Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 February 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)

Up to now, there has been a bi-monthly rolling programme to collate updates from services to coincide with reporting to ARAC however this is going to be reviewed following the commencement of the Improving Together sessions in January 2023. As these sessions include reviewing progress against audit and inspection recommendations with Directorate leads, requests for updates from services needs to align to this process to reduce duplication

and pressures on operational services, however assurance will continue to be provided to ARAC.

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

Since the previous report, 16 reports have been closed or superseded on the Audit Tracker and 13 new reports have been received by the UHB, as detailed in Appendix 2.

As of 23 January 2023, the number of open reports has decreased from 91 to 88. 39 of these reports have recommendations that have exceeded their original completion date, which has decreased from the 52 reports previously reported in December 2022. 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 132 to 128. 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 from 73 to 58, as reported in December 2022. The table below provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC December 22	New reports since December 22	Closed reports since December 22	Open reports at ARAC February 23	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	5	1	1	5	4	4	2
CHC	2	1	1	2	1	5	2
CHC / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	4	1	0	5	3	7	6
HEIW	0	0	0	0	0	0	0
HSE	0	0	0	0	0	0	0
HIW	12	2	5	9	4	27	10
HTA	0	0	0	0	0	0	0
IA	24	8	5	27	16	35	14
Internal Review	1	0	0	1	1	0	0
MHRA	1	0	0	1	1	1	1
MWWFRS	23	0	0	23	3	19	0
NHS Wales Cyber Resilience Unit	1	0	0	1	0	2	0
Peer Reviews	4	0	0	4	3	23	19
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	11	0	4	7	0	1	0
Royal Colleges	2	0	0	2	2	4	4
Other (External Consultant)	0	0	0	0	0	0	0
WLC	1	0	0	1	1	0	0
TOTAL	**91**	**13**	**16**	**88**	**39**	**128**	**58**

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

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

There are currently **262 open recommendations** (a slight decrease from 267 reported in December 2022) on the audit tracker. In addition to the new recommendations issued since the previous report, Appendix 1 includes the 29 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.

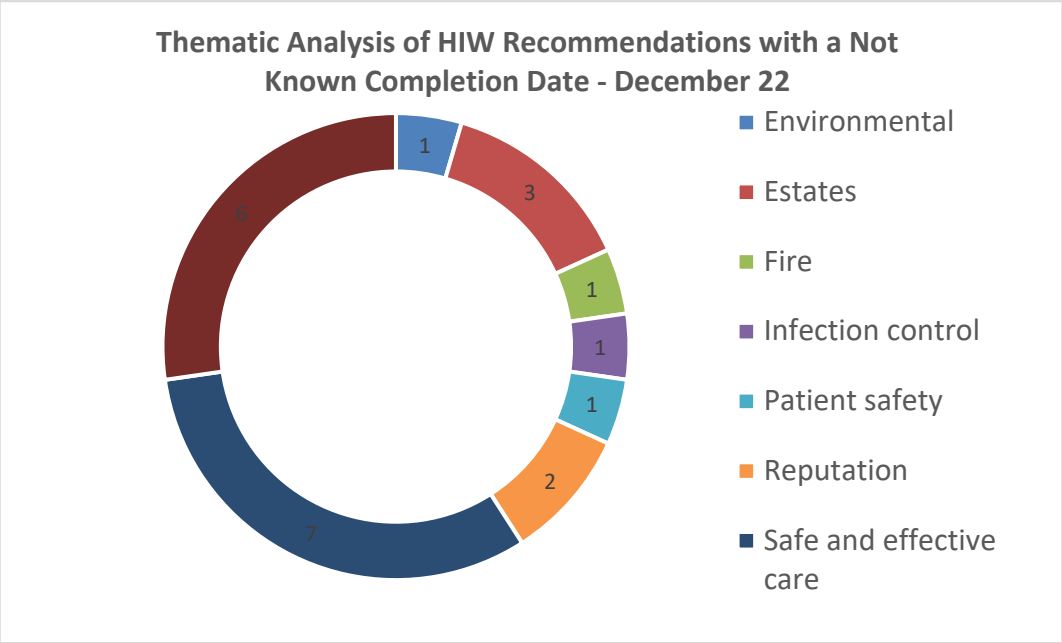
There are 49 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported), which has decreased from the 63 previously reported. The individual recommendations are included in Appendix 3, which details the date at which point the recommendation became N/K. The majority of recommendations referenced in Appendix 3 have only recently lapsed to N/K status, reflecting the current operational pressures and demands on services. Recommendations with a longstanding status of N/K are dependent on additional funding or resources in order to implement.

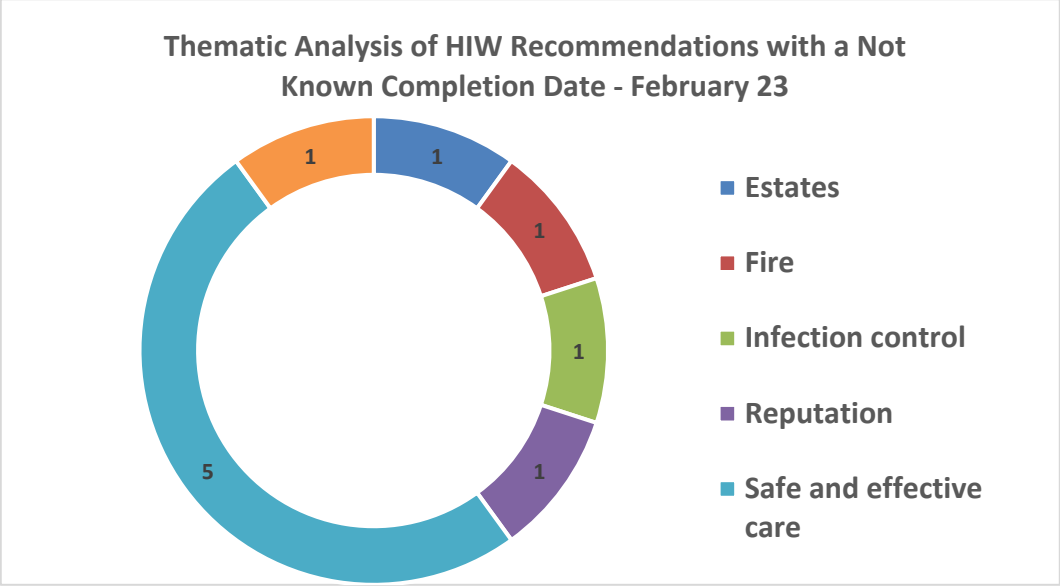
As requested at ARAC in December 2022, the report now provides additional detail regarding the 22 HIW recommendations which were overdue by more than 6 months, as presented to investigate common themes, and to consider the recommendations in the context of Targeted Intervention. The 22 recommendations were raised in 8 reports assigned across 6 services as detailed in the table below – the table also details the position as at February 2022.

Report Title	**Service**	**Recs as at Dec 22**	**Recs as at Feb 23**
National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Acute Services (Unscheduled Care)	6	5
PACU and Cilgerran Wards, Glangwili General Hospital (Publication date 7 August 2020)	Women and Childrens	1	N/A – report now closed
Quality Check: Morlais Ward, GGH 4 March 2021 (Publication date 5 May 2021)	Mental Health and Learning Disabilities	2	2
St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Mental Health and Learning Disabilities	2	2
Thematic Review of Ophthalmology 2015/16 issued January 2016	Scheduled Care	1	1
Tregaron Community Hospital 7/8 September 2021 (Publication date 10 December 2021)	Ceredigion	1	N/A – report now closed

Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Mental Health and Learning Disabilities	8	N/A – all recs completed and report due for closure March 23
Ward 7, Prince Philip Hospital 2/3 November 2021 (Publication date 4 February 2022)	Prince Philip Hospital	1	N/A – report now closed
Total		**22**	**10**

The charts below demonstrate the key themes behind the recommendations at both December 2022 and February 2023.

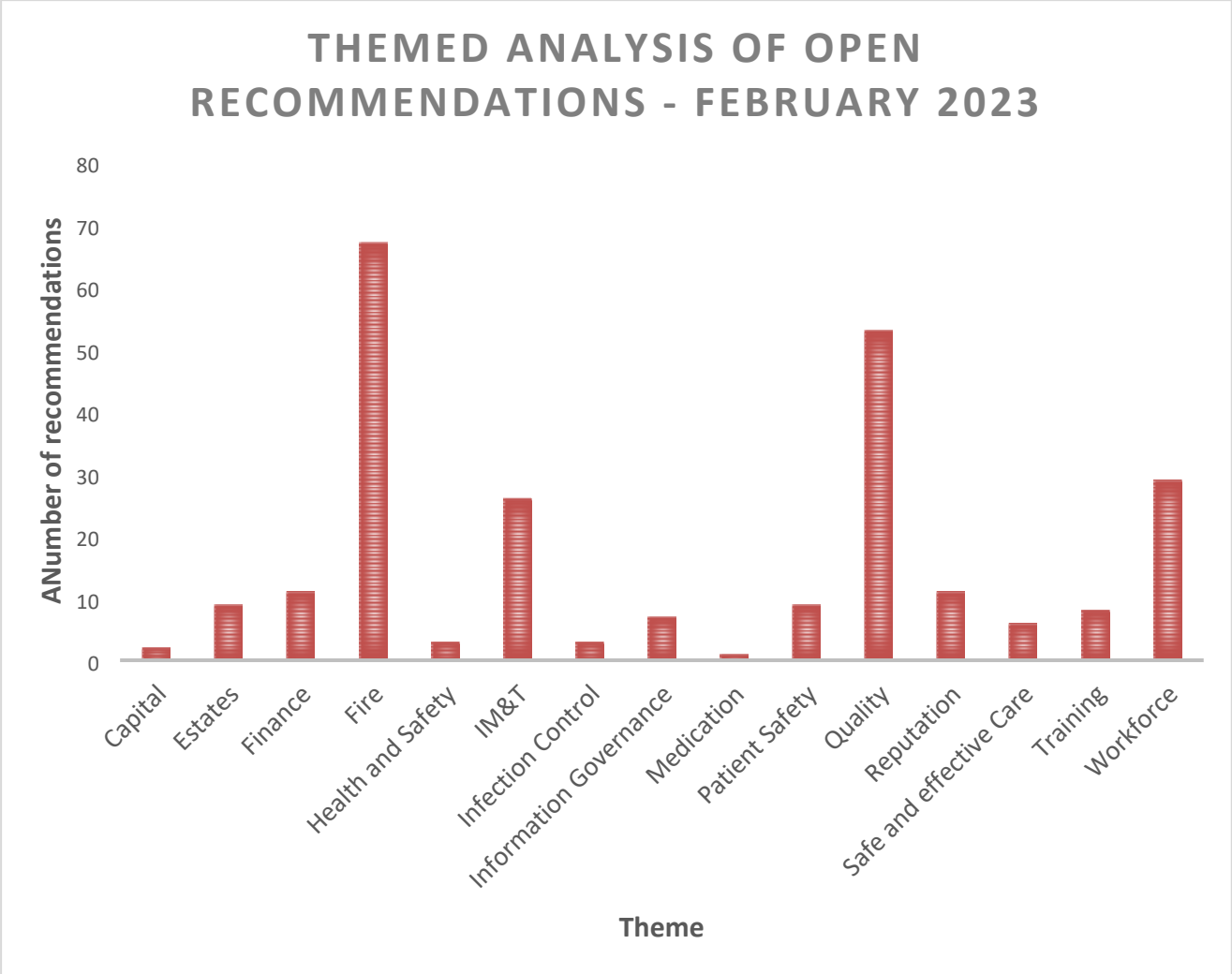




The two main themes behind the 22 recommendations as noted in December were around safe and effective care (7 recommendations) and workforce (6 recommendations). 50% of the recommendations which remain as not known in February 2023 relate to safe and effective care, and raised in the National Review on WAST report. Progress against HIW

recommendations are provided to the Assurance and Risk Team by the Quality Assurance and Safety Team.

Below is a chart providing a thematic analysis for all open recommendations on the Audit and Inspection Tracker as at February 2023:



Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 23 January 2022, including trends since the last report to ARAC in December 2022. A rolling programme to collate updates from services on a bi-monthly basis is in place in order to report progress to the Committee. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager.

The arrows included in the table below are as follows:

⬆	Increase in number of recommendations / reports
⬇	Decrease in number of recommendations / reports
⬌	No change in number of recommendations / reports

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

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

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
Acute Services	1 →	1 →	12 ↑	6 →	6 →	• HIW National Review on WAST - 6 overdue recommendations, which are now overdue by more than 6 months. The Quality Safety and Assurance Team have received revised dates from the service ranging from January to March 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 of March 2023.
Cardiology	1 N/A	1 N/A	1 N/A	1 N/A	1 N/A	*Cardiology is now being reported separately from USC:GGH section below* • 1 DU report on All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review – 1 recommendation overdue by more than 6 months, with a revised completion date of March 2023.
CEO Office (Welsh Language)	2 ↑	2 ↑	3 →	3 →	2 →	• 1 IA report - 1 outstanding recommendation with an 'External' status. The recommendation is overdue by more than 6 months, with a revised completion date of June 2023. • 1 follow-up IA report Welsh Language Standards - 2 overdue recommendations with revised completion dates of March 2023. 1 recommendation is overdue by more than 6 months.
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	1 ↓	1 ↓	1 ↓	0 ↓	0 ↓	• 1 AW report with 1 'external recommendation.' • 1 HIW report closed since the 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 Q1 2023/24. • 1 Peer Review – 4 recommendations overdue by more than 6 months. A new peer review was undertaken in July 2022, with revised management responses currently being drafted jointly with 111. Recommendations from the new review will supersede existing recommendations.

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
Digital and Performance	6 ↑	2 ↓	31 ↑	3 →	1 →	• 1 report by NHS Wales Cyber Resilience Unit on Cyber Assessment Framework - 24 recommendations, 2 of which are overdue, with a completion date of March 2024. • 1 IA IM&T Assurance (Follow Up) - 1 recommendation overdue by more than 6 months, with a revised completion date of March 2023. • 1 IA report on Network and Information Systems (NIS) Directive – all recommendations have been completed, and currently awaiting confirmation from IA to formally close report. • 1 IA report on IT Infrastructure with 6 recommendations with a report completion date of March 2024. • 1 IA on Cyber Security all recommendations completed. Awaiting confirmation from IA to close the report. • 1 IA report on Follow Up: Deployment of Welsh Patient Administration System (WPAS) into MH&LD – awaiting confirmation from IA to formally close report.
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 →	6 ↓	73 ↓	24 ↑	0 →	• The number of recommendations has decreased from 78 to 73 (the majority of these recommendations are from the 5 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)). • Since the data was run off for this report, MWWFRS letter dated 20/01/23 confirmed they are comfortable with the revised timescales provided by the UHB reducing the number of recommendations that have passed their original completion date against MWWFRS items from 20 to 4. • 4 IA reports with a total of 3 recommendations within original agreed timescales, and 4 which have passed their implementation date (3 from WGH Fire Precautions Works: Phase 1, and 2 from Fire Governance) whereby IA are due to confirm if evidence submitted by the Estates services means these recommendations can now be closed.A further 2 IA reports with a total of 2 recommendations within original agreed timescales. • All MWWFRS recs overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting.
Finance	1 →	1 →	2 →	2 →	2 ↑	• IA report on Financial Planning, Monitoring and Reporting - 2 recommendations overdue by more than 6 months. No revised completion dates as IA confirmed a follow up is progress, and evidence of completion of previous recommendations are being sought.

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
Governance	1 →	0 →	4 ↓	0 →	0 →	• 1 new report from AW on Structured Assessment 2022, with management responses to the recommendations raised and corresponding timescales for implementation to be considered at the February ARAC meeting. • 1 IA report on Risk Management and Board Assurance Framework has been closed since December 2022.
Medical	1 ↑	0 →	1 ↑	0 →	0 →	1 IA report on Individual Patient Funding Requests with 1 recommendation due for completion in March 2023.
Medicines Management	1 →	1 →	2 ↑	1 →	1 →	• 1 AW report on Medicines Management in Acute Hospitals - 1 recommendation more than 6 months overdue with revised date of March 2023, and 1 'external' recommendation.
MH&LD	9 ↓	4 ↓	33 ↓	20 →	6 ↓	• Total number of recommendations which have passed their original completion date remains at 20. • Total number of recommendations overdue by more than 6 months has reduced from 13 to 6. • The details of recommendations that have passed their original completion dates are below: ○ IA on Prevention of Self Harm – 4 recommendations have passed their original completion dates, of which 2 by more than 6 months. IA are undertaking a follow up which is planned to be reported to ARAC February 2023 meeting. ○ HIW Quality check: Morlais Ward - 2 recommendations 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. ○ 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 recommendations 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 report. • 1 new DU report - 7 recommendations with varying completion dates up to December 2023. • 2 HIW reports closed since previous ARAC report (details included in Appendix 2).

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
NQPE	6 ➔	1 ➔	19 ➚	10 ➚	0 ➔	• 1 new CHC report received since December 2022 on Accident & Emergency Departments, with 9 recommendations, of which 3 are overdue with no revised completion dates. Overall report completion date noted as June 2023. • 1 IA report on Falls Management, with 3 recommendations overdue, with no revised completion dates provided. • 1 IA report on Quality Governance, with 3 recommendations overdue • 3 PSOW reports – Evidence has been submitted to PSOW regarding 2 reports, and currently awaiting confirmation to close. 1 additional report with 1 recommendation whereby the service is awaiting confirmation from PSOW on an extension request. • 1 PSOW report closed since previous ARAC report.
Pathology	1 ➔	1 ➔	1 ➔	1 ➔	1 ➚	• 1 MHRA report for WGH - 1 outstanding recommendation which is overdue by more than 6 months with a revised completion of February 2023.
Primary Care, Community and Long Term Care	3 ➘	2 ➘	11 ➚	5 ➘	5 ➘	• 1 new IA report with 3 recommendations to be implemented by February 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 Officer will be contacting the newly appointed Director for Transforming Urgent & Emergency Care (TUEC) to discuss progress of these recommendations being incorporated into the relevant Policy Goals of the Regional UEC Programme. Recommendations to be considered for closure once this discussion has taken place. • 1 WLC report with 1 'external' recommendation. • 1 IA report and 1 PSOW report closed since previous ARAC report (details included in Appendix 2).
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	1 ➚	1 ➚	1 ➚	1 ➚	0 ➔	1 HIW IRMER report reopened since December 2022, as the inability to appoint to a Governance position in the Directorate impacts on the ability to comply with IRMER standards on document management and training requirements. Revised completion date of March 2023.
Scheduled Care	5 ➘	4 ➔	9 ➔	8 ➘	8 ➘	• 1 CHC report – 3 recommendations overdue by more than 6 months, 2 of which have revised timescales of March 2023. 1 recommendation has an unknown timescale due to awaiting the rollout of a national workstream for digital communication, and is noted as "external". • 2 DU reports – 4 recommendations overdue by more than 6 months, with unknown timescales for completion. • 1 HIW report - 1 recommendation which is overdue by more than 6 months with a revised completion date of March 2023. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report.

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
Strategic Development & Operational Planning	4 ↑	3 →	10 ↑	1 ↓	1 ↓	• 1 new IA report with 2 recommendations on schedule with dates of January and March 2025, and 3 'external' recommendations. • 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 on Capital Governance - 1 'external' recommendation. • 1 IA report on Glangwili Hospital Women & Children's Development - 1 recommendation with July 2023 timescale (IA has confirmed recommendation stays open until the project is completed as it is related to the ongoing monitoring of contractor performance).
Therapies	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
USC BGH	1 →	1 →	3 ↓	3 →	3 →	• 1 RCP report with 3 recommendations overdue by more than 6 months. 1 recommendation with revised completion date of March 2024, with 2 currently noted as N/K. • Assurance and Risk Officer to meet with General Manager in March 2023 to establish the relevance of these recommendations as report was issued in 2016, and if they should be closed.
USC GGH	1 ↓	1 ↓	1 ↓	1 ↓	0 ↓	• 1 PSOW report closed. • 1 IA report on GGH Directorate Governance review with 1 recommendation passed its original completion date. Revised completion date of March 2023.
USC PPH	2 ↓	0 →	1 ↓	1 ↓	1 ↓	•1 Peer Review on Respiratory Cancer report - 1 recommendation which is 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 HIW report closed. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report.
USC WGH	1 →	1 →	6 →	6 →	0 →	1 IA report on Directorate Governance with 6 overdue recommendations. The revised completion date for this report is March 2023.
Women & Children	5 ↓	3 ↓	25 ↓	20 ↑	12 ↑	• 1 new HIW report with 4 overdue recommendations, with revised completion dates of March 2023. • 1 IA report with one recommendation reclassified to 'external' with a revised completion date of March 2023. • 1 Peer Review with1 'external' recommendation, and 15 recommendations overdue, 11 of which by more than 6 months. • 1 Royal College report with 1 recommendation overdue by more than 6 months, with no revised completion date provided. • 1 PSOW report - compliance evidence submitted to PSOW, awaiting confirmation to close report. • 1 HIW report and 1 CHC report closed since the previous meeting.

Service	Open reports as at January 23	Overdue reports As at January 23	Total number open recs January 23*	Total overdue (red) recs January 23	Of which overdue by more than 6 months	Comments
Workforce & OD	3 ↓	0 ↓	0 ↓	0 ↓	0 ↓	• 3 IA reports on Medical Staff Recruitment, Non-Clinical Temporary Staffing and Overpayment of Salaries – all recommendations have been confirmed by the service as implemented, and currently awaiting IA approval for closure of the report. • 1 AW report on Taking Care of the Carers – 1 AW report closed since the previous meeting.
Total	**88**	**41**	**262**	**127**	**58**	

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

Services with improved performance

Mental Health and Learning Disabilities

There has been an improved performance with the Directorate since December 2022, with the total number of recommendations overdue by more than 6 months reducing from 13 to 6. In addition, 2 HIW reports have been closed in period, with a further 2 reports where recommendations have been confirmed as implemented however awaiting formal approval for closure. The total number of recommendations which have passed their original completion date remains at 20, therefore the Assurance and Risk Officer will continue to liaise with the service, and the Patient Safety and Assurance, Team for updates for the next Audit Tracker report in April 2023, in the hope that these numbers will continue to improve.

Workforce and OD

All 11 IA recommendations have been confirmed by the service as implemented, and currently awaiting IA approval for closure of these 3 reports. In addition, 5 recommendations have been confirmed as implemented in relation to the AW report "Taking Care of the Carers", and subsequently closed since December 2022, demonstrating an improving picture on progress made.

Potential Service of Concern

Women and Children

The number overdue recommendations have increased slightly from 19 to 20 since December 2022, with those overdue by 6 months increasing from 11 to 12. However, progress updates have been obtained from the service since the data was run for this report as follows:

- Peer Review: Congenital Heart Defects – 5 recommendations have been confirmed as implemented, with revised timescales provided for the remaining recommendations
- Royal College of Paediatricians and Child Health: National Diabetes Quality Programme – 1 remaining recommendation has since been confirmed as implemented, and the report has been formally closed on the Audit and Inspection Tracker.

In light of these positive updates, the total number of overdue recommendations stand at 14, demonstrating an improving position. These updates will be reflected numbers as will be presented in the paper submitted to ARAC in April 2023.

Argymhelliad / Recommendation

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital BPPAG – Business Planning and Performance Assurance Group CHC – Community Health Council DCP – Discretionary Capital Programme DU – Delivery Unit

	EWTD – European Working Time Directive GGH – Glangwili General Hospital HEIW – Health Education and Improvement Wales HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IGSC – Information Governance Sub Committee IRMER – Ionising Radiation (Medical Exposure) Regulations Management & Technology Sub Committee MH&LD – Mental Health & Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience NWIS – NHS Wales Informatics Service PAMOVA – Prevention, Assessment & Management Of Violence & Aggression QSEC – Quality and Safety Experience Committee SDEC – Same Day Emergency Care PPE – Post Project Evaluation PPH – Prince Philip Hospital PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SIFT – Service Increment For Teaching SSU – Specialist Services Unit UEC- Urgent and Emergency Care UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.

Gweithlu: **Workforce:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: **Risk:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and identified risks are not being managed.
Cyfreithiol: **Legal:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: **Reputational:**	As above.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	No direct impacts from this report

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber-on schedule, Green-complete)	Progress update/Reason overdue
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Medicines Management	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_001	High	R1b: Refresh its Medicines Management Strategy to provide an integrated vision across primary and secondary care that is developed in full partnership between pharmacy, medical and nursing staff.	One of the key roles for the newly appointed Head of Medicines Management will be to update and refresh the strategy for the service. Employing the County Leads, who all have busy operational and managerial roles, as rotating interim Heads of Medicines Management has not allowed strategic aims to be tackled.	Apr-16	~~Sep-22~~ ~~Nov-22~~ 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.
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	N/K	External	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales.
AW_603A2018-19	Jun-18	Audit Wales	District Nursing: Update on Progress	Open (external rec)	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans / Sharon Daniel	Director of Operations	AW_603A2018-19_001	N/A	R6. Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the case mix between teams compared with team resources.	The Health Board said that it expects this issue to be definitively addressed through the publication of the All Wales dependency tool, currently expected in 2020.	Jan-19	~~Mar-20~~ ~~Nov-20~~ ~~Dec-21~~ ~~N/K~~ ~~Sep-22~~ Jan-23	External	19/08/2021- The Draft District Nursing (DN) Welsh Levels of Care Acuity and Dependency tool (WLoC tool) underwent phase 1 of testing in July 2021. Evaluation and analysis of this pilot is currently underway with a report due to be shared with the All Wales Nurse Staffing Programme in December. The next phase of testing/rollout is likely to commence in January 2022. 20/10/2021- Work remains ongoing with this and no further updates currently. The review for this is January 2022. 21/03/2022- requested update from lead officer 21/02/2022, no update received. 04/05/2022- requested update from lead officer, no update received. 07/07/22-Work is progressing on an all Wales basis with the development of a dependency tool with the roll out planned for September 2022. 29/09/22- The Draft DN WLoC tool is now being piloted for use with the CIVICA Scheduling system, 6 teams across Wales including a team from HDUHB are participating in a month long pilot in Sept/Oct 2022. Once the pilot is completed and evaluated, recommendations and timescales for the formal roll out of the draft tool will be issued. It is likely that this time frame will now be January 2023. Delays have been due to the CIVICA Scheduling system building the additionality the app requires to capture the WLoC.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	TBC	Director of Strategic Development and Operational 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.	The Health Board has recently appointed a new Executive Director for Strategic Development and Operational Planning. This is intended to support the integration of plans across the Health Board, particularly between the strategic and operational planning portfolios.	N/K	N/K	Amber	05/07/2021 - Recommendations added without management responses as not yet received. Management response to be submitted to ARAC August 2021. 19/08/2021- Management response reported to ARAC August 2021 shows action as complete. 23/01/2023 - Additional capacity has enabled the planning team to increasingly become more involved in wider plans through the Operational Planning and Delivery Programme, and the ARCH programme.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Primary Care, Community and Long Term Care	Daniel Warm	Director of Strategic Development and Operational 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.	The UHB is establishing a new Delivery Programme Group and Operational Delivery Groups, which has representation from both Planning and the wider delivery arms of the organisation. These will support the development and delivery of the operational planning objectives and ensure that plans are more clearly aligned (see R4).	Sep-21	Sep-21	Amber	19/08/2021- Management response reported to ARAC August 2021. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/09/2021- The Operational Planning and Delivery Programme has been established and has a weekly meeting, including TORs, minutes, etc. Head of Planning sits on this group and ensures key planning processes are effectively linked. 23/01/2023 - Additional capacity has enabled the planning team to increasingly become more involved in wider plans through the Operational Planning and Delivery Programme, and the ARCH programme.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	AW_2360A2021-22_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.	The Planning Steering Group, introduced for the development of 2021/22 Annual Plan, will be strengthened to include Operational colleagues, and will be used as a forum to advise, review and amend plans through the development of the next planning cycle. The Health Board is reviewing the processes by which our Annual Plans / Integrated Medium Term Plans are developed – this included a review session with the Planning Steering Group in July 2021, which sought to address the question: 'Reflecting on the Planning Steering Group over the last year, what are the lessons and improvements you would suggest for the year ahead in how PSG can support the delivery of an IMTP for 2022/25 by the end of 2021?'	Sep-21	~~Sep-21~~ N/K	Amber	19/08/2021- Management response reported to ARAC August 2021. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- The Planning Steering group has been introduced with bi-weekly meetings. The TORs have been produced. Due to current operational pressures it has been decided at this stage not to include them in the steering group, but instead engaging with them through other avenues and opportunities. 10/11/2021- Revised management response confirms recommendation is completed. 23/01/2023 - Additional capacity has enabled the planning team to increasingly become more involved in wider plans through the Operational Planning and Delivery Programme, and the ARCH programme.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	AW_2360A2021-22_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 a result we are developing our Planning Cycle for 2021/22 to ensure there is a better integration of plans across the Health Board, particularly as the 2022/25 Plan will be able to use the 2021/22 Plan and its core components of our Strategic and Planning Objectives as a clear baseline for the development of plans. A paper will shortly be presented to the Executive team. Further, as noted in the response to recommendation 2, we are reviewing the capacity of the Planning Team, which will allow planners to be more directly involved in the development of plans and ensuring alignment across plans. The establishment of a new Planning Directorate function - which includes Capital Planning, the Transformation Programme Office and Programme Management Office, and the Engagement team - will support further integration across those disciplines under the recently appointed Executive Director.	Sep-21	~~Sep-21~~ N/K	Amber	19/08/2021- Management response reported to ARAC August 2021. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- the planning team capacity remains an issue and discussions are taking place with discussions taking place between Director of Strategic Development and Operational Planning, and Director of Operations. A paper was reported to Exec Team in August 2021 around the planning structure which was accepted, which now needs to be built upon. 10/11/2021- Revised management response confirms recommendation is completed. 23/01/2023 - Additional capacity has enabled the planning team to increasingly become more involved in wider plans through the Operational Planning and Delivery Programme, and the ARCH programme.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	AW_2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	Work is underway to review the capacity and capability of the Planning Team. A proposal will be taken to the Executive Team to recurrently increase the capacity of the service planning team and further develop the 'business partnering' approach.	Sep-21	~~Mar-22~~ ~~Jun-22~~ ~~Sep-22~~ ~~Oct-22~~ Sept-23	Red	19/08/2021- Management response reported to ARAC August 2021. 26/01/2022- Head of Planning was unable to provide update. Assurance and Risk Officer to contact Director of Strategic Development and Operational Planning for clarification of timescale. 03/02/2022- Director of Strategic Development & Operational Planning confirmed this recommendation is part of the IMTP discussions. An outline plan is in place to address this, with the aim to progress in Q1 of2022/23. This recommendation will be dependent on that resource. 21/06/2022- update to ARAC June 2022 - In progressing the action relating to R2, work is continuing to understand the skills required by the Planning Team moving forward. To support this work and to understand fully the skills required, the Director of Strategic Developments and Operational Planning along with members of the Strategic Planning Team have been mapping out the planning cycle. In doing so, the key skills required have been identified and will be used to aid the recruitment to the Team. The process has also identified where better collaboration with existing teams and resources could be utilised to support the Planning Cycle. This is expected to be completed by the end of Q2 2022/23. 30/08/2022 - Director of Strategic Developments and Operational Planning advised that being cognisant of the UHB's financial challenges, changes have been made to increase support in Planning Team. These will be further strengthened when WG support the PBC. Building resilience in the team will be completed once the Commissioning Team has been brought within the Planning Directorate's remit. This needs to go through the HR process and therefore the date of completion is likely to be October 2022. 04/01/2023- Commissioning team has been brought into the Planning team as of January 2023, bringing some additional resource. The capacity and capability of the planning team has been highlighted in the targeted Intervention escalation of the Health Board (Planning and Finance). Now the Commissioning Team has been brought into the Planning Directorate's remit a further review of the staffing resource requirement will be undertaken by the new Deputy Director of Operational Planning and Commissioning. 23/01/2023 - Changes have been made to streamline existing capacity along with the recruitment of four additional staff. Further capacity is dependent on the outcome of the PBC. The transfer of the commissioning function will add additional resilience.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	AW_2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	With the increase in capacity, it is the intention that the members of the Planning team are exposed to a wider range of Planning activities to build their knowledge, understanding and capabilities in order to strengthen the overall Planning function (to include Operational Delivery Groups, ARCH etc)	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Sep-22~~ ~~Oct-22~~ Sep-23	Red	19/08/2021- Management response reported to ARAC August 2021, timescale noted as 'Quarter 4 (subject to recruitment timescales)'. 26/01/2022- Head of Planning was unable to provide update. Assurance and Risk Officer to contact Director of Strategic Development and Operational Planning for clarification if March timescale will be met. 03/02/2022- Director of Strategic Development & Operational Planning confirmed this recommendation is part of the IMTP discussions. An outline plan is in place to address this, with the aim to progress in Q1 of2022/23. This recommendation will be dependent on that resource. 28/04/2022- Work is progressing, with an update being requested to ARAC in June 2022. 21/06/2022- update to ARAC June 2022 - timescale confirmed as Q2 2022/23. 30/08/2022 - Director of Strategic Developments and Operational Planning advised that being congnisant of the UHB's financial challenges, changes have been made to increase support in Planning Team. These will be further strengthened when WG support the PBC. Building resilience in the team will be completed once the Commissioning Team has been brought within the Planning Directorate's remit. This needs to go through the HR process and therefore the date of completion is likely to be October 2022. 04/01/2023- Commissioning team has been brought into the Planning team as of January 2023, bringing some additional resource. The capacity and capability of the planning team has been highlighted in the targeted Intervention esclatation of the Health Board (Planning and Finance). Now the Commissioning Team has been brought into the Planning Directorate's remit a further review of the staffing resource requirement will be undertaken by the new Deputy Director of Operational Planning and Commissioning. 23/01/2023 - Changes have been made to streamline existing capacity along with the recruitment of four additional staff. Further capacity is dependent on the outcome of the PBC. The transfer of the commissioning function will add additional resilience.
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

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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 associated governance arrangements progresses as a matter of urgency.	Management responses to the recommendations due to be approved at ARAC in February 2023.	TBC	TBC	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.	Management responses to the recommendations due to be approved at ARAC in February 2023.	TBC	TBC	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.	Management responses to the recommendations due to be approved at ARAC in February 2023.	TBC	TBC	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.	Management responses to the recommendations due to be approved at ARAC in February 2023.	TBC	TBC	Amber	
CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open (external rec)	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ ~~Apr-22~~ ~~Jun-22~~ N/K	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 25/08/2020 update- still awaiting national roll out as part of national work stream. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 08/10/21- further national delays to the roll out of EPR due to network concerns. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update by 14/10/22 if HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found. 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-22~~ Mar-23	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ Mar-23	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023
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_002b	N/A	R2. Health Board to ensure it is collecting patient experiences including those relating to staff attitude to help its own organisational learning and continuously improve.	Formal Oversight operational Patient Experience Group established. ToR will include feedback from Relationship managers or other staff surveys.	Nov-22	~~Nov-22~~ N/K	Red	28/11/2022 - Previous Seating and environmental group refreshed and will become Patient Experience Operational oversight group, Meeting took place 11th November 2022.
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_002e	N/A	R2. Health Board to ensure it is collecting patient experiences including those relating to staff attitude to help its own organisational learning and continuously improve.	PALS team support the Emergency Department and wider teams to capture patient experience and feedback to line managers and managers at time. Themes are fed through governance reports at Directorate and Board level.	Nov-22	~~Nov-22~~ N/K	Red	
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_002f	N/A	R2. Health Board to ensure it is collecting patient experiences including those relating to staff attitude to help its own organisational learning and continuously improve.	There are Health Board wide initiatives ongoing to improve communication and staff attitude, including our internal customer care programme.	Nov-22	~~Nov-22~~ N/K	Red	28/11/2022 - Training programme is in place and being rolled out to all staff. Ongoing monitoring of feedback, including complaints is undertaken and fed back to the relevant areas for improvement. Further training and support regarding difficult conversations and empathy will be provided as part of the duty of candour training.
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_003a	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.	Seating across Health Board has been reviewed as part of Seating and Environment Task and Finish Group.	Dec-22	~~Dec-22~~ N/K	Red	28/11/2022 - New seating has been ordered for GGH site. This seating has extra padding and is compliant with IP&C, H&S requirements November 6th anticipated 6-week delivery. Seating will remain the same in WGH and BGH, although will continue to be reviewed via the Operational patient & experience group. General environment and patient experiences will be agenda item on operational patient experience group and relevant actions taken forward through the group to support improving patient experiences.
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_003b	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.	Service Operating Procedures are being developed which will identify the roles and responsibilities of staff and the actions to be taken when patients are in waiting areas for long periods of time. This will include pressure relieving care, nutrition and hydration.	Jan-23	Jan-23	Amber	28/11/2022 - Senior Nurses are developing local service operating procedures to support safe care of patients in waiting areas – will be reviewed at Operational Patient Experience Group once completed.
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_003d	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.	Vending machine planned for GGH	Jan-23	Jan-23	Amber	28/11/2022 - General manager liaising with 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_004a	N/A	R4. Toilet cleanliness needs addressing with regular cleaning schedules	Cleaning schedules in place	Dec-22	~~Dec-22~~ N/K	Red	28/11/2022 - To be considered as part of core audits.

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_AEDHDHBA11 22	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_AEDHDHBA112 2_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	Red	28/11/2022 - To be considered as part of core audits.
CHC_AEDHDHBA11 22	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_AEDHDHBA112 2_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_AEDHDHBA11 22	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_AEDHDHBA112 2_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_AEDHDHBA11 22	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_AEDHDHBA112 2_006a	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.	Confidentiality is of utmost importance and is always considered when patients attend ED, to support these notices will be displayed advising that if required an alternative area for discussion can be accommodated. However, it is recognised that due to capacity a separate room may not always be available immediately.	Jan-23	Jan-23	Amber	28/11/2022 - Consideration being given to appropriate signage.
CHC_AEDHDHBA11 22	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_AEDHDHBA112 2_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_AEDHDHBA11 22	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_AEDHDHBA112 2_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_AEDHDHBA11 22	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_AEDHDHBA112 2_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	Amber	28/11/2022 - SDM for scheduled care GGH benchmarking across HB's.
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.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	Mar-23	Red	22/02/2022- SDM confirmed recommendation to remain open until we're in a position to review the progress of the Glaucoma patients in March 2022 - then we'll have an idea of when the work will be completed by. 21/03/2022- Recommendation added back to the main audit tracker. 13/05/2022- SDM provided revised date of March 2024. This will be depending on the regionalisation with Swansea Bay (ARCH), in principle this should cover the whole of UHB. Ceredigion discussions on Mid Wales Collaborative with Powys and Betsi- discussions taking place on Mid Wales lead for Ophthalmology to be advertised, difficulties in recruiting in Ceredigion area. 07/07/2022- Risk stratification of Glaucoma patients now complete. Work continues on outpatient templates to ensure capacity to review patient backlog. Current difficulties with staff capacity March 2023, as per Ministerial measures for addressing backlog. Meeting to take place with WG which will hopefully provide clarity on targets. 30/09/2022- Revised completion date to be kept as March 2023. A discussion has taken place with WG, they want eye care measures and MD to be implemented; the service are micro-managing capacity and booking to ensure both targets are prioritised. 9/1/2023- Meeting with team planned this month (capacity, model for delivery etc).
DU_AWCCSTPAR05 19	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_AWCCSTPAR051 9_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.
DU_AWRPTDECM0 919	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_AWRPTDECM09 19_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.
DU_AWRPTDECM0 919	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_AWRPTDECM09 19_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.
DU_AWRPTDECM0 919	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_AWRPTDECM09 19_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. 9/1/2023 - Position still the same. Exploring regional posts with Swansea Bay.
DU_AWARCLPSA03 22	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005a	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	The Health Board is currently developing a new assessment form, which will incorporate a section on risk, and safety, to ensure this, is completed at point of assessment.	Dec-22	Mar-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.
DU_AWARCLPSA03 22	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005b	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clear process to be identified in both Liaison and CMHC SOP about recording of risk and safety plan.	Dec-22	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.

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_AWARCLPSA03 22	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005c	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	6 Monthly audit of patient risk assessments to be completed by team managers to review quality.	Dec-22	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.
DU_AWARCLPSA03 22	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005d	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clinician to attend WARN and Storm training	Dec-22	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.
DU_AWARCLPSA03 22	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA032 2_005e	N/A	The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Process for sharing assessment and intervention outcomes are currently being developed by Team mangers to ensure a consistent and timely approach with the sharing of information with refers.	Dec-22	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.
DU_AWRPSMHS11 22	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 _001	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. 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_AWRPSMHS11 22	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 _002	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. S-CAMHS will ensure clarity for the different service functions are outlined in the Service Specification	Jul-23	Jul-23	Amber	
DU_AWRPSMHS11 22	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 _003	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. S-CAMHS Service Specification will be updated to ensure consistency. 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_AWRPSMHS11 22	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 _004	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. An improvement trajectory will be developed to monitor the numbers of clients waiting for clinical interventions following assessment under Secondary CAMHS. Workforce capacity will be reviewed to address demand imbalance in each locality team and increase recruitment into vacant posts. A review of clinicians' Job Plans overseen by locality team leads in conjunction with professional clinical leads will be undertaken. 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. 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	
DU_AWRPSMHS11 22	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 _005	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 CTP audit pathway for line managers will be developed in line with Health Board Policy. 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_AWRPSMHS11 22	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 _006	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. 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. A service user evaluation will be undertaken to evaluate effectiveness	Jul-23	Jul-23	Amber	
DU_AWRPSMHS11 22	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 _007	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. Secondary S-CAMHS will undertake Demand and Capacity Training.	Jul-23	Jul-23	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	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.
HIW_20136_GGHM W	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_GGHM W_001a	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Morlais is classified within C4C as significant. The most recent audit was undertaken on the 25th February 2021. A detailed action plan is being compiled to identify the extent of repairs required and to establish a target cost, funding source and an achievable timescale for completion. The initial analysis will be undertaken by May 2021 with subsequent action (subject to funding approval) phased in following the bid and approval process. In the event capital funding is unavailable to address these concerns then the service will escalate accordingly.	May-21	~~May-21~~ ~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	19/05/2021 Operations Manager Confirmed: We commenced the redecoration work in the area on the 11/04/21 , this work is due for completion on the 18/07/21 The bathroom refits required capital funding , which was approved last week 11/05/21 (Completed) Capital funding approved. We are in the process of completing a multi-quote to appoint a contractor for this element of the work. This type of sanitary wear tends to have a significant lead to delivery date , so we have allowed 8 weeks. Anticipated commencement on site 16th August 21 -completion 15th November 21. 31/05/2021 Recommendation revert back to Amber as not completed until Nov 2021. 4/06/2021 Recommendation is now Red. 07/09/2021 - confirmation from ward manager received that no bathroom refits/work had started in August. Recommendation to remain red. 29/11/2021 - confirmation received that redecoration work is now complete, however there has been a delay in receiving new toilet pans due to required specifications. Expected delivery date of end of November, with anticipated completion following delivery of January 2022. Update 23/02/22 Works currently underway to change broken toilets and sinks in en-suite bathrooms. Update required from Simon Chiffi for further information as lead for this action. 18/05/2022 chased, no update received. QAST update 11/07/2022 Ward manager is aware that works are still not complete. The bathroom refits are outstanding. Estates/operations manager is leading on this recommendation and has been chased for an update February, March, April and May 2022. QAST update 07/09/2022 - Update from Estates the toilets are completed, and a couple of wash hand basins to be fitted (but were additional to the HIW report) QAST update 01/11/22 - no further update since Sept 22.
HIW_20136_GGHM W	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_GGHM W_001b	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Outside of this specific challenge within Morlais, The Estates team are phasing in a new Synbiotix system (already in place in other Health Boards) that will allow real time data, reaction and improvements in efficiency in cleaning standards. This system is being phased in throughout the 2021/22 financial year.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	19/05/2021 New system delayed, although the C4C work identified is being progressed and capital funding has been approved work is likely to be completed November 21. 29/11/2021 - update received that work is due to be complete by March 2022, in line with original completion date provided to HIW. Recommendation therefore to remain Amber. 23/02/2022 update Unaware of update regarding synbiotix system. I believe operations manager is leading on this action and will have further information to update. 18/05/2022 - chased, no update received. QAST update 11/07/22 Estates have been chased for an update February, March, April and May 2022. QAST update 07/09/22 update requested July/ Aug from Estates. QAST update 01/11/22 update requested from Estates Sept/ Oct.
HIW_20136_GGHM W	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_GGHM W_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.

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HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	~~June 22~~ ~~Oct 22~~ ~~N/K~~ Jan-23	Red	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_001b	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Point of Ligature, Major works to be completed. Plans currently out to tender. Construction Phase 1 on target to be commenced 15/11/21. Phase 2+3 to be commenced 03/01/22, completion expected April 2022.	Apr-22	~~Apr 22~~ ~~Jul 22~~ ~~N/K~~ Jan-23	Red	16/11/21 - MHLD PoL Capital Works Meeting - Edmunds & Webster have been assigned the contract, and waiting for Finance to approve. Construction Stage to start on the 22/11/21. 22/10/21 - Fire Stopping Meeting - Fire Stopping works are to start on the 08/11/21 and the PoL works to start on the 22/11/21 working parallel with each other, as majority of work is outside with minimal work on the ward. 09/11/21 - Pre-Contract Meeting with Contractors 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in April 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 PO work is currently being undertaken with a provisional completion date of end of July 2022. QAST update 07/09/2022 requested update 18/07/22, none received to date. QAST 01/11/22 QAST chased for update Sept / Oct none received.
HIW_21037_WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSCW_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov 21~~ ~~Jan 22~~ ~~Oct 22~~ ~~N/K~~ ~~Jan 23~~ 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
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_010b	High	During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	To note the current policy in relation to FoC is still in use and staff are working closely with WAST colleagues to minimise the risk of skin tissue damage when there are delays in line with current policy.	Mar-22	~~Mar-22~~ ~~N/K~~ Jan-23	Red	16/02/2022 Previous management response - This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Where appropriate the ED nursing staff will undertake intentional rounding paperwork on patients whilst on the ambulance. Patients are turned on the trolleys in the ambulance if they are delayed with offload for more than 1 – 2 hours. Additional suitable equipment is being sought by the Health Board for use during offload delays. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 chased PPH & GGH for update Feb, April and May 2022, none received. QAST update chased all sites Sept/ Oct Update 27/10/22 (BGH)Patients at risk identified eg ?#NOF prioritised for offload and Xray ,if positive air mattress and facia block . Good communication with WAST Team Leader regarding existing pressure damage or long lie patients for priority pressure relieving measures. Health Board to focus on exit blocks to avoid offload delays (WGH) Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled Care HoN. Utilisation of Rapid assessment area in WGH to support appropriate care delivery when patients are awaiting offload.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_011b	High	WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	To note the current policy in relation to FoC is still in use and staff work closely with WAST colleagues to ensure patients who are delayed in ambulances maintain adequate nutrition and hydration in line with current policy	Mar-22	~~Mar-22~~ ~~Oct 22~~ ~~N/K~~ Jan-23	Red	16/02/2022 Previous management response - This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Where appropriate the ED nursing staff will undertake intentional rounding paperwork on patients whilst on the ambulance. Patients are turned on the trolleys in the ambulance if they are delayed with offload for more than 1 – 2 hours. Additional suitable equipment is being sought by the Health Board for use during offload delays. Ensure that food and drink is available to the patients if clinically appropriate. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 Update GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. ED nursing staff allocated to support care in ambulance and will undertake appropriate assessments and onward Fundamentals of care delivery on patients whilst on the ambulance. QAST update 01/11/22 all sites chased, no further update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	23/02/2022 (BGH) - The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. Doctors' rotas reviewed every day to ensure appropriate cover. The Executive Director of Patient Experience and Quality agreed that if ED have to surge into minors, then one additional RN to be put on duty for nights. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E / AMAU have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST Update 01/11/22 - 27/10/22 (BGH) Free access to kitchen beverages and sandwiches stocked in fridge . Excellent rapport between WAST and Emergency staff regarding fundamentals of care (WGH) Confirmation from WGH that hot food and drinks provided to all patients waiting in department or awaiting handover.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_015	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved	N/A – for WAST consideration	N/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.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been setup chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation. 23/02/2022 (BGH) - Ambulance offload policy arrangements are ongoing. Meetings due to be held in February. Acute stroke pathway has been in place long standing and the crews can handover immediately to teams in the CT scanner area. 18/05/2022 - position in WGH same as BGH (above). QAST update 11/07/22, no update from PPH & GGH to date. 07/09/22 GGH & PPH Ambulance offload policy being updated currently with WAST representatives on group, individual department handover processes are in appendices within this policy. QAST update 01/11/22 chased sites , no further update received.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber-on schedule, Green-complete)	Progress update/Reason overdue
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ Jan-23	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Ambulance offload policy, embedded in which is the Care of the patient in the ambulance policy. Actions are awaiting to be agreed by the Health Board with a meeting due in early March to discuss, led by Unscheduled care HoN with Task and Finish Group. 18/05/2022 - requested, none received. QAST update 11/07/22 requested update from PPH & GHH Feb, March, April and May 2022, none received. QAST update 07/09/22 for GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. QAST update 01/11/22 chased all sites, no further update received.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001c	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will develop a consistent format for documentation that is meaningful for patients.	Jan-23	Jan-23	Amber	QAST update 07/09/22 T&F group developed.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_001d	N/A	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The T&F group will co-produce with service users a leaflet to support the documentation	Jan-23	Jan-23	Amber	QAST update 07/09/22 T&F group developed.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_003	N/A	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	All CMHT's have identified practitioners who will ensure the annual health checks are undertaken. Each CMHT operates a link worker system with GP practices to promote physical wellbeing for patients.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Jan-23~~ 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.
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
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_015a	N/A	Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	To progress the work, that is already underway with 3rd sector partners, to understand the issues in the local context.	Dec-22	~~N/K~~ Mar-23	Red	18/05/2022 - Understand the issues in the local context before identifying further actions through discussions with WWAMH. Aileen Flynn will support with this QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22 chased Oct 22. No response yet received. 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_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_019a	N/A	Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.	To progress the work, that is already underway with partners, to understand the issues in the local context.	Dec-22	~~N/K~~ Mar-23	Red	18/05/2022 - Understand this within our local context through engagement with WWAMH QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no update received. 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_019b	N/A	Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.	To discuss the findings with the WWAMH and identifying further actions required.	Dec-22	~~N/K~~ Mar-23	Red	QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no 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.
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.
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.
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.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_011	N/A	Tea bay needs a complete refurbishment, and a fridge must be made available for the patients	Estates to review to be carried out including the provision of a fridge and regular maintenance of tea bay and surroundings to be arranged.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_012	N/A	A designated office space is made available on the ward for Dr and medical staff	Senior Nurse and Ward Manager have identified area. Estates work required to modify area.	Mar-23	Mar-23	Amber	QAST update 01/11/22 chased action Oct 2022.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_015	N/A	Shelving in clinical room is replaced and reorganised.	Estates work to be carried out and regular maintenance of shelves and surroundings to be arranged. Shelves to be reorganised once Estates work has been completed.	Dec-22	~~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_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_002	N/A	The health board is advised to ensure that cleaning and related substances are stored in a locked cupboard as an additional safeguard due to the patient group on the ward.	A new lockable cupboard ordered, in the interim the 5 litre chemicals (too large for the current cupboard) are stored in a secure cupboard prior to use. Staff will dispose of any left-over cleaning solution after use. The 5 litre container is stored in secure cupboard following use in line with COSHH regulations.	Dec-22	~~N/K~~ Mar-23	Red	23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
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_005	N/A	The health board must ensure that patient information is recorded on all relevant clinical documents.	Staff will be reminded of the importance of the recording of allergies and patient weights on drug charts. Communication will be via a memo to all staff.	Dec-22	~~Dec-22~~ ~~N/K~~ Mar-23	Red	23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
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_006	N/A	The health board must ensure that signatures are countersigned with a printed name on all relevant documentation.	Staff will be reminded of the importance of ensuring signatures are countersigned with a printed name. Communication will be via a memo to all staff and, if deemed necessary, staff will be asked to undertake documentation training.	Dec-22	~~Dec-22~~ ~~N/K~~ Mar-23	Red	23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
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_007	N/A	The health board must ensure that the domestic fridge is replaced with a clinical medication fridge in a timely manner.	A clinical medication fridge has been ordered, awaiting delivery.	Dec-22	~~Dec-22~~ ~~N/K~~ Mar-23	Red	23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023.
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	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	~~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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber-on schedule, Green-complete)	Progress update/Reason overdue
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_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.
HDUHB-1920-05	Oct-19	Internal Audit	Welsh Language Standards Implementation	Open (external rec)	Reasonable	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	Director of Communications	HDUHB-1920-05_001	Low	R1. Management should consider introducing a Welsh Language Standards e-learning module as part of the ESR training programme to ensure staff and managers understand their roles and responsibilities in line with the Standards.	The Welsh Language Services Team has contributed to a national piece of work being co-ordinated by Betsi Cadwaladr UHB and Shared Services, in the Once for Wales spirit of partnership, and the outcome is an e-learning resource. Timescale for this is currently unknown, but we plan to roll out once launched. In the meantime, we are targeting focused training and awareness and cascading through key teams.	Oct-19	~~Oct-20~~ ~~Apr-21~~ ~~Oct-21~~ ~~Dec-21~~ ~~Apr-22~~ Jun-23	External	21/10/2020 update-Work is on-going at an All-Wales level to produce an e-learning module for all Health Boards. This has been delayed due to Covid-19, but the group plans to launch the new e-learning model in April 2021.It is anticipated that face-to-face corporate induction sessions will recommence within the next month (November 2020). Revised date of April 2021 provided. 28/01/2021 update-Work is progressing at an All-Wales level, with Hywel Dda UHB input, to produce an e-learning module for all Health Boards in Wales. This has been delayed due to Covid-19, but the group is on track to launch the new e-learning model in April 2021 by the amended deadline. Recommendation is currently outside the gift of the UHB to implement. 26/05/2021- Reporting officer confirmed no update provided at this moment but the UHB has inputted into the process. Welsh Language standards meeting due in June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 18/08/2021- At a recent All Wales Welsh Language Officers meeting (July 2021), Betsi Cadwaladr informed the meeting that the expected date for completion is October 2021. 02/11/2021-Demo has been provided of the new e-learning module, should be ready by December 2021. 29/03/2022- WL Service Manager confirmed draft was shared in a meeting earlier in March and should be live end of April 2022. 11/05/2022- Director of Communications confirmed this has been delayed at an All Wales level but a revised timescale is not yet known. 08/09/2022- Director of Communications to check current position with All Wales work and feedback to the Assurance and Risk Team. 11/11/22 - Welsh Health Circular (WHC/2022/028) received 10/11/22 - e-learning module will be available to all Health Boards via ESR. Reporting expected through More than just words reporting framework in June 2023.
HDUHB_1920_40	Mar-20	Internal Audit	IM&T Assurance – Follow Up	Open	Reasonable	Digital and Performance	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB_1920_40_003	Medium	R3. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	The business manager was able to supply a paper which was produced for the Executive Team in June 2019, this paper evidences that work is underway to address the noncompliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence that this recommendation, to seek advice on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to is in train.	May-19	~~May-21~~ ~~Aug-21~~ ~~Oct-21~~ ~~Nov-21~~ ~~Feb-22~~ ~~Apr-22~~ ~~Jul-22~~ ~~Sep-22~~ Mar-23	Red	18/07/2022 - Withybush Switchboard has been live on the new infrastructure for the past 3 months, this has highlighted some technical issues in the new infrastructure and we are working with suppliers to overcome these challenges. Currently the other three sites have the new switchboards operating in a test environment where there are additional challenges owing to a mixture of Philips and Mitel phone systems. In addition due to the recent TUPE arrangements for the Withybush switchboard staff where they have moved employing organisation from Welsh Ambulance Services NHS Trust to Hywel Dda we have to pause some technical elements of the project which has caused the go live dates on GGH, BGH and PPH to move to the middle of September 01/11/2022 - awaiting completion of the final stages of work in order to close this recommendation, revised timescale provided. This is in line with the risk action plan as noted on the corresponding risk on the Digital register. 10/1/2023 - Post-implementation review of system planned for 19/1/2023.
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_002	Medium	R2. The PBCs and as they progress to Outline and Full business case stages will need to determine the in-house Estates staff requirements, and how these will be satisfied given current pressures.	Agreed. The Health Board will need to determine how the necessary Estate in-house staff resources is established in order to successfully deliver the AHMWW and Business Continuity/Major Infrastructure PBCs.	Feb-21	~~Feb-21~~ Jan-24	Amber	21/03/2022- Recommendation turned from red to amber, as this is a future action that cannot yet be evidence as completed, but is within the gift of the HB to implement. 03/05/2022- January 2024 revised completion date provided to align with AHMMW report timescales, recommendation to remain amber as this future action cannot yet be evidenced as completed. Director of Estates, Facilities and Capital Management to send detail of the analysis of in house resources required for Major Infrastructure PBC. 18/07/2022- Documentation has been shared with Internal Audit, however further clarity required if this satisfies the recommendation requirement. 12/08/2022- Further detailed evidence required from IA - dates, plans and resources submitted to WG, more detail has been requested including phasing over the next 7 years. Further funding provided for wider delivery model- when that is signed off the UHB will issue resources required for full business case. Estates has progressed as much as possible at this stage. 12/09/2022-- On 22/07/22 funding of £150k of fees to develop the Business Continuity PBC. Further discussions with WG around future fee contributions will be had FY 23/24. 11/11/2022- costing work is now well underway and the current programme will present the outcome of this work in circa January 2023. Update being reported to SDODC November 2022. Internal Audit to check what is still required for this recommendation to be noted as completed. 10/01/2023-Internal Audit confirmed they will check what is still required for this recommendation to be noted as completed.
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lisa Humphrey/Project Director	Director of Strategic Development and Operational Planning	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP:SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ Jul-23	Amber	26/05/2021 no update. 09/06/2021 in progress. Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract. 02/03/2022 & 03/05/2022- Expected to remain open until July 2023. 03/05/2022- outstanding rec expected to remain open until July 2023. Exec Lead amended from Director of Operations to Director of Strategic Development and Operational Planning as remaining recommendation is for Strategic Development and Operational Planning Directorate to implement. 12/08/22-Date remains July 2023 30/08/2022 - Director of Strategic Developments and Operational Planning confirmed no change. 10/11/2022 - Head of Captial Planning confirms no change. 10/01/2023-Head of Captial Planning confirms no change - ongoing monitoring of contractor performance which will continue until completion of the contract planned for July 2023.

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_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.
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.
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.
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.
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.
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.
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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-22~~ Mar-23	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is 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.
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 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 progress of this recommendation.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber-on schedule, Green-complete)	Progress update/Reason overdue
HDUHB-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.
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_001	Medium	The Health Board should ensure that all budget holders sign the Accountability Agreement letters, as evidence of accepting ownership of their individual budgets, in order that they can be held to account for the financial performance.	Through the annual financial planning process, all Accountability Agreement Letters should be signed no later than the end of two months into the new financial year.	Jun-22	~~Jun-22~~ N/K	Red	08/07/2022 - discussion with internal audit confirmed that Financial Management Review due this financial year, where outstanding recommendations will be picked up 09/11/2022 - confirmation received from internal audit that a follow up is planned, and awaiting confirmation of scope of the review prior to fieldwork commencing
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_002	Medium	Budget holders should be reminded of their responsibility to monitor and manage their budgets, and make use of the available tools to do this. Management should consider monitoring budget holder use of the BI Dashboards and QlikView systems.	Recognising the need for familiarisation with the reports and systems across budget holders, there are different methods employed by Finance Business Partnering teams to support their budget holders with how to access and review their financial information. Each FBP team should review the financial position monthly with their budget holders, in an appropriate manner, and ongoing training provided to ensure budget holders move towards a self-service approach.	Jul-22	~~Jul-22~~ N/K	Red	08/07/2022 - discussion with internal audit confirmed that Financial Management Review due this financial year, where outstanding recommendations will be picked up 09/11/2022 - confirmation received from internal audit that a follow up is planned, and awaiting confirmation of scope of the review prior to fieldwork commencing
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001b	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	Oct-23	Amber	11/11/2022-Progress to be requested in early 2023 to ensure this is on track.
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_002b	High	R2. Training should be made available to staff to ensure that they are able to identify and manage ligature risks and perform ligature audits in line with the guidance.	A bespoke training session will be arranged for key members of staff already involved in POL audit work which will include but not be limited to the procedure, audit forms and process for managing action plans	Jun-22	~~Jun-22~~ ~~Dec-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/22 - request for update sent to Head of Health and Safety, with the following response received: Training has commenced with three wards and one Nurse Forum meeting attendance - This is continuing. To confirm with internal audit if the ongoing process is sufficient to close this recommendation. 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - Tim Harrison has added to H&S training and bespoke training. 03/10/2022 - training content has been updated, and is currently being delivered to key staff. Revised recommendation date of December 2022. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_003c	High	R3. Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile.	There will be a process introduced whereby the HB Quality Assurance and Safety Team to oversee the closure of all actions on completion. This will be included in the SOP.	Jul-22	~~Jul-22~~ ~~Dec-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - The service are in discussion with internal audit in order to obtain assurance that this recommendation has been implemented. 03/10/2022 - query raised by the Chair of the Accommodation Group, Assistant Director of Nursing, MHLD and Head of Health, Safety and Security that the Quality team will be involved in the walkabout, however action plans should be closed and agreed at the accommodation group. To request confirmation from internal audit if this satisfies the original recommendation. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_005a	High	R5. Where remedial action is required, these actions should be captured in an action plan and assigned a priority RAG rating, responsible officer and deadline for completion. A single, centralised MH&LD ligature action plan may be appropriate as this would facilitate central oversight (for example, by the Quality & Safety Team, as for HIW actions), monitoring and sharing of risks identified for consideration at other sites.	As part of the development of the WCD the template will be amended to ensure that the RAG rating, responsible officer and deadline for completion are able to be captured.	May-22	~~May-22~~ ~~Sep-22~~ ~~Dec-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update, with the following response received: Recommended for wards to start using this latest template to document their assessments and action plans. Completion date revised in line with formal approval of the procedure at HSAC scheduled for September 2022. 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - Will be completed once guidance document has gone through HSC on 12/09/2022. Revised date of 30/09/2022. 03/10/2022 - WCD approved at 11th September HSAC meeting, however the RAG status not currently included on the template. The risk score is included on the template in lieu of the RAG status, and is felt to be more meaningful than the use of a RAG status. To confirm with internal audit of this is sufficient to close the recommendation. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
HDUHB-2122-45	Apr-22	Internal Audit	Prevention of Self Harm	Open	Limited	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll/Sara Rees	Director of Nursing, Quality and Patient Experience	HDUHB-2122-45_006	High	R6. Actions should be monitored through to implementation, with assurance reported to an appropriate forum/sub-committee.	Actions should be monitored through to implementation, with assurance reported from the MH/LD accommodation group to the MH/LD QSEG.	Aug-22	~~Aug-22~~ ~~Sep-22~~ ~~Dec-22~~ N/K	Red	08/07/2022 - internal audit to request progress updates from the service 02/08/2022 - request sent to service for update 01/09/2022-Following meeting with Director of Nursing, Quality and Patient Experience, the Head of Assurance and Risk has emailed Head of Health & Safety, and Head of Adult MH Service, requesting updates for this recommendation by 05/09/2022. 09/09/2022 - To be included in report to BPPAG end of Sept 2022 and verbal update from Liz to QSEC in October 2022. 03/10/2022 - actions arising from the accommodation group are escalated to MHLD BPPAG, and where necessary to MHLD QSE. As this is a new mechanism in place, revised completion date suggested of December 2022 in order to evidence the process. 09/11/2022 - internal audit due to undertake a follow up in Q4 of FY 2022/23. Internal audit to provide progress updates and revised completion dates in the meanwhile
SSU_WHSSC_2122-02	Apr-22	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Reasonable	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	SSU_WHSSC_2122-02_005	Medium	R5. The Health Board should confirm provision of a Parent Company Guarantee in respect of Phase II of the Women and Childrens project at Glangwili.	5.1 Agreed. A new Parent Company Guarantee which includes changes to registered head office for both contractor and parent company, and the rebranding of the contractor, are in the process of being completed. The SCP is currently actioning, and has advised that this could take a further two months to complete.	Jul-22	~~Jul-22~~ ~~Sep-22~~ Mar-23	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.
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 if anything can be evidenced to close this recommendation. 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 if anything can be evidenced to close this recommendation. 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. 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. 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.
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.
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

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-26	Aug-22	Internal Audit	Fire Governance	Open	Substantial	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	HDUHB-2223-26_001a	Medium	R1a. Engagement with directorate senior management to reinforce mandatory training requirements and target compliance of >85%	The training performance statistics for levels 1-3 will now be reported to each Strategic Operations Board. Performance will be monitored on a monthly basis. Individual Clinical and General Manager leads will be required to present assurances that the 85% target is on program to be achieved.	Nov-22	N/K	Red	12/08/22-DOO flagging at his operational group. Director of Estates, Facilities and Capital Management to provide the information required for senior group reporting. Director of Operations to encourage teams re. mandatory training 07/09/2022- on track. Raised at Senior Operations Board requesting directorate support, including statistics provided. Minutes from Senior Operations Board to be shared IA when available to close off this recommendation. 10/11/2022- Estates to send evidence to Internal Audit to close this recommendation. 10/01/2023- Reporting of compliance and engagement has been shared with internal audit, awaiting confirmation.
HDUHB-2223-26	Aug-22	Internal Audit	Fire Governance	Open	Substantial	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	HDUHB-2223-26_001b	Medium	R1b. Monitor Level 4 & Level 5 fire safety training compliance and include in the report to the H&S Committee.	The training performance statistics for levels 4-5 will now be reported to each Strategic Operations Board: Performance for level 4 will report on training delivered to the volunteer Fire Wardens in the HB, (delivered by a specialist external contractor). Performance for level 5 will report on training delivered to managers at 8b and above and will be generated by the ESR system.	Feb-23	Feb-23	Amber	12/08/22-DOO flagging at his operational group. Stats required from ESR, cleansing exercise required with ESR time. 10/11/2022- On track to be included in papers reported to Senior Operations Board. in February 2023. 10/01/2023- still on track for February 2023 date.
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.
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_001	High	R1. Determine an appropriate forum for the monitoring and scrutiny of finance related matters/performance.	Reinstate the business/ performance forum to include scrutiny of finance related matters/ performance.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_003	Medium	R3a. Identify actions to mitigate the finance risk (ref 980), seeking input from the Finance Team where appropriate	Update financial risk to include mitigation and main drivers for year to date and end of year projected overspend.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_004	Medium	R3b. Update the risk register to reflect the new actions agreed following annual review, and ensure that these are completed within the stipulated timescales.	Risk Register to update to reflect current position, agreed actions with revised timescales.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_005b	Medium	R4b. Develop an action plan and timeline to improve the Directorate position for incidents and complaints.	Action plan to be developed to support the continued reduction in outstanding incident reports.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_006a	Medium	R5a. Identify and prioritise service areas with the lowest training compliance rates (relative to staff numbers)and set a reasonable deadline for improving compliance, allowing staff protected time to complete mandatory training.	Continued review of nursing compliance rates and monthly scrutiny.	Sep-22	~~Sep-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_006b	Medium	R5b. Identify and prioritise service areas with the lowest training compliance rates (relative to staff numbers)and set a reasonable deadline for improving compliance, allowing staff protected time to complete mandatory training.	Service Delivery Manager to develop action plan with consultant leads to improve mandatory training compliance for medical staff	Nov-22	~~Nov-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-11	Oct-22	Internal Audit	Directorate Governance – WGH Unscheduled Care	Open	Reasonable	Unscheduled Care (WGH)	Unscheduled Care (WGH)	General Manager, Unscheduled Care	Director of Operations	HDUHB-2223-11_007	Medium	R6. Line managers to be reminded of the requirements of the All-Wales Managing Attendance at Work Policy.	Updated version of Management at Work Policy to be circulated to all Dept leads reinforcing policy requirements.	Oct-22	~~Oct-22~~ N/K	Red	09/11/2022 - IA currently obtaining progress updates from the service and revised timescales where any recommendations remain outstanding
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_001	Medium	R1. Ensure that all directorates adopt the Health Board standard ToR and agenda templates for directorate QS&E groups.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include use of the template Terms of reference and agenda. Members will receive a copy of the templates.	Nov-22	~~Nov-22~~ N/K	Red	
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_002	Medium	R2. QSE Group minutes should clearly document the key points discussed and identified for further discussion/escalation.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include clear documentation of key points and consideration of all items (as recommended above).	Nov-22	~~Nov-22~~ N/K	Red	
HDUHB-2223-02	Oct-22	Internal Audit	Quality and Safety Governance, issued October 2022	Open	Reasonable	Nursing	Nursing	Head of Quality and Governance	Director of Nursing, Quality and Patient Experience	HDUHB-2223-02_003	Medium	R3. Minutes should demonstrate consideration of all items on the standard agenda template, even if only to confirm that there is nothing to report.	The findings of this review by Internal Audit will be shared with Directorates through the Operational Quality Safety and Experience Sub-Committee. This will include clear documentation of key points and consideration of all items (as recommended above).	Nov-22	~~Nov-22~~ N/K	Red	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_001	Medium	R1. Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	In-patient falls group set up and Task & Finish group established to update Falls Policy.	Dec-22	~~Dec-22~~ N/K	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.
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	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_003	High	R2. An MFRA must be completed for all eligible patients (as identified in the NICE guidance and Health Board Falls Policy) within 6 hours of admission.	Staff reminded of the importance of completing the MFRA on admission in line with guidance. Through professional forums, Practice Development Nurses on sites and monitored through site scrutiny meetings. Though professional forums, staff will be reminded of the importance of completing the MFRA (Multifactorial Risk Assessment) on admission in line with guidance and Health Board policy and re-assessed in response to the patient clinical need. This will be supported by Practice Development Nurses on sites and compliance monitored through site scrutiny meetings, using WNCR (Welsh Nursing Care Record) compliance data.	Dec-22	~~Dec-22~~ N/K	Red	20/01/2023 - This recommendation will also be included within the inpatient falls group action log/plan for ongoing review and support of implementation
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_004	High	R2. Consider implementing independent checking controls to ensure the existence and quality of MFRAs, particularly in falls 'hot spots'. This control has been observed at other Welsh Health Boards.	Spot check audits of MFRA quality and forms to be undertaken quarterly and actions fed back to relevant sites. Action to be monitored through PNMFThe audit findings will be included as an agenda item to enable discussion with the Heads of Nursing and the Executive Director of Nursing will write to Senior Nurse Management Team members to highlight the findings and necessary actions.	Jan-23	Jan-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_005	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	Apr-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_006	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	Apr-23	Amber	

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HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_007	Medium	R5. Monitoring/review of falls incidents to identify those not investigated in a timely manner and noncompliance with the requirement for focused review. Issues identified should be addressed with the responsible individual(s), with action taken for repeated non-compliance where appropriate.	Scrutiny meetings to be reviewed and Terms of reference will be updated to include monitoring of falls incidents and quality of the investigation. Action identified to be reviewed at each meeting.	Jan-23	Jan-23	Amber	
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_008	Medium	R6. Review existing governance arrangements for falls prevention and management and identify an appropriate forum for Health Board-wide sharing of lessons learned.	The 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	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.
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.
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	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_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	
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~~ N/K 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.
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~~ N/K Mar-23	Red	05/12/2022 - This report superseeded HDUHB-2122-12. 05/12/2022 - This 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.
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-22~~ Mar-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
HDUHB-2223-14	Dec-22	Internal Audit	Individual Patient Funding Requests	Open	Reasonable	Medical	Medical	Head of Effective Clinical Practice & QI	Medical Director	HDUHB-2223-14_001	High	R1. The IPFR Team, Finance and Pharmacy should collectively agree and establish a suitable mechanism for capturing and monitoring IPFR spend to ensure that approved costs and treatment duration are not exceeded. Noting that the IPFR budget sits outside of the IPFR Team, responsibility and arrangements for monitoring cumulative IPFR spend should be agreed. If this is outside of Finance (as budget holder), sufficient information needs to be provided Clarify ownership and accountability for the IPFR budget, including responsibility for monitoring spend,	To agree a mechanism with Finance (budget holder) and pharmacy to ensure spend is monitored and not exceeding the approved treatment duration. Agree a reporting process for monitoring cumulative IPFR spend against defined budgets and within standing budgetary control requirements.	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
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_001	Medium	R1. Financial approval requirements for CHC/FNC care packages should be reviewed, noting observations at other Welsh Health Boards, and reflected in the Health Board's Financial Scheme of Delegation.	As outlined, the Senior LTC Team have been requesting that the Scheme of Delegation be updated for some time and as annual cost have risen. This is now awaiting approval and will be put into operation use with immediate effect.	Jan-23	Jan-23	Amber	
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_002	Low	R2. Explicit evidence of authorisation (such as email) should be retained on the case file to demonstrate appropriate approval in line with requirements.	Email evidence of authorisation will be incorporated into common practice within the Business Support Function with immediate effect to ensure a clear audit trail for approval.	Jan-23	Jan-23	Amber	
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	Feb-23	Amber	
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Strategic Development and Operational Planning	HDUHB-2021-11_0014	N/A	R14. The process for the prioritisation of schemes for the Infrastructure Investment Enabling Plan	Work has already been undertaken on the development of a prioritisation matrix for the allocation of part of the UHB's discretionary programme. WG Planning Framework call out the need to prioritise the bids for All Wales Capital. The prioritisation framework will need to link with the • UHB Strategic objectives • UHB's Planning Objectives • Implementation of AHMWW Strategy • Business continuity Infrastructure Investment Enabling Plan to be signed off as part of IMTP	Jan-22	~~Jun-22~~ ~~Feb-22~~ ~~Mar-22~~ ~~Sept-22~~ N/K	External	07/01/2022- Completion date moved to align with sign off as part of IMTP. 02/03/2022- A Report is being prepared for Executive Team to consider in March 2022 prior to a WG submission by 31/03/2022. 03/05/2022 - Prioritisation of schemes currently included in our Infrastructure Plan was undertaken for the submission of a draft 10 Year NHS Wales Plan to WG. Feedback from this national exercise will be utilised to inform the next steps in this process. Revised date of September 2022 provided. 07/07/22 On hold pending feedback from WG on 10 Year Infrastructure Plan 01/08/22 Continues to be on hold. Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K 12/08/22-N/K until feedback from WG received 12/09/22- Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K. 10/11/2022- Same comment as above- Feedback from WG on 10 Year Infrastructure Plan is expected in due course . Revised Completion date is therefore N/K. 09/01/2023- Same comment as above. Agreed with Internal Audit for recommendation to be amended from red to external (i.e. outside the gift of the UHB to currently implement).
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	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
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 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.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	~~Jul-20~~ ~~Dec-21~~ ~~Apr-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 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.
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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber-on schedule, Green-complete)	Progress update/Reason overdue
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ Mar-23	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 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.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. 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.
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.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_002	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_003	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_005	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_007	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.
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	~~Oct-22~~ Mar-24	Red	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_013	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Aug-23	Red	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 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.

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/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_001	High	R1. A fire door survey is required at the Tenby cottage hospital site due to a number of defects found at the time of inspection. The findings of this survey must be completed within the mentioned timescale. Fire resisting doors need to be fitted with: • A self-closing devices including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_002	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. WHTM 05-02 Chapter 5 and paragraph 5.12. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_003	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22	~~Oct-22~~ Mar-23	Red	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_001	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	Nov-22	~~Nov-22~~ Oct-23	Red	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.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_003	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	Nov-22	~~Nov-22~~ Oct-23	Red	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.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_004	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	Nov-22	~~Nov-22~~ Oct-23	Red	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.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_005	High	R5. The cross-corridor doors in "Picu" was missing a self-closing device. A self-closing device is required on this door to ensure it closes fully into its rebate.	Full action plan held by Estates.	Nov-22	~~Nov-22~~ Oct-23	Red	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.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_008	High	8. A hold open device (or alternative solution) is required on the "Step Down" kitchen door. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Nov-22	~~Nov-22~~ Oct-23	Red	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.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_001	High	R1. Additional electrical sockets are to be provided where trailing leads, adapters or extension leads are in use. Multi-plug adaptors can be hazardous and are not to be used.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_003	High	R3. All combustible materials, ignition sources and obstructions should be removed from all the means of escape routes, internally and externally. Ensuring good housekeeping is maintained.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_004	High	R4. A Review of signage is required throughout the property. Indicate the nearest way out (in case of fire) with fire exit signs that comply with BS 54F. Exit Signs must be visible for people that might need to refer to them.	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00111715	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00111715_005	High	R5. Records must be kept of events, tests, or maintenance of the following equipment / installations. Records must be made available to an inspector during an audit: •Suppression system •Roller shutter •Dampers •Automatic operated vent (AOV) linked to the fire alarm system It is recommended the records are kept in a logbook	Full action plan held by Estates.	~~Nov-22~~ Jan-23	~~Nov-22~~ Jan-23	Amber	07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022- letter dated 31/08/2022 from MWWFRS confirms UHB has 5 months to complete recommendation by the date of the letter.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout the block. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	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.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_008	High	R8. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion January 2023.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Blue Block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Unscheduled Care (BGH)	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ 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.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_008	High	R8. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms Jan 2023 date.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.

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.
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.
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	Unscheduled Care (BGH)	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_007	High	R7. An assessment should be undertaken to ensure there is a suitable and up to date Fire management Plan. The fire management plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-22	~~Sep-22~~ 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.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_001	High	R1.A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_004	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_006	High	R6. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027.
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.
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	Red	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.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_010	High	R10. The responsibility for Horizontal, Vertical and Total Evacuation lies with responsible persons under The Order, and staff working for such responsible persons, and not the Fire and Rescue Service. It is essential that all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises…. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time….' Evidence of this training must be made available to fire safety inspecting officers when they audit your premises. It is good practise to have a live evacuation training session to ensure that the evacuation procedure is suitable and sufficient	Full action plan held by Estates.	Jan-23	Jan-23	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion January 2023.
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	
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	
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 DS7 needs replacing.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/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	

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_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	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_006	High	R6. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided at; • All external escape routes Signs should be designed and installed in accordance BS 5499-4:20	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_007	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_008	High	R8. Locate the solar PV isolator in a position away from the roof area or add a device that would allow isolation away from an area of risk.	Full action plan held by Estates.	Mar-23	Mar-23	Amber	
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	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_002	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_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~~ 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_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-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_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	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_010	Low	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_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	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_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	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_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	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	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_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).

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_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. 21/03/2022 - Report re-opened and rec 6 placed back on the audit tracker from the Strategic Log. New SDM in post has confirmed she will be reviewing this with the Clinical lead to review respiratory as a whole pathway, and a risk will be raised on Datix regarding the service. This will take place once SDM returns from annual leave. 12/05/2022 Anna Thomas is now in place as SDM for Respiratory Medicine. Weekly meetings are in place for Keir Lewis and SDM. The overall respiratory Plan has had to dynamically change due to failure to recruit respiratory consultants after voluntary resignations, issues with personal circumstances and planning for imminent retirement. This has put huge stress on the respiratory system at the time when the Covid pandemic has increased demand for respiratory physicians worldwide. Recruitment continues to be ongoing and although there has been a lack of interest in the past, there seems to be an appetite recently so we are hopeful. A plan is in place to train-up known junior doctor staff but this is a medium term plan. Other avenues are being explored to support the service including approaching neighbouring trusts. Realistic and operational short term plans are now in place to release specialist physicians from work that other physicians can undertake (acute on call, General ward rounds), in order to free up specialist time providing input on a health board wide basis. This of particular relevance to Lung cancer where Dr Robin Ghosal has taken responsibility as Lung Cancer lead running the Lung Cancer service single handed. This interim service provision will continue until we can recruit. Respiratory service are arranging an Away Day in June which will focus on strategic planning and review of the service model with the support of the Quality Improvement & Service Transformation.
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director.	Dec-19	~~Dec-21~~ ~~Oct-22~~ N/K	Red	09/02/2021- update from new SDM- We have improved boarder free working amongst the clinicians and this has reduced the need to have an enhanced clinical leadership on shift in the short to medium term. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Meetings have begun with the clinicians from across Hywel Dda. These meetings cover multiple topics including OOH working practices such as border free working. These meetings will continue over the next 2-3 months. Further updates will be available following the meetings and evaluation of points raised and actions. The Shift Supervisors are being encouraged to manage the shifts more robustly to enable a more efficient service and access to care by patients contacting the service. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 - The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (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
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_003	N/A	R3. Multi-Disciplinary Workforce Physician Associates to also be considered as part of the longer term strategy.	This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign.	Mar-20	~~Dec-21~~ ~~Oct-22~~ N/K	Red	09/02/2021- update from new SDM- After assessment physician associates are not for immediate deployment in Out of Hours but will be considered as part of the longer term Multi-disciplinary team. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- A multi-disciplinary team continues to be a high priority of the OOH workforce plan. Recently the new SDM and OOH management team with the Workforce Development team have reconvened to continue with work that began pre Covid-19. This evaluation of the OOH workforce and development of future workforce models is underway with plans and actions set. The use of Physicians Associates will be considered within this work. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 – The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (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
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_006	N/A	R6. Wider Workforce Planning The clinical competencies framework need to be considered for supporting ACP's, UCP, HCSW etc. and should now drive the future workforce planning	Initial meetings with Assistant Directors of Nursing have taken place. Senior Workforce Development Manager is assisting in mapping out workforce requirements.	Dec-19	~~Dec-21~~ ~~Oct-22~~ N/K	Red	Initial meetings with Assistant Directors of Nursing have taken place and frameworks will be assessed within the nursing directorate. Senior Workforce Development Manager is assisting in mapping out workforce requirements as a part of TCS agenda, delayed significantly by COVID. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- New SDM now in place to drive this work forward. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Similar to the multi-disciplinary team action the wider workforce plan will form part of the work recently reconvened between OOHs and the Workforce Development team. Stakeholders are being identified and will be invited to participate in the evaluation and design of the OOH workforce. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 – The recommendation remains valid and relevant, and work has commenced in addressing it. It is noted that full implementation has been delayed due to Covid, and an on-going review of the OOH service model. Given the developments of new initiatives since the recommendations were originally raised (eg SDEC and the 111 service), consideration is to be given as to whether the TOR for the original peer review report has now been superseded – Deputy Director of Operations to discuss with the ED of Operations 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 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
PR_OHPR1119	Nov-19	Peer Review	Out of Hours Peer Review, issued November 2019	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR1119_014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical /operational staff in hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	~~Mar-20~~ ~~Oct-20~~ ~~Dec-21~~ ~~Oct-22~~ N/K	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- recommendation still delayed due to Covid, however in the meantime any significant issues are reported to the Director of Operations. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021-The Clinical Lead and Service Delivery Manager are planning to meet all the OOH workforce to discuss issues and seek a team approach to identify good practice and areas requiring improvement. Regular contact with the Deputy Medical director and Associate Medical Director and their inclusion in meetings is allowing a timely response to discussion points and access to further support and advice. The SDM has begun discussion to design and implement a staff survey which will be made available to the entire OOH workforce. The results will enable a meaningful evaluation of the OOH workforce, allowing consideration of the needs and opinions in service improvement. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH. 10/03/2022 - Deputy Director of Operations to meet with ED of Operations to determine if this recommendation is relevant as at March 2022, given initial report raised in November 2019. 03/05/2022 - e-mail sent to SDM and Deputy Director of Operations to clarify if the recommendations can be closed based on previous update received. 12/05/2022 - New peer review scheduled to commence on 31st May 2022, although this may be postponed due to operational pressures. 24/08/2022 - confirmation that the peer review was conducted in July 2022, and service currently awaiting updated report 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

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_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Digital and Performance	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_001b	N/A	Each Local Children's Cardiology Centre will provide appropriate managerial and administrative support for the effective operation of the network.	IT system development under way.	Mar-22	~~Mar-22~~ ~~Dec-22~~ 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
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_002	N/A	e. address how paediatric cardiologists and paediatricians with expertise in cardiology (PECs) will work across the network, including at the Specialised Children's Surgical Centre, the Specialist Children's Cardiology Centres and Local Children's Cardiology Centres, according to local circumstances;	Review of job plans - EMBED IN PROCESS	Mar-22	~~Mar-22~~ ~~Oct-22~~ 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- cardiac clinical team have improved engagement with tertiary education program and clinical discussion via virtual technology- Job planning has yet to formalise this but support to attend is given- new clinical lead has been appointed and all job plans are now under review with SDM- with a view to protecting time for tertiary centre visits. 18/08/2022 - awaiting job planning 30/11/2022- Job Planning being prioritised (in progress) during Q4 2022/23 and formal time will be assigned to the PEC's during this process. Where appropriate, Honorary Contracts have been 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_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).	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. 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_011	N/A	Each Local Children's Cardiology Centre must have a locally designated 0.25 WTE registered children's nurse with a specialist interest to participate in cardiology clinics, provide support to inpatients and deal with requests for telephone advice.	Ensure link nurse business case includes time needed to meet these standards. ODN can provide letter of support.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ 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 No funding forthcoming form IMTP submission to support county- based nurse support, Nurse leads to revisit possible developments within nursing establishment 05/08/2022 - Nurse leads continue to review establishment, however due to lack of funding, recommendation difficult to proceed. 18/08/2022 - awaiting update
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ N/K	Red	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	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_015	N/A	Governance arrangements across the Children's Congenital Heart Network must ensure that the training and skills of all echocardiographic practitioners undertaking paediatric echocardiograms are kept up to date.	Revise current governance process around this.	Nov-22	~~Nov-22~~ 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. 30/6/22- This is reflected in the appraisal and revalidation processes- and will also be reflected in job planning in terms of protected time. 18/08/2022 - reflected in the appraisal, and awaiting job planning 30/11/2022 - as above, job planning underway-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_016	N/A	Nurses working within Local Children's Cardiology Centres must be offered allocated rotational time working in the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre, to enhance development of clinical knowledge and skills enabling professional development and career progression. A formal annual training plan should be in place.	Revise current governance process around this.	Jun-22	~~Jun-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/22- new specialist nurse post in development- this will be reflected in the job plan of that role. 05/08/2022 - Job description is currently with matching for approval, and awaiting confirmation 18/08/2022 - JD completed waiting for comments back from job match in panel 30/11/2022 - Update from SNM/Dir Nurse requested
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_017	N/A	Paediatricians with expertise in cardiology (PECs) should have a named cardiologist within the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre who acts as a mentor; this mentor would normally be the link cardiologist.	Names to be formalised	Mar-22	~~Mar-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 30/06/2022 Mentors have been identified and willing to support. This is in progress and the HB is leading the project within the cardiology network. 18/08/2022 - in progress 30/11/2022 - A/w from Cons team
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
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_020a	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Information boards to be progressed in all sites	N/K	~~Oct-22~~ 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- This continues to be managed from UHW - no robust groups are in existence- there are peer-to-peer support groups but this is not widely available. New Specialist nurse will be tasked to develop when in post 18/08/2022 - Information boards are in progress, and the nurse role will also support this recommendation 30/11/2022 - Info Boards present in all relevant locations- recruitment of new Specialist Nurse will support info sharing
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_020b	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Ensure patients provided with information/contact of named CNS (in L1/2)	Mar-22	~~Mar-22~~ ~~Oct-22~~ 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- CNS post in development- UHW cardiologists already provide info as required. 05/08/2022 - Job description is currently with matching for approval, and awaiting confirmation 18/08/2022 - Information boards are in progress, and the nurse role will also support this recommendation 30/11/2022 - Info Boards now present in all relevant locations- recruitment of new Specialist Nurse will be shared as soon as applicable.
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-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_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	~~Mar-22~~ Jan-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - discussions have commenced with the dental pathways, awaiting further response to progress the recommendation. 30/06/22- HB Dental leads continue to review the process- update requested from deputy director today 18/08/2022 - Awaiting update 30/11/2022 - Paeds service still awaiting update from HB Dental service- SDM has chased.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_001	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Approach is via ARCH. 24/08/2022 - DB to update PR.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_002	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Currently working with SBUHB to update the Oncology Strategy that was put in place in 2015. This will include the BGH Oncology service. Cover is currently provided by Dr S Gwynne, SBUHB along with CNS support/ Telephone advice for Dr E Jones/CNS when away. SBUHB have now also appointed Dr C Barringtom to cover the LGI Oncology service within HDUHB.

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_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_003a	N/A	R3. Pathway Performance. The SCP pathway performance is 51.8% for the Health Board (see appendix 4), however the SCP target is 75%.It is acknowledged that achieving this target while recovering from the pandemic is challenging.	Need to carry out an audit to understand the bottlenecks in the pathway. To explore installation of another CT Scanner in WGH.	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Actively auditing the pathway to identify the bottlenecks. Radiology has had a huge impact on the pathway.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_003b	N/A	R3. Pathway Performance. The SCP pathway performance is 51.8% for the Health Board (see appendix 4), however the SCP target is 75%.It is acknowledged that achieving this target while recovering from the pandemic is challenging.	Develop a FIT in Primary Care pathway	Mar-22	~~Mar-22~~ ~~Jul-22~~ Mar-23	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. We are developing a FIT Testing pathway for Primary care. This is anticipated to streamline our referral pathways and facilitate optimised use of diagnostic resources. This should potentially significantly improve pathway time compliance.
PSOW_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
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	
RCP_NDQP0420	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP), issued April 2020	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	RCP_NDQP0420_011 a	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition programme suspended due to COVID 19. HB to support all Clinicians across all areas to participate in the Transition programme when re-started.	N/K	~~Dec-21~~ ~~Jun-22~~ N/K	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 26/05/2021 initial discussions started ongoing. 12/07/2021 SDM confirmed this work is likely to be completed by Dec 2021. 15/09/2021 SDM confirmed this work is likely to be completed by Dec 2021. 14/12/2021Further wave of Covid has delayed progress. 02/02/2022 - progress delayed due to workforce and covid pressures.
RCP_NDQP0420	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP), issued April 2020	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	RCP_NDQP0420_011 b	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition is more successful by an employed youth worker. Paper to be developed to evidence best practice.	Aug-21	~~Aug-21~~ ~~Mar-22~~ ~~Sep-22~~ N/K	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 25/05/2021 No update 12/07/2021 No further progress at this time. 15/09/2021 No progress at this time. 14/12/2021 Further wave of Covid has delayed progress. 02/02/2022 - progress delayed due to workforce and covid pressures. 30/06/2022 - SDM to contact the service to evaluate the current transition arrangement, and to reconsider the original management response.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_00 1	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.
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_00 1	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.
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_00 1	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.
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_00 4	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.
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_00 5	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.
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_00 5	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.
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_00 5	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.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	WLC_PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments.

Reports closed on the Audit Tracker since ARAC December 2022

Report name	Lead Executive/Director
Audit Wales: Taking Care of the Carers?	Director of Workforce & OD
CHC: Maternity Care in Hywel Dda	Director of Operations
HIW: PACU and Cilgerran Wards, Glangwili General Hospital (Publication date 7 August 2020)	Director of Operations
HIW: St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019 (Publication date 1 September 2019)	Director of Operations
HIW: Tregaron Community Hospital 7/8 September 2021 (Publication date 10 December 2021)	Director of Operations
HIW: Ward 7, Prince Philip Hospital 2/3 November 2021 (Publication date 4 February 2022)	Director of Operations
HIW: Joint Thematic Review of Community Mental Health Teams 2017-2018 issued February 2019	Director of Operations
Internal Audit: Primary Care Clusters	Director of Primary Care, Community and Long Term Care
Internal Audit: Risk Management & Board Assurance Framework	Board Secretary
Internal Audit: Welsh Language Standards	Director of Communications
Internal Audit: Overpayment of Salaries	Director of Workforce & OD
Internal Audit: Blackline, Issued December 2022	Director of Finance
PSOW: 202003517	Director of Primary Care, Community and Long Term Care
PSOW: 202005624	Director of Nursing, Quality and Patient Experience
PSOW: 202100189	Director of Nursing, Quality and Patient Experience
PSOW: 202100351	Director of Nursing, Quality and Patient Experience

Reports opened on the Audit Tracker since ARAC December 2022

Report name	Lead Executive/Director	Final report received at
Audit Wales: Structured Assessment 2022	Board Secretary	Audit and Risk Assurance Committee (Management responses to the recommendations due to be approved at ARAC in February 2023.)
CHC: Accident & Emergency Departments in the Hywel Dda Health Board area	Director of Nursing, Quality and Patient Experience	Quality, Safety and Experience Committee
Delivery Unit: All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Director of Operations	To be confirmed

HIW: Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Director of Operations	Quality, Safety and Experience Committee
Internal Audit: Backlog Maintenance	Director of Operations	Audit and Risk Assurance Committee
Internal Audit: Follow-up: Welsh Language Standards	Director of Communications	Audit and Risk Assurance Committee
Internal Audit: Follow up: Overpayment of Salaries	Director of Workforce & OD	Audit and Risk Assurance Committee
Internal Audit: IT Infrastructure	Director of Finance	Audit and Risk Assurance Committee
Internal Audit: Cyber Security	Director of Finance	Audit and Risk Assurance Committee
Internal Audit: Decarbonisation	Director of Strategic Development and Operational Planning	Audit and Risk Assurance Committee
Internal Audit: Individual Patient Funding Requests	Medical Director	Audit and Risk Assurance Committee
Internal Audit: Continuing Healthcare and Funded Nursing Care	Director of Primary Care, Community and Long Term Care	Audit and Risk Assurance Committee

Reports reopened on the Audit Tracker since ARAC December 2022

HIW IRMER: Nuclear Medicine Department, Withybush General Hospital 27/28 July 2021 (Publication date 29 October 2021)	Director of Operations	Quality, Safety and Experience Committee

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. As of December 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.
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board (October 2021)	2 (1 External)	December 2022	Director of Operations	Assistant Director of Assurance and Risk met with the Deputy Director of Operations to establish a revised process and timescale for implementation for the recommendation relating to Governance arrangements. 1 recommendation relates to the roll-out of the All-Wales Datix risk management system, which is currently not yet confirmed.
Audit Wales - Structured Assessment 2021: Phase 1 Operational Planning Arrangements (June 2021)	1	December 2022	Strategic Development and Operational Planning	Recommendation has been re-opened following progress made on previous-year recommendations included in Structured Assessment 2022. Audit & Risk Officer to contact service for revised completion date.

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)	3	November 2022	Nursing	Awaiting revised completion dates from the service, which will be discussed Director of Nursing, Quality and Patient Experience and Heads of Nursing at the Core Team meeting scheduled for February 2023.
Delivery Unit - All Wales Review of progress towards delivery of Eye Care Measures (September 2019)	3	October 2020	Scheduled Care	Update received from service in January 2023 that further progress on these recommendations is dependent on funding and additional resources.
Delivery Unit - Focus on Ophthalmology: Assurance Reviews (January 2016)	1	November 2022	Scheduled Care	The Ophthalmology service are awaiting confirmation from Information Governance to progress with the recommendation related to the lack of progress with the Ophthalmic Diagnostic Treatment Centre (ODTC) and were unable to give a timescale for completion. It is noted that the report dates back to 2016 and originally did not include a completion date for implementation, however the service have provided the Assurance and Risk Team with revised completion dates throughout 2022.
Internal Audit - Directorate Governance – WGH Unscheduled Care (October 2022)	6	September 2022	Unscheduled Care (WGH)	Since the figures were prepared for this report, 3 of these recommendations have since been confirmed as completed, with remaining recommendations assigned a revised completion date of February 2023. This, and any further progress will be reflected in the next report to ARAC in April 2023.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Internal Audit - Financial Planning, Monitoring and Reporting (December 2021)	2	June 2022	Finance	Follow-up audit planned, and awaiting confirmation of the scope of the review prior to fieldwork commencing, which will include a review of previous recommendations raised. The Audit Tracker will be updated to reflect the outcome of this report once received.
Internal Audit – Discharge Processes (December 2021)	3 (2 External)	June 2022	Primary Care, Community and Long Term Care	The Assurance and Risk Officer will be contacting the newly appointed Director for Transforming Urgent & Emergency Care (TUEC) to discuss progress of these recommendations being incorporated into the relevant Policy Goals of the Regional UEC Programme. Recommendations to be considered for closure once this discussion has taken place.
Internal Audit - Falls Prevention and Management (October 2022)	3	December 2022	Nursing	Awaiting revised completion dates from the service, which will be discussed with Director of Nursing, Quality and Patient Experience and Heads of Nursing at the Core Team meeting on scheduled for February 2023.
Internal Audit – Fire Governance (August 2022)	1	November 2022	Estates	Awaiting confirmation from Internal Audit that recommendation can be closed based on the evidence submitted by the Estates service.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Internal Audit – Prevention of Self Harm (April 2022)	4	December 2022	Mental Health & Learning Disabilities	Follow up review by Internal Audit to be reported to ARAC in February 2023, which will include a review of previous recommendations raised. The Audit Tracker will be updated to reflect the outcome of this report once received.
Internal Audit - Quality and Safety Governance (October 2022)	3	November 2022	Nursing	Awaiting revised completion dates from the service, which will be discussed with Director of Nursing, Quality and Patient Experience and Heads of Nursing at the Core Team meeting on scheduled for February 2023.
Internal Review - Capital Governance Review (December 2021)	1 (External)	January 2022	Strategic Development and Operational Planning	Awaiting feedback from Welsh Government on the 10 Year Infrastructure Plan before recommendation can be progressed.
NHS Wales Cyber Resilience Unit - Cyber Assessment Framework Report (February 2022)	1	December 2022	Digital and Performance	The Assurance and Risk Team are currently clarifying a revised timescale with the service in relation to this recommendation.
Peer Review – Respiratory Cancer (June 2016)	1	July 2016	Respiratory	The Assurance and Risk team are to clarify the service delivery model, as the recommendation relates to respiratory consultants and their capacity. It is noted that the report dates back to 2016 and originally did not include a completion date for implementation.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Peer Review - Out of Hours (November 2019)	4	October 2022	Central Operations	Management response to the new peer review on the Out of Hours service being developed jointly with 111. These recommendations are expected to supersede the existing recommendations as currently included on the Audit and Inspection Tracker.
Peer Review - Congenital Heart Defect Provider (October 2021)	5 (2 External)	October 2022	Women and Children's Services	A Children and Young Person's (CYP) working group has been established, with psychology provision being assessed, the outcomes of which will inform revised completion dates for 3 of the 5 recommendations. Discussions are ongoing with the cardio-respiratory department, the outcomes of which will provide further progress update and a revised completion date for 1 recommendation. The remaining recommendation is dependent on factors outside of the gift of the Health Board to implement and therefore currently noted as 'external'.
Public Service Ombudsman for Wales - 202003189 (September 2022)	1	December 2022	Nursing	A request for an extension to the original completion date has been sent to PSOW, and currently awaiting confirmation.
Royal College of Paediatrics & Child Health - National Diabetes Quality Programme (NDQP) (April 2020)	1	June 2022	Women and Children's Services	Since the figures were prepared for this report, updates have been provided by the service to confirm that this recommendation has been implemented. This information will be reflected in the report being presented to ARAC in April 2023.

Report	Number of N/K Recs	Date rec became N/K	Service Area	Progress Update
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	2	December 2022	Unscheduled Care (BGH)	The Assurance and Risk Team to meet in March 2023 with BGH General Manager to establish the relevance of these recommendations due to the age of the report, and if they should be closed as it is felt that some recommendations are no longer achievable.