 2023 Project Group and any changes will be ratified at the February 2023 Project Board meeting.	Apr-23	Apr-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_002	Medium	R2. The UHB should liaise with Specialist Estates Services to agree a framework approach to ensuring the SCP completes contractual documentation in a timely manner.	Future assurance – at future contracts	N/A	N/A	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_003	Medium	R3. Ensure the call of contract guarantee for the SCP is appropriately signed.	Actioned since audit fieldwork.	N/A	N/A	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_004	Low	R4. Reporting within the WG dashboard reports should be enhanced to ensure a consistent message is being shared.	The sensitivity analysis reported within the commercial report will be embedded within the dashboard to provide the potential forecast outcomes based on current assumptions.	May-23	May-23	Amber	09/03/2023- Estates colleagues confirmed this recommendation is on track for May 2023 timescale.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_005	Medium	R5. Identity checks should be undertaken to ensure that the correct labour rates are being applied.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_006	Medium	R6. Additional labour rates should be removed or agreed with the UHB as a contractual amendment.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_007	Medium	R7. A time & cost analysis of shared resource across both GGH and WGH project should be undertakento demonstrate value for money.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_008	Low	R8. Additional information should be supplied within the commercial report differentiating disallowed and unsubstantiated costs.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_009	Medium	R9. Delegated limits should be reviewed to provide an upper financial limit for Project Manager approvals. Where external resource is used to support items such as room clearances; these instances should be recorded/ approved by the UHB.	Enhanced approval mechanisms will be implemented. However, the requirement for external resource will be reduced with the approval of soft FM support for the project at the January Project Group.	Jul-23	Jul-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_010	Low	R10. The reporting of project changes should be made more specific and meaningful for the Project Group.	Enhanced approval mechanisms will be implemented. However, the requirement for external resource will be reduced with the approval of soft FM support for the project at the January Project Group.	Apr-23	Apr-23	Amber	
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_011	Medium	R11. Further efforts are required to ensure design resolutions are undertaken in a timely manner; and an effective audit trail of evidence needs to be maintained that supports the performance issues raised with the contractor.	UHB will co-ordinate with the Project Manager to ensure the performance of the design team is improved.	May-23	May-23	Amber	
SSU-HDUHB-2223-02	Feb-23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	SSU-HDUHB-2223-02_001	Low	R1. Overall project cost performance should include the additional project sponsorship fees.	Project cost performance reporting will include additional project sponsorship fees.	Mar-23	Mar-23	Amber	16/03/2023- Reporting of sponsorship fees will be addressed in the CA report due at the end of the month.
SSU-HDUHB-2223-02	Feb-23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	SSU-HDUHB-2223-02_002	Low	R2. The Project Manager's report should ensure clarity as to the outstanding number of Compensation Events, Early Warnings and other notifications awaiting action by the client and the SCP.	The Project Manager will clearly report the outstanding number of Compensation Events, Early Warnings and other notifications awaiting action by the client and the SCP.	Mar-23	Mar-23	Amber	16/03/2023- Reporting of CE's will be addressed in the PM report due at the end of the month.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU-HDUHB-2223-02	Feb-23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	SSU-HDUHB-2223-02_003	Low	R3. Management should undertake a lessons learnt review of the project following completion.	An interim lessons learnt exercise was undertaken in 2021. A Capital Governance Review was also undertaken in 2021 whichhas picked up on learnings from previous audit reports on the scheme. A lessons learnt exercise will be carried out 6-12 months after scheme completion in line with best practice.	Dec-24	Dec-24	Amber	16/03/2023- Lessons learnt review will take place when construction activity is complete. Target date December 2024.
SSU-HDUHB-2223-02	Feb-23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	SSU-HDUHB-2223-02_004	Low	R4. The cost of items of potential challenge, should be separately identified from risk provision e.g. as separate Health Board contingency within the project forecast.	We will identify this sum separately from the risk provision.	Mar-23	Mar-23	Amber	16/03/2023- Reporting of cost for disputed items. Actioned in CA report presented to Project Team on 14/03/2023. Evidence to be submitted to Audit.
MHRA-28172/119309-0018	May-22	MHRA	Insp BLCA 28172/119309-0018 - Withybush General Hospital	Open	N/A	Pathology	Pathology	Hannah Albery	Director of Operations	MHRA-28172/119309-0018_012c	High	R12. Laboratory training was inadequate in that there has been no assessment to determine staff training requirements for the maintenance and troubleshooting of the Ortho Vision analyser. For example, staff could not demonstrate how to troubleshoot analyser maintenance failures to bring the analyser back into operational use.	Review training and competency documentation for Ortho Vision analyser to ensure it adequately covers maintenance and troubleshooting.	Jun-22	~~Jun-22~~ ~~Sep-22~~ ~~Feb-23~~ ~~May-23~~ Sept-23	Red	05/09/22 - will be reviewed post training on 07/09/22. 25/10/22 - training provided by OD but it was felt that this didn't fully address the training the MHRA has noted in the finding. Funding has been agreed to send the blood bank manager at WGH and one other member of staff to the advanced operator training that OCD provide. 21/12/22 - Study leave forms completed for two members of staff and they are due to attend the training in May 2023 15/03/2023 - The training has been postponed until September 2023.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ Jul-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ Jul-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the M 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.WWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023.
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.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ Jul-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023.
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.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ Jul-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023.
BFS/KS/SJM/00114719- KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719-KS/890/04	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Apr-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22. 20/12/2022- A programme completion date will be developed as the above BJC work is progressed to encompass the work content and complexity of this Phase 2 project. Early indications are that due to the multiple Decant needs of Ward areas the programme may need to be extended as part of the due diligence work within the Business Case. As this becomes more developed, MWWFRS will be fully involved in these discussions so that appropriate changes can be made to the Phase 2 Enforcement dates. This matter has been discussed with MWWFRS who appreciate that a revision may be required to this programme should the nature of the works dictate that an extension to this timeline becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2025 date.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ Jul-23	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct 20~~ ~~Feb 21~~ ~~Jul 22~~ ~~Feb 23~~ Nov-23	~~Jul 22~~ ~~Feb 23~~ Nov-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. 20/12/2022- A revised completion date of November 2023 has now been accepted by the Project Management Team following all their due diligence checks. This programme update has been fully reported to the MWWFRS in a formal meeting held on 08/12/2022 and they fully accept the need for this adjustment. MWWFRS have noted that they will look to revisit the UHB prior to the currently set end date (February 2023), so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is November 2023.
KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/09_01	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct 20~~ ~~Feb 21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid-November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme, should the nature of the works dictate that an additional period of time becomes necessary. 20/12/2022- It is important to note that Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Regular discussions continue with MWWFRS, including a formal meeting held on 08/12/2022, who appreciate that a revision may be required to the FEN dates should the nature of the works dictate that an additional period of time becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2024.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_002	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. • Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	~~Oct 22~~ Mar-25	~~Oct 22~~ ~~Mar 23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivey plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_003	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	~~Oct 22~~ Mar-25	~~Oct 22~~ ~~Mar 23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivey plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_005	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct 22~~ Mar-25	~~Oct 22~~ ~~Mar 23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. All remaining doors under future phasing Overarching delivey plan for the site is to March 2025.Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_007	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	~~Oct 22~~ Mar-25	~~Oct 22~~ ~~Mar 23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_008	High	Item 4- R8. All door release devices (including floor pneumatic release devices) should work in accordance with the relevant British standard: BS 7273-4:2015 actuation of release mechanisms for doors and comply with WHTM 05-02 Appendix C: Door Closers and Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. • Diabetic unit • This action should be carried out over the whole site and as part of the fire door survey mentioned in item 1 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22 Mar-24	~~Oct 22~~ Mar-24	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. This recommendation will be picked up in phase 1 as part of the EFAB funding for 2023/24. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Will be addressed in Phase 1. Completion date March 2024.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_013	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to 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.	Full action plan held by Estates.	~~Oct-22~~ Mar-23	~~Oct-22~~ Mar-23	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of completion by March 2023. Recommendation moved back from red to 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_002	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. WHTM 05-02 Chapter 5 and paragraph 5.12. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-23	~~Oct-22~~ Mar-23	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of completion by March 2023. Recommendation moved back from red to 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_003	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Revised date of Maarch 2024 provided and agreed by MWWFRS. Recommendation moved back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_001	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022-AFT survey now completed. Detailed costs obtained for 106 repairable doors. Site review with NWSSP-SES to agree prioritisation of door replacements for EFAB funding. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_003	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_004	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_005	High	R5. The cross-corridor doors in "Picu" was missing a self-closing device. A self-closing device is required on this door to ensure it closes fully into its rebate.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year. 15/12/2022- Head of Estates Risk & Compliance to confirm with GGH colleagues if this recommendation is now implemented. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_008	High	8. A hold open device (or alternative solution) is required on the "Step Down" kitchen door. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Brongiais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Brongiais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498 _003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498 _004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498 _005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498 _006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout the block. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Unscheduled Care (BGH)	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498 _007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ Mar-23	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response. 10/01/2023- The Fire Defence plan is now being reviewed based on the evacuation exercise planned for February 2023, which will give evidence of the number of additional staff needed to comply with fire service recommendations. Additional staff needed will be in place following this February 2023 review and we will ensure the defence plan is fully signed off by end March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. 08/03/2023- Meeting scheduled with GM at BGH 09/03/2023 to sign off the plan.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499 _001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499 _002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
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Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499 _004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499 _005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027.
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Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500 _001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
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Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
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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_001	High	R1.A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_004	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc	Open	N/A	Estates	Estates	Director of Estates, Facilities and	Director of Operations	Admin - General/00329501_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_006	High	R6. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Unscheduled Care (BGH)	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ Mar-23	Red	02/11/2022- awaiting final confirmation that this has been completed. 10/11/2022- Fire Management Plan has been issues to BGH Management team, awaiting response. 10/01/2023- The Fire Defence plan is now being reviewed based on the evacuation exercise planned for February 2023, which will give evidence of the number of additional staff needed to comply with fire service recommendations. Additional staff needed will be in place following this February 2023 review and we will ensure the defence plan is fully signed off by end March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. 08/03/2023- Meeting scheduled with GM at BGH 09/03/2023 to sign off the plan.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_008	High	R8. An assessment should be undertaken to ensure all Internal and external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Dec-22	Dec-25	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion December 2022. 10/01/2023- Head of Estates Risk & Compliance to check if this has been implemented. 13/01/2023- A scheme has been completed to address all vertical escape routes with new emergency lighting, all remaining areas of the block will be considered as part of the main firecode scheme as agreed with MWWFRS. Revised date of December 2025 provided to encompass all works at the BGH site. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to December 2025.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_001	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_002	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_003	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_004	High	R4. Remove the printer photocopier from within the area F84. This appliance should be located within a hazard room.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_005	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_006	High	R6. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided at; • All external escape routes Signs should be designed and installed in accordance BS 5499-4:20	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_007	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_008	High	R8. Locate the solar PV isolator in a position away from the roof area or add a device that would allow isolation away from an area of risk.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023.
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_001	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jun-23	Jul-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_003	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Dec-22	~~Dec-22~~ Apr-23	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_004	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-24	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_005	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	Aug-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_006	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_007	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_008	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_009	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Jul-24	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_010	Low	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	Dec-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_011	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ N/K	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_012	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ N/K	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_013	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ N/K	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_014	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	Mar-24	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_015	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ N/K	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_016	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jun-23	Jun-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_018	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_019	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_020	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_021	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_022	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_023	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	Mar-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_024	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jul-23	Jul-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_025	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	Aug-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
PR_RCR0616	Jun-16	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	PR_RCR0616_001	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	Ongoing	N/K	Red	10/02/2022 - Recommendation owner amended to reflect recent changes in SDM role. 10/01/2023- Weekly meetings continue between the Clinical Lead and SDM. Recruitment remains a challenge within Respiratory with Consultants and Middle Grades supporting services, this continues to put huge stress on the respiratory system . The plan to train-up known junior doctors remains ongoing but this is a medium term plan. 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. We do currently have a bcum consultant working remotely managing the general chest waiting lists across the sites to alleviate pressure on sub speciality work Following our Away Day an IMTP is currently being drafted which includes the succession plan for the Lung Cancer Service and this involves the planning and recruitment of one of our existing Middle Grade Doctor to become a Consultant to support the robust provision of lung cancer. Cancer Services continue to work alongside the service management team monitoring cancer waiting times in their weekly lung cancer MDT tracker meetings. 16/03/2023- Funding sources have been obtained from establishment across Carmarthenshire and sites to provide lung cancer services across the UHB footprint, the barrier now facing the service is the difficulty in recruiting the middle grade doctor. At present the Hospital Director is long working as the only consultant for the lung cancer service. A succession plan is in place but recruitment remains difficult. A risk is to be added to Datix to capture the difficulties in recruiting and the risk to the sustainability of the service due to the dependency on one consultant. Once the risk is added this recommendation will be raised to the Director of Operations to request the recommendation be closed
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director.	Dec-19	~~Dec-21~~ ~~Oct-22~~ N/K	Red	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 (e.g. SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 19/01/2023 - Finalising Management response to this Peer Review is on the agenda for the meeting planned for 24/01/23 to be discussed by SDM 23/01/23- paper to be presented at QSEC on 14/02/2023 10/03/2023 - letter of response to the Peer Review team was drafted, and this accompanied by the table of actions will be shared with the Assurance and Risk team.This new report will supersede the 2019 Peer Review.
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_003	N/A	R3. Multi-Disciplinary Workforce Physician Associates to also be considered as part of the longer term strategy.	This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign.	Mar-20	~~Dec-21~~ ~~Oct-22~~ N/K	Red	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 (e.g. SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 19/01/2023 - Finalising Management response to this Peer Review is on the agenda for the meeting planned for 24/01/23 to be discussed by SDM 23/01/23- paper to be presented at QSEC on 14/02/2023 10/03/2023 - letter of response to the Peer Review team was drafted, and this accompanied by the table of actions will be shared with the Assurance and Risk team.This new report will supersede the 2019 Peer Review.
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_006	N/A	R6. Wider Workforce Planning The clinical competencies framework need to be considered for supporting ACP's, UCP, HCSW etc. and should now drive the future workforce planning	Initial meetings with Assistant Directors of Nursing have taken place. Senior Workforce Development Manager is assisting in mapping out workforce requirements.	Dec-19	~~Dec-21~~ ~~Oct-22~~ N/K	Red	10/03/2022 – The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (eg SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 19/01/2023 - Finalising Management response to this Peer Review is on the agenda for the meeting planned for 24/01/23 to be discussed by SDM 23/01/23- paper to be presented at QSEC on 14/02/2023 10/03/2023 - letter of response to the Peer Review team was drafted, and this accompanied by the table of actions will be shared with the Assurance and Risk team.This new report will supersede the 2019 Peer Review.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical /operational staff In hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	~~Mar-20~~ ~~Oct-20~~ ~~Dec-21~~ ~~Oct-22~~ N/K	Red	10/03/2022 - Deputy Director of Operations to meet with ED of Operations to determine if this recommendation is relevant as at March 2022, given initial report raised in November 2019. 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 19/01/2023 - Finalising Management response to this Peer Review is on the agenda for the meeting planned for 24/01/23 to be discussed by SDM 23/01/23- paper to be presented at QSEC on 14/02/2023 10/03/2023 - letter of response to the Peer Review team was drafted, and this accompanied by the table of actions will be shared with the Assurance and Risk team.This new report will supersede the 2019 Peer Review.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Digital and Performance	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_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.	Mar-22	~~Mar-22~~ ~~Dec-22~~ Mar-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 IT system development under way- work has commenced and categories to record and prioritise have been identified- awaiting completion by IT team and then paeds teams will need to commence data inputting. Project is more significant and labour intensive than initially predicted - this is reflected in the amended completion date 05/08/2022 - work is ongoing with system development 18/8/2022 - e-mail from IT Gareth Beynon. Following meeting with SDMs implementation put on hold as part of wider work in paediatric IT system 30/11/2022 = This action is now formally a part of a wider piece of coding work to include Community Paediatrics. The Cardiology code has been assigned and the list is currently being evaluated and validated as a part of a wider IT workstream due to be concluded by 31.03.2023 25/01/23- creation of sub-speciality clinical codes will be undertaken by Information Services' team
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_004	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External	03/05/2022 - Health Board are still awaiting receipt of the standardised national template. Unable to progress the recommendation until received, therefore status amended to External. 30/06/22 no update to position- template awaited. However, access to "Cardiobase" for Cardiff- based cases has now been formally secured for all HD PECs 18/08/2022 - standard national template still awaited 30/11/2022 - no further progress or update since last review
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_007	N/A	Each designated paediatrician with expertise in cardiology will attend (in person or by VC link) the weekly network MDT meeting at least six times per year, and must also attend the annual network meeting. This requirement will be reflected in job plans.	Job plan review	Mar-22	~~Mar-22~~ ~~Oct-22~~ Mar-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- all clinicians actively engaging as per descriptor- yet to be formulated in job planning but this is to be addressed following appointment of new clinical lead 18/08/2022 - actions completed however need embedding in job plan 30/11/2022 - job planning under way - to be completed during Q4 2022/23
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_009	N/A	Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health professionals.	Job plan review	Mar-22	~~Mar-23~~ ~~Oct-22~~ Mar-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 - every cardiac clinic has a PEC when held, and covers all sites. Further clarification on job plans required and a revised timescale. 30/06/22- all clinicians actively participate within the network and work in collaboration with the tertiary consultants. Job planning activity yet to be completed but will now be revisited following appointment of new clinical lead. Job planning will also support the development of formalised honorary contracts. 18/8/2022 - Awaiting job planning & honorary contract 30/11/2022 - Job plans to be completed (in progress) during Q4 2022/23- 1 honorary contract arranged.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ N/K	Red	30/11/2022 - Initially unable to agree additional Echo technician capacity due to existing constraints in capacity- however, discussions and solutions are being revisited with Echocardiology team and Cardiology SDM. Unable to assign a date at this time. 19/01/23 - Discussion under way with Cardio-Respiratory department who would need to identify resources. Potential revised date to be identified after this discussion.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Digital and Performance	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_018	N/A	Each Local Children's Cardiology Centre will have a robust internal database for congenital cardiac practice with seamless links to that of the Specialist Children's Surgical Centre.	Needs to be developed/improved	Jun-22	~~Jun-22~~ ~~Oct-22~~ Mar-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- The HB system in development will support this - and in collaboration with "cardiobase" this situation will improve 18/08/2022 - awaiting IT to finalise 30/11/22- This action is now formally a part of a wider piece of coding work to include Community Paediatrics. The Cardiology code has been assigned and the list is currently being evaluated and validated as a part of a wider IT workstream due to be concluded by 31 March 2023 25/01/2023- further update, creation of sub-speciality clinical codes will be undertaken by Information Services' team 09/03/2023 - We have digitised our waiting lists, database is now much more robust. There is direct access to Cardiff IT system (Cardiobase). Cardiff cardiologists can access our imaging database. IEP (Image Exchange Portal) has been set up to enable echo image transfer direct to Bristol. Progress with WPAS and coding to be provided by Service's SDM or SM.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_021	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	~~Nov-22~~ N/K	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_022	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	~~Nov-22~~ N/K	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_023	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment.	Response requested from lead officer.	Nov-22	~~Nov-23~~ N/K	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	~~Mar-22~~ ~~Jan-23~~ N/K	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - discussions have commenced with the dental pathways, awaiting further response to progress the recommendation. 30/06/22- HB Dental leads continue to review the process- update requested from deputy director today 18/08/2022 - Awaiting update 30/11/2022 - Paeds service still awaiting update from HB Dental service- SDM has chased. 25/01/2023-AMD- Dental has identified a pathway in SBUHB and is assessing whether this is a primary pathway that would be accessed by HDUHB patients. 09/03/2023 - Discussion with DoN at the IT meeting to clearly identify what sits outside of our direct influence/ responsibility- this may be one as dental services have their own management structure. Update on issues in relation to dental risks from a patient-facing perspective: all patients at risk are advised to have good dental care and see a dentist regularly. Difficulty accessing NHS dentists is a potential contributor to increased risk. SM to provide an update on the timeline for the coding rollout if any available.Including advice on dental and other IE prophylaxis now every clinic letter.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_001	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ Mar-24	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Approach is via ARCH. 24/08/2022 - DB to update PR. 22/02/2023 - Debra Bennett has met with MDT lead and update sent to Mr Rao. Response said this is part of their Pathology program, building central facility in Morriston. FBC will be signed off in next 3-12 months - no progress expected until after this.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_002	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ Mar-24	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. 22/02/2023 - Currently working with Swansea Bay on Strategic Business Case. This piece of work is included. Relooking at whole Oncology service for whole S.Wales. Within next 12 months, single-handed Oncologist is going to have review of work plan and build better clinical governance into her practice up north - details TBC.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_003b	N/A	R3. Pathway Performance. The SCP pathway performance is 51.8% for the Health Board (see appendix 4), however the SCP target is 75%.It is acknowledged that achieving this target while recovering from the pandemic is challenging.	Develop a FIT in Primary Care pathway	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ Apr-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. We are developing a FIT Testing pathway for Primary care. This is anticipated to streamline our referral pathways and facilitate optimised use of diagnostic resources. This should potentially significantly improve pathway time compliance. 22/02/2023 - FIT pathway being rolled out to Primary Care April 2023

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_001	N/A	R1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as oneHealth Board and not hospital by hospital.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_002	N/A	R2. Review the detail of the Orthopaedics Action Plan at Annex A which includesrecommendations about identified unwarranted variation	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_003	N/A	R3. There is currently an appointed Orthopaedics Health Board Clinical Lead (CL). This is akey strength of the Hywel Dda Orthopaedic service, which is lacking in some of the otherHealth boards that have multiple silo Orthopaedic units. The CL clearly projects a unifiedvoice from the 3 Orthopaedic units in Hywel Dda despite their geographical distance.We are concerned however that the CL is not supported by the HB in making the essential operational and strategic changes required. We recommend that throughenhanced management support, the Orthopaedics Clinical Lead role is enabled toinstigate Health Board level change at pace and empowered to provide steer anddirection to the Health Board executive team on regional models of working withneighbouring Health Boards.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_004	N/A	R4. HDUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent needto re-engagewith clinicians to rebuild trust and ensure that they are listened to andinvolved at each stage of restart and change proposals. It is imperative that cliniciansare an integral part of the "sign off" and delivery of changes.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_005	N/A	R5. Carry out a staff survey without delay to understand the issues affecting staff morale andhow these can be addressed. We consider that improved and open communicationwithcolleagues about the short, medium and long term plans will help to improve staff morale. We do recognise, that there are a number of recent factors affecting staffmorale.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_006	N/A	R6. Implement elective recovery at pace. We are aware that capital investment is currently limited. However, most of our recommendations rely on better use of existing assets and on using revenue budgets and resources more efficiently. We expect that an urgentinitial plan, which sets out how the Health Board will fully restart orthopaedic surgery tobe inplace, no later than the end of March 2022. Any barriers or risks to delivery of this plan need to be urgently resolved. The plan should include a communication and engagement plan with all patients so that patients fully understand the timetable for their surgery.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_007	N/A	R7. Patients for elective surgery to be assessed as part of the pre-admission process andany equipment that may be required be delivered to the patient's home prior to admission. For emergency admissions (e.g. fracture neck of femur), these should be assessed early on during their admission to agree their likely support package, whichcan be tweaked if the patient's condition changes. Currently, a Social Servicesassessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficientuse of valuable beds, thereby reducing elective surgical admissions. We needa risk share between the hospitals and Social Services as elective patients aredisadvantaged due to lack of bed availability.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_008	N/A	R8. Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recordedand used across all Health Boards.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_009	N/A	R9. We recognise that the Health Board do review litigation claims, which we are pleased tosee. They should, however, broaden this to a programme which ensures that litigation claims are regularly reviewed in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient careor documentation could be improved. Claims should be discussed in clinical governance meetings to share the learning; junior doctors should also be involved in these review meetings. Claims should be triangulated with learning themes from complaints, inquestsand serious untoward incidents (SUI) and where a claim has not already been reviewedas a SUI we would recommend that this is carried out to ensure no opportunity for learning is missed. Note that we did find some good practice in reviewing litigation claimsbut we think it could still be improved.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_010	N/A	R10. Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular reviews of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_011	N/A	R11. As part of the medium and longer term orthopaedic planning, all outsourcing and external commissioning of services should be reviewed. The aim should be to deliver all outsourced activity to the same level and standard e.g. the minimum number of knee revisions by one consultant.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012a	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Carry out full demand and capacity planning and do this across the Health Board and in collaboration with neighbouring Health Boards and other providers who can serve HDUHB.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012b	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Set up a weekly sitrep specifically focused on elective recovery with the Executive.This should include all patients waiting for elective orthopaedic surgery and sub categorised by: ASA score; time on waiting list; both expected and actual operations carried out on a weekly basis and reasons, if underperformance. There needs to be close scrutiny of forward projections to reduce waiting lists with robust targets set. These should also include adoption of the HVLC pathways and ensure 90% of those cases are Day Case. We suggest that to gain optimum momentum in elective recovery that the sitrep should cover all elective surgery and not just orthopaedics. In our report to the Welsh Government, we will be recommending that these sitreps are provided weekly until Elective Recovery is on track and the risk to patients is reduced.	Awaiting management response.	N/K	N/K	Red	

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RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012c	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Establish a delivery model to restart elective recovery. This needs to be established at pace. RNOH/GIRFT supports the development of Prince Philip Hospital (PPH) as the designated HVLC centre for the HB and as a centre for more complex LVHC work. There is also an opportunity to develop PPH as a regional LVHC centre in collaboration with SBU. Centralisation of trauma services to a single site in the South of Hywel Dda at Glangwili General hospital (GGH) would provide additional capacity at the Withybush General Hospital (WGH) site creating additional capacity for ambulatory trauma and short stay elective workload. Increased elective capacity at the BGH site would provide additional regional capacity for South Gwynedd (BCU) and West Powys. Ensure this unit is appropriately staffed.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012d	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Develop a recovery plan of how to effectively utilise Glanwilli (Trauma Centre)Bronglais and Withybush Hospitals.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012e	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012f	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Develop an enhanced recovery unit operated 24 hours a day, seven days a week, that allows upskilled nurses to provide care and assessment to the sickest and most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012g	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Upskill and empower therapy staff to undertake greater roles.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012h	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012i	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012j	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	Awaiting management response.	N/K	N/K	Red	

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RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012k	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012l	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Where there is recognised "good practice" in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012m	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Review emergency and urgent pathways to improve patient flow.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012n	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Review patients that are deconditioning on the waiting list and identify patientsthat require urgent care.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012o	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Determine effective and efficient follow up plans, which should be carried outvirtually if possible.	Awaiting management response.	N/K	N/K	Red	
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012p	N/A	R12. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Review patients with high BMI and weight management services and identify improvement strategies and how to best respond to patients wanting surgery with high BMI.	Awaiting management response.	N/K	N/K	Red	

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RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_013	N/A	R13. Create and implement a workforce plan both short, medium, and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.	Awaiting management response.	N/K	N/K	Red	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_001	N/A	R1. The outbreak has not yet concluded and the high level of latent TB infection in the population implies further risk. This risk is heightened because the active disease in this population is predominantly pulmonary and therefore more infectious. Although the level of active TB infection is low in West Wales, delayed presentation in unrecognised cases may lead to further outbreaks and deaths. The level of awareness amongst the public and their health care professionals must be therefore increased and maintained. This also applies to trainee health professionals.	To manage the risk of the outbreak and raise awareness amongst the public and Healthcare Professionals, to reduce the risks of any future outbreaks.	Jun-23	Jun-23	External	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_002	N/A	R2. Any future outbreaks should be overseen by PHW from the outset with a TB-specific standard operating procedure for the conduct and recording of outbreak management. The current SOP and OCT policy needs to be updated in this respect. The latter needs to be developed alongside modern data analysis and WGS typing so that outbreaks are identified and contained. Comprehensive contact networks of all cases should be recorded electronically and plotted with social network analyses undertaken to ensure links between cases are uncovered quickly and easily.	To work with PHW to create a Standard Operating Procedure and updated OCT policy. Development of a revised methodology for managing contact networks and analyses to ensure links between cases are uncovered quickly and easily.	Jul-23	Jul-23	External	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_003	N/A	R3. Funding should be identifiable ahead of time for outbreaks of infectious diseases so that such outbreaks can be managed in a timely and effective manner without the need for time-wasting discussion.	To develop an agreed service modeland contingency plans for resourcing any future outbreak	Jul-23	Jul-23	External	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_004	N/A	R4. The local TB service has improved but still has inadequacies. In particular, cross-cover arrangements need to be in place for annual, sick and study leave in order to prevent delays in treatment. Pharmacy and administrative support needs improvement. Succession planning for the TB Specialist Nurse also needs to be clear	Development of a resilience plan for both future outbreaks and maintaining current TB case management. Agree a plan for Pharmacy, administrative and Specialist nursingsupport required for TB management.	Jun-23	Jun-23	Amber	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_005	N/A	R5. At a national level, the Cohort Review Programme needs to be supported with adequate funding for each contributing health board.	To agree a plan with WG, other HB's & External Partners to agree an adequate funding model	TBC	TBC	External	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_006	N/A	R6. Welsh Government should support both the Cohort Review Programme and the proposal for a National Service Specification that includes the development of a TB pathway to tackle delayed diagnosis (e.g. investigating cough lasting longer than three weeks).	To work with WG and PHW to agree a way forward for the cohort Review Programme and the National Service Specification	TBC	TBC	External	
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_007	N/A	R7. Wales does not seem to be properly prepared for the challenges of new migrants, refugees, and the occurrence of future drug resistance. These factors should be included in a future TB plan supported and funded by Welsh Government.	To work with WG and at an All Wales level to agree a TB Plan which addresses the shortfalls highlighted for new migrants, refugees and the occurrence of future drug resistance.	TBC	TBC	External	
PSOW_202003189	Sep-22	Public Service Ombudsman (Wales)	202003189	Open	N/A	Nursing	Nursing	Sian Passey Helen Dawkins	Director of Nursing, Quality and Patient Experience	202003189_003	N/A	R3. Develop a TNP care plan/template for clinical staff to complete so that there is evidence to demonstrate that a consistent approach has been given to the therapy from all disciplines.	Action plans held with Ombudsman Liaison Manager.	Dec-22	~~Dec-22~~ N/K	Red	13/12/22 - Request to PSOW for an extension to the deadline. Awaiting response 02/03/2023 - Update received from Ombudsman Case Manager: still awaiting response from PSOW regarding the requested extension.
PSOW_202003189	Sep-22	Public Service Ombudsman (Wales)	202003189	Open	N/A	Nursing	Nursing	Sian Passey Helen Dawkins	Director of Nursing, Quality and Patient Experience	202003189_004	N/A	R4. As part of the Standard Operating Procedure, prepare a plan to provide nursing staff with training on the correct nursing documentation standards in respect of evidencing detailed dressing treatment plans.	Action plans held with Ombudsman Liaison Manager.	Mar-23	Mar-23	Amber	02/03/2023 - Update from Ombudsman Case Manager: this is due to be evidenced by 10/03/23. Awaiting update from the T&F group.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	~~Mar-21~~ Mar-23	Red	23/03/2022- GM working closely with other sites of the Health Board to ensure safe services, e.g. through channels such as the senior Ops team meetings. Good collaboration between community and acute services. GM looking at scheduled care elements. Real challenges in terms of tertiary level pathways and getting the right patient in the right place for the right clinical supervision. Exploring joint consultant posts with Powys and Betsi, however progress has been significantly hampered due to Covid. This is in the recovery phase and the UHB has restarted this process with neighbouring Health Boards post Covid. Clinical advisory group for Mid Wales in place which started pre-Covid. Working with Powys to establish optimal flow for their patients using Hywel Dda services, and how to work together to deliver care. This is less developed with Betsi. GM is hopeful to make significant progress and have a programme of work in place by March 2023. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Quarterly commissioning meetings in place with Powys to develop pathways, and the Mid Wales Clinical Advisroy Group in place which explores joint appointments with Powys, surgical pathways and identify improvements. The site also works collaboratively with other Health Board sites, and links with clinical groups and peer reviews. Site lead advising that recommendation can be closed from the Lead Executive.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.2 Improve networking and collaboration with other sites and health boards	Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid.	Mar-21	~~Mar-21~~ Mar-23	Red	23/03/2022- Covid has been problematic in progressing this recommendation however there are Immensely improved relationships between BGH and scheduled care. Working with team to deliver elective care and repatriate back where appropriate. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - BGH have a large capacity to deliver int erms of Theatre space, with greater engagement received from Powys' Consultant Surgeon for Scheduled Care. Plans for the new hospital will require for this continued engagement to be in place. Request to be made to Lead Execuitve to close this recommendation.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	Mar-24	Red	23/03/2022- GM to liaise with officer on digital strategy of the UHB for current progress on virtual systems. A lot of changes still taking place and Covid still presents challenges for this. Revised date of March 2024 provided 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Attend Anywhere system in use, and BGH are also taking part in the Telemed roll-out. Assurance and Risk team to enquire if BGH's participation is reported anywhere to support closing this recommendation.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_004	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility.	Dec-20	~~Dec-20~~ N/K	Red	23/03/2022- GM will pick up with recommendation owner for current position of this recommendation. 05/05/2022- Requested revised timescale from GM, no response received as of 18/05/2022. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 10/03/2023 - BGH are not able to do the core training for trainees in the current set up. BGH are accredited but cannot recruit. The new SAS contract came into force last year (2022) for specialist grade, which provides mid-grade specialist with acknowledgement of their skills. There is a SAS tutor in place (from Surgery) for support. Leadership and management training is offered to clinical fellows and SAS doctors. All trainees are provided with self-directed learning and teaching time (quality improvement) with a few doctors following into the teaching path now. There is a monthly middle grade meeting where the doctors can discuss training, issues, and areas for improvement. There is also a regular meeting for junior doctors with consultants in attendance where training for juniors is part of the agenda. Due to the improvements made the GM is requesting this recommendation be closed.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth |University. Both developments will include clinical skills facilities.	Sep-22	~~Sep-22~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed as no funds available at this time with the intention to be part of the Capital plan. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. The original management response in this report was made on the assumption that funds were available which was incorrect.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	~~Dec-21~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed. BGH are part of ongoing discussions for the postgraduates build which requires WG Capital investment. However, it is felt that this is not achievable in the current conditions. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. BGH feel the risk for not having this will impact in poor training and will be reflected in not doing enough to support activities. A major issue is the lack of space for teaching and meetings. BGH have 3 available rooms which are fully booked all the time. This will affect the trainees' satisfaction. This impact to be incorporated into the existent BGH Datix risk (1586-Harm associated with lack of space).
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	~~Sep-22~~ N/K	Red	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting this recommendation to be closed as lack of funding does not allow this recommendation to be fully implemented. There is however a designated RESUS officer just for Ceredigion, which has helped provide more RESUS training dates. Due to lack of funding BGH are discussing opportunities to access training space through the University Medical School.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	WLC_PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments. 28/02/2023- there is no further update on the above.

Reports closed on the Audit Tracker since ARAC February 2023

Report name	Lead Executive/Director
Audit Wales: District Nursing: Update on Progress	Director of Operations
Counter Fraud Authority: PO vs non-PO report of findings for HYWEL DDA UNIVERSITY LHB	Director of Finance
Internal Audit: Backlog Maintenance	Director of Operations
Internal Audit: Financial Planning, Monitoring and Reporting	Director of Finance
Internal Audit: IM&T Assurance – Follow Up	Director of Finance
Internal Audit: Network and Information Systems (NIS) Directive	Director of Finance
Internal Audit: Non-Clinical Temporary Staffing	Director of Finance
Internal Audit: Prevention of Self Harm	Director of Nursing, Quality and Patient Experience
Internal Audit: Welsh Language Standards Implementation	Director of Communications
Internal Audit: Follow-up: Deployment of WPAS into MH&LD, issued July 2022	Director of Finance
Internal Audit: Directorate Governance – WGH Unscheduled Care	Director of Operations
Internal Review: Capital Governance Review	Director of Strategic Development and Operational Planning
PSOW: 202003339	Director of Nursing, Quality and Patient Experience
PSOW: 202101855	Director of Nursing, Quality and Patient Experience
Royal College of Paediatrics & Child Health (RCPCH): National Diabetes Quality Programme (NDQP), issued April 2020	Director of Operations

Reports opened on the Audit Tracker since ARAC February 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
CHC: S-CAMHS	Director of Operations	8	Audit and Risk Assurance Committee
CHC: Babies and births in Hywel Dda	Director of Operations	5	Audit and Risk Assurance Committee
Counter Fraud Authority: PO vs non-PO report of findings for HYWEL DDA UNIVERSITY LHB	Director of Finance	6	Audit and Risk Assurance Committee
Counter Fraud Authority: Covid-19 Post Event Assurance Report of findings for HYWEL DDA UNIVERSITY LHB	Director of Finance	5	Audit and Risk Assurance Committee

Delivery Unit: All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Director of Operations	4	Quality, Safety and Experience Committee
HIW: Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Director of Operations	7	Quality, Safety and Experience Committee
HIW: Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Director of Operations	15	Quality, Safety and Experience Committee
HIW IRMER: Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Director of Operations	17	Quality, Safety and Experience Committee
Independent Review: Governance and decision making in relation to Bluestone Field Hospital	Director of Corporate Governance	4	Audit and Risk Assurance Committee
Internal Audit: Follow-up: Prevention of Self Harm	Director of Nursing, Quality and Patient Experience	4	Audit and Risk Assurance Committee
Internal Audit: Non-Clinical Temporary Staffing Follow Up	Director of Workforce & OD	0	Audit and Risk Assurance Committee
Internal Audit: Glangwili General Hospital Fire Precautions Works: Phase 1	Director of Operations	11	Audit and Risk Assurance Committee
Internal Audit: Glangwili Hospital - Women & Children's Development,	Director of Operations	4	Audit and Risk Assurance Committee

issued February 2023			
Internal Audit: A Healthier Mid & West Wales Programme	Director of Strategic Development and Operational Planning	16	Audit and Risk Assurance Committee
Peer Review: Getting It Right First Time (GIRFT) Orthopaedic Review	Director of Operations	13	Quality, Safety and Experience Committee
Public Health Wales: Llwynhendy Tuberculosis Outbreak External Review	Medical Director	7	Audit and Risk Assurance Committee
Total		**126**	

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Audit Wales - Medicines Management in Acute Hospitals (June 2015)	1 External	June 2016	Medicines Management	One 'external' recommendation relating to electronic prescribing/discharging. This work is being led by the Head of Digital Programmes supported by a small 'pre-implementation' team, who are developing a Business Case for submission to Welsh Government which will be aligned with the national Electronic Prescribing and Medicines Administration (ePMA) programme across Wales, the outcomes of which will provide a revised completion date.
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board (October 2021)	2 (1 External)	December 2022	Director of Operations	Directorate Improving Together Sessions established in January 2023. Assistant Director of Assurance and Risk and Head of Assurance and Risk to meet with Director of Operations in April 2023 to confirm if the recommendation can be closed in relation to Governance arrangements. 1 'external' recommendation relates to the roll-out of the All-Wales Datix risk management system, the date of which has not yet been confirmed.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Community Health Council - Accident & Emergency Departments in the Hywel Dda Health Board area (November 2022)	1	January 2023	Nursing	Recommendation relates to the Health Board requiring improved communication to keep patients regularly informed of waiting times in the A&E department. The Assurance and Risk team are currently awaiting progress update from the service.
Community Health Council - Eye Care Services in Wales, issued March 2020	1 External	June 2022	Scheduled Care	Completion of this recommendation relies on the national rollout of an Electronic Patient Record (EPR) system administered by Digital Health and Care Wales (DHCW), which has been delayed due to technical issues and staffing. The Assurance and Risk Team are currently awaiting an update on this project from the supporting lead in Digital.
Counter Fraud Authority – Covid-19 Post Event Assurance Report of findings for Hywel Dda University LHB	1	September 2022	Finance	Service currently awaiting an update from NHS Wales Shared Services Partnership which will determine the timescale for completing this recommendation.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Delivery Unit - All Wales Review of progress towards delivery of Eye Care Measures (September 2019)	3	October 2020	Scheduled Care	Further investment into specific services is required to develop long term models and to support recruitment in order to fully implement outstanding recommendations raised within this report.
Delivery Unit - Focus on Ophthalmology: Assurance Reviews (January 2016)	1	November 2022	Scheduled Care	Ophthalmology service are awaiting confirmation from UHB's Information Governance (IG) team to progress with Ophthalmic Diagnostic Treatment Centre (ODTC), which will enable the service to provide a revised completion date for this recommendation.
HIW - Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	1	February 2023	Women and Children	Progress updates are currently being sought for the recommendations raised in this newly-published report by the QAST team, with updates to be reflected to ARAC in June 2023.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	2	February 2023	Radiology	Progress updates are currently being sought for the recommendations raised in this newly-published report by the QAST team, with updates to be reflected to ARAC in June 2023.
Internal Audit – Discharge Processes (December 2021)	3 (2 External)	June 2022	Primary Care, Community and Long Term Care	The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. The Audit Tracker will be updated once the new report is received at ARAC.
Internal Audit - IT Infrastructure	1	February 2023	Digital and Performance	Progress updates currently being sought from the service, and revised completion dates by the Assurance and Risk team.
NHS Wales Cyber Resilience Unit - Cyber Assessment Framework Report (February 2022)	4	February 2023	Digital and Performance	A meeting was held between the Assurance and Risk Team and the service in March 2023 to clarify timescales within the report, with a further meeting scheduled in April 2023 to complete the review.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Peer Review - Getting It Right First (GIRFT) Orthopaedic Review (May 2022)	13	March 2023	Scheduled Care	This report was published in May 2022 but has only recently been added to the UHB tracker. The Assurance and Risk Team are currently working with the Orthopaedic service to establish a timeline for completion, with updates to be reflected in June 2023.
Peer Review – Respiratory Cancer (June 2016)	1	July 2016	Respiratory	A risk is to be added to Datix to capture the difficulties in recruiting to the service, and the risk to the sustainability of the service due to the dependency on one consultant. The Assurance and Risk team are supporting the service to articulate this risk on Datix, after which the Director of Operations will be asked if the recommendation can be closed.
Peer Review - Out of Hours (November 2019)	4	October 2022	Central Operations	A new peer review was undertaken in July 2022. Management responses have been drafted and will be presented to OQSEC in May 2023. Once approved, recommendations from the new review will supersede the 4 existing recommendations.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Peer Review - Congenital Heart Defect Provider (October 2021)	5 (1 External)	October 2022	Women and Children's Services	Workforce pressures in terms of recruitment and capacity, along with financial constraints are impacting the services' ability to implement the outstanding recommendations as raised in the report. The Assurance and Risk team are currently awaiting revised timescales from the service.
PSOW - 202003189	1	December 2020	Nursing	A request has been made to PSOW for an extension to the original timescale provided for this recommendation, the outcome of which is pending as at March 2023.
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	2	September 2022	Unscheduled Care (BGH)	Assurance and Risk Team met with BGH management team in March 2023, with recommendations to be presented to Director of Operations in April 2023 for closure as contingency plans are in place mitigating the lack of funding and recruitment issues which are noted as main reasons for inability to fully complete recommendations.
Total number of N/K Recs	47			