Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 June 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	UHB Central Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Debbie Stone, Assurance and Risk Officer Charlotte Beare, Head 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.

Inspection activity across the UHB has started to increase as auditors, inspectorates and regulators start to refocus on service delivery across the UHB.

HIW continue to undertake quality checks with 3 reports being issued since the previous meeting: Morlais Ward (Mental Health & Learning Disabilities) Glangwili General Hospital (GGH), 10 Church Close (Mental Health & Learning Disabilities) Begelly and IRMER Remote Inspection Prince Philip Hospital (PPH).

Audit Wales (AW) and Internal Audit (IA) continue with their work as per agreed Audit Plans, although plans are under regular review.

The Health and Safety Executive (HSE) and Mid and West Wales Fire and Rescue Service (MWWFRS) continue to monitor activity across the UHB.

Asesiad / Assessment

Management of outstanding recommendations

This will be the final report to ARAC where the progress on high priority recommendations will be reported separately, as the Health Board returns to relative normality following COVID-19.

Bi-monthly reports will continue to be sent to Services to provide them with a status report of outstanding recommendations and request progress against them.

The table below sets out a summary of the status of the high priority recommendations. Appendix 1 provides an individual breakdown.

External Body	**Open High Priority Recommendations**	**Update summary**
Health Inspectorate Wales (HIW) (pre-COVID)	1 immediate improvement recommendation	One immediate recommendation at Withybush General Hospital (WGH) Ward 7, relating to fire safety doors, has not gone beyond the timescale for completion August 2021 and is part of the Estates fire safety work programme.
HIW 'Quality Checks'	20 recommendations from 5 reports	4 of the 20 high priority recommendations are behind schedule: • Towy Ward at (GGH) two recommendations behind schedule, one due to slippage from January 2021 to May 2021 and one from February to August 2021. • Ionising Radiation Medical Exposure Regulations (IRMER) (PPH) contains one recommendation behind schedule, completion date identified as April 2021 the bimonthly schedule is due to be issued for update in early June 2021. • Morlais Ward (GGH) contains one recommendation behind schedule, completion date has slipped from May to July 2021. Two HIW reports (10 Church Close Begelly and Mass Vaccination Centres) currently have no recommendations behind schedule.

Health and Safety Executive (HSE)	15 recommendations from 4 improvement notices (IN2, IN6, IN7 & IN8) and 4 material breaches (MB3, MB4, MB7 & MB9)	4 of 15 recommendations are behind schedule, relating to Material Breaches. (*previous ARAC meeting reported 5 of 15 recommendations exceeding HSE timescales*). 1 recommendation from IN6 has been re-opened, following being previously closed in error. All 3 outstanding recommendations against IN6 have an extension to 24 September 2021. All actions for Material Breach MB1 have been completed and reported to HSE on 11 February 2021. The Health and Safety Assurance Committee (HSAC) is overseeing implementation.
Mid and West Wales Fire and Rescue Service (MWWFRS)	29 recommendations from 7 Enforcement Notices and 4 Letters of Fire Safety Matters.	There are 2 high priority recommendations currently behind schedule. (*previous ARAC meeting reported no recommendations exceeding HSE timescales*). This is due to a MWWFRS letter dated 21 May 2021 confirming an inspection of completed works associated with Enforcement Notice KS/890/02 at WGH were not of the required standard. MWWFRS have requested the schedule of works to be further upgraded to provide the required fire safety standard within 28 days of the letter (17 June 2021). As a result KS/890/02 has been re-opened on the audit tracker. 2 amber recommendations from the Letter of Fire Safety Matters for Glangwili General Hospital (BFS/KS/SJM/00107739) have been implemented since the last ARAC meeting. A Letter of Fire Safety Matters for Tregaron Community Hospital (00111720) was received on 12 May 2021. This letter includes 10 recommendations to be implemented by 12 August 2021. The UHB and MWWFRS have regular meetings in respect of the fire safety work programme. All current Enforcement Notices and Letters of Fire Safety Matters fully align with the delivery programme being managed by the UHB.

		The Health and Safety Assurance Committee is overseeing implementation.
Audit Wales (AW)	0 recommendations	There are no 'high' priority recommendations behind schedule.
Internal Audit (IA)	10 recommendations.	6 of the 10 high priority recommendations are behind schedule (5 *of 9 'high' priority recommendations previously reported to ARAC*). 1 recommendations have been implemented since the last ARAC meeting. 6 of the 10 recommendations are behind schedule as below: • 1 recommendation from the Theatres Directorate report due for completion September 2021. • 1 recommendation from National Standards for Cleaning in NHS Wales. This was previously noted as an external recommendation and has since reverted back to Red (behind schedule) as it is now within the gift of the Health Board to implement. • 1 recommendation from the IM&T Assurance - Follow Up report due for completion May 2021. • 1 recommendation from the Radiology Directorate report due for completion December 2021. • 1 recommendation from the IM&T Control and Risk Assessment report due for completion October 2021. • 1 recommendation from GGH Women and Children Development Phase 2. The recommendation has been re-opened as a result of the follow up report. A revised timescale is currently being clarified with the service.

Appendix 2 provides a list of other recommendations that still need to be implemented (these are RAG rated amber 65 (in progress and on schedule) or red 70 (behind schedule). It does not include recommendations from HIW and CHC reports relating to inspections of independent contractors (i.e. GP and dental practice not managed by the UHB). The practices remain directly accountable for implementing these recommendations. The appendix also contains 30 recommendations, which do not have revised timescales (7 reported at previous meeting) this is where the date has passed and not known (N/K) is reported. This includes 3 advisory internal audit reports with a combined total of 16 recommendations that had no timescales included in the reports. The remaining 14 recommendations noted as N/K are as follows:

- 3 recommendations are awaiting confirmation from Internal Audit that they are completed and can be closed.
- 4 recommendations relate to the new GGH Phase 2 Internal Audit report, revised timescales are being clarified with the service as these dates were not included in the follow up report.
- 3 recommendations from the Welsh Language Commissioner (WLC) which have been delayed due to Covid-19. The UHB will be sending WLC its current position in June 2021 and will await clarification of the way forward and possible extension.
- 1 recommendation relating to SIFT money and accommodation, Director of Operations and Medical Director to resolve issue.
- 1 recommendation from the BGH Royal College report. Recommendation being discussed with service if appropriate to request moving to the Strategic Log.
- 1 recommendation relating to Public Service Ombudsman Wales (PSOW). Awaiting confirmation from PSOW that recommendation can be closed following evidence submitted.
- 1 recommendation relating to Transition Services, initial discussions commenced identified as NK.

The assurance and risk team will continue to work with services to clarify completion dates.

UHB Central Tracker

Since April 2021, a further 15 reports have been closed or superseded, with 16 new reports received by the UHB. These are listed in Appendix 3.

As of 31 May 2021, there are 99 reports currently open, 60 of which have recommendations that have exceeded their original completion date, this has increased from 48 previously reported in April 2021. This is partly due to the timing of the service schedule and a number of recommendations becoming overdue in April 2021. There is an increase in recommendations where the original implementation date has passed from 84 to 93, and where recommendations have gone beyond six months of their original completion date from 51 to 52 as reported in April 2021.

Below is a summary of activity from the audit tracker since previously reported to ARAC in April 2021:

	No of reports open at ARAC Apr-21	No of reports received since ARAC Apr-21	No of reports closed since ARAC Apr-21	No of reports open at ARAC Jun-21	No of reports that have passed their original implement-ation date	No of red recommend-ations i.e. Original implementation date has passed or will not be met	No of red recommend-ations beyond 6 months of original completion date
AW	5	1	2	4	4	2	2
CHC	2	0	0	2	2	2	0
CHC / HIW Contractors	2	0	0	2	0	0	0
Coroner Reg 28	0	0	0	0	0	0	0
DU	5	0	2	3	3	7	3
HEIW	0	0	0	0	0	0	0
HSE	19	0	2	17	13	4	4
HIW (Acute & Community)	8	1	0	9	4	7	3

HIW (MH&LD)	4	2	0	6	4	10	9
IA	25	10	5	30	19	44	16
MWWFRS	9	2	0	11	1	2	2
Peer Reviews	3	0	0	3	3	4	4
PSOW - S16	0	0	0	0	0	0	0
PSOW - S21	11	0	4	7	3	1	1
Royal Colleges	2	0	0	2	2	3	2
Other	1	0	0	1	0	4	3
WLC	2	0	0	2	2	3	3
TOTAL	**98**	**16**	**15**	**99**	**60**	**93**	**52**

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to take an assurance on the following:

- 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	5.3 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 Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A

Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW- Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CHC- Community Health Council DU- Delivery Unit GGH - Glangwili General Hospital HEIW-Health Education and Improvement Wales HIW- Health Inspectorate Wales HSE- Health and Safety Executive IA- Internal Audit MWWFRS – Mid & West Wales Fire & Rescue Service NWIS – NHS Wales Informatics Service PPH – Prince Philip Hospital PSOW- Public Services Ombudsman for Wales SSU – Specialist Services Unit UHB – University Health Board WLC- Welsh Language Commissioner WGH- Withybush General Hospital
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

Appendix 1 - High Priority Recommendations June 2021

Reference Number	Date of report	Report issued by	Report Title	Type of Plan	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
LPJ/HD/041020199/06	Oct-19	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_003	High	R3. Design the system to effectively capture the accurate recording of incident details including the clear setting out of responsibilities for those expected to use this system.	May-20 Jul-20 Jan-21 Sep-21	Apr-21 Sept-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021. 07/09/2020- HSE has granted extension to 29/01/2021. 25/01/2021- Action Plans submitted to HSE, feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber.
LPJ/HD/041020199/06	Oct-19	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_004	High	R4. Determine how the system will be monitored by senior managers to ensure that follow-up action is carried out, and how it will be audited and reviewed.	May-20 Jul-20 Jan-21 Sep-21	Jan-21 Sept-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE has granted extension to 29/01/2021. This recommendation is on track to be implemented by this date. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE, showing this recommendation not being fully implemented until post Covid. Feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber.
LPJ/HD/041020199/06	Oct-19	Health and Safety Executive	Improvement notice - Incidents 02-11/07/19 IN6	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/06_005	High	R5. Implement a programme for making available the relevant information, instruction and training to those required to investigate and record incidents. OR Implement any other equally effective measures to remedy the said contravention.	May-20 Jul-20 Jan-21 Sep-21	Dec-20 Sep-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE has granted extension to 29/01/2021. This recommendation is on track to be implemented by this date. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE showing this recommendation as complete. Feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber.
LPJ/HD/041020199/08	Oct-19	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_001	High	EITHER R1. Implement an effective management system to ensure all incidents where employees and others (such as Agency staff) have suffered an injury from a medical sharp are fully recorded and investigated. This system should also be used to manage any remedial actions required to ensure ongoing risks are mitigated.	May-20 Jul-20 Jan-21 Sep-21	Dec-20 Sep-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE has granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE, reporting that recommendation cannot be fully implemented until post-Covid. Feedback from HSE January 2021 visit awaited. 19/03/2021-HSE confirmed by letter an extension of 24/09/2021 against this notice. Recommendation changed to amber.
LPJ/HD/041020199/08	Oct-19	Health and Safety Executive	Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/08_002	High	AND R2. Implement a suitable follow up monitoring system for managing employees and others (e.g. Agency workers) post injury (caused by a medical sharp) that exposed, or may have exposed, the person to a biological agent, to ensure they receive appropriate medical advice, treatment and counselling. OR Implement any other equally effective measures to remedy the said contraventions.	May-20 Jul-20 Jan-21 Sep-21	Dec-20 Sep-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE has granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE, reporting that recommendation cannot be fully implemented until post-Covid. Feedback from HSE January 2021 visit awaited. 19/03/2021-HSE confirmed by letter an extension of 24/09/2021 against this notice. Recommendation changed to amber.
JHET/HD/041020199/02	Oct-19	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_003	High	R3. Identify sources of information on manual handling incidents and near misses, and use these to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded; b. Referrals to Occupational Health related to musculoskeletal disorders; c. Sickness absence records related to musculoskeletal disorders; d. Information from employee groups who do not have access to Datix; e. Information from employee representatives; f. Information from those providing training under the All Wales Manual Handling Training Passport.	May-20 Jul-20 Jan-21 Jun-21	Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.
JHET/HD/041020199/02	Oct-19	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_001	High	R1. Establish a management system to monitor and review the implementation of your Manual Handling Policy number 273. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	May-20 Jul-20 Jan-21 Jun-21	Oct-20 Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.
JHET/HD/041020199/02	Oct-19	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_002	High	R2. Identify the resources needed to effectively implement and sustain the systems developed in response to 1 above.	May-20 Jul-20 Jan-21 Jun-21	Oct-20 Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-The M&H Team are in the process of developing an SBAR to request funding for a new 0.6FTE Band 4 to assist the team in fulfilling their duties. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.
JHET/HD/041020199/02	Oct-19	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_004	High	R4. Identify how the findings from monitoring, auditing and review will be considered and consulted on, and responsibilities allocated to ensure that suitable and timely action is taken and completed.	May-20 Jul-20 Jan-21 Jun-21	Oct-20 Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.

JHET/HD/04102019/02	Oct-19	Health and Safety Executive	Improvement notice - Manual Handling 02-11/07/19 IN2	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/02_005	High	R5. Start to implement the system identified as far as reasonably practicable in the timescale of this Notice.	May-20 Jul-20 Jan-21 Jun-21	Oct-20 Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.
LPJ/HD/04102019/07	Oct-19	Health and Safety Executive	Improvement notice - Theatres, Bronglais Hospital 02-11/07/19 IN7	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	JHET/HD/04102019/07_002	High	R2. Where such manual handling operations cannot be avoided you should in consultation with the Health Board's health & safety competent persons, and with their employee representatives, assess the risks and identify additional controls for all manual handling activities in theatres: You should take into consideration the following: a) Identifying all of those activities which pose a risk to employees' health and are not included in the All Wales Manual Handling Passport including: static support of patients' limbs, moving and handling patients into the prone position, repositioning patients during surgery. b) Developing systems to carry out suitable and sufficient risk assessments c) Identifying changes in processes to avoid manual handling or additional controls to reduce the risk to employees' health. d) Providing suitable and sufficient information, instruction and training to those who will be carrying out the patient handling e) Providing suitable and sufficient information, instruction and training to those who will be carrying out inanimate load risk assessments including wheeled operations.	May-20 Jul-20 Jan-21 Jun-21	Jul-20 Oct-20 Dec-20 May-21 Jun-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. Delayed to October 2020. Some of the delays are due to the impact of COVID-19 and the required re-directing of resource to manage the evolving Health Board response to the situation. Others, such as the contractor compliance work, are based on a phased approach to compliance. 07/09/2020- HSE has granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE, showing one action outstanding to May 2021. Feedback from HSE January 2021 visit awaited. 17/03/2021- H&S Manager confirmed HSE requested additional information that has been submitted, therefore they are hoping this improvement notice will be formally signed off by HSE shortly. 19/03/2021- Health & Safety Manager confirmed HSE confirmed they consider this recommendation to be outstanding, recommendation amended from green to red. HSE granting extension to June 2021. Formal letter from HSE should be received next week. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021.
MB3	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Bronglais Hospital MB3	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB3	High	You should undertake a suitable and sufficient assessment for all employees (e.g.. Agency staff) required to work alone at Bronglais Hospital and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.	May-20 Jul-20 Jan-21	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020. 07/09/2020- HSE Granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper- PAMOVA training has been identified as a priority action. Training with regards to safe holding is in place but is unfortunately currently disrupted due to COVID-19 restrictions. Timescale stated as just the year 2021, therefore December 2021 assumed as implementation date. 25/01/2021- Action Plans submitted to HSE. Notice to stay as red on the tracker for now until feedback is received from HSE. 19/03/2021- Health & Safety Manager confirmed HSE will are happy for all MBs to be closed. Formal letter from HSE should be received next week. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021.
MB7	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Glangwili Hospital A&E (inc. reception) MB7	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB7	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g.. Agency staff) within Glangwili Hospital A&E (inc. reception) and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.	May-20 Jul-20 Jan-21	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020. 07/09/2020- HSE Granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-PAMOVA training has been identified as a priority action. Training with regards to safe holding is in place but is unfortunately currently disrupted due to COVID-19 restrictions. Timescale stated as just the year 2021, therefore December 2021 assumed as implementation date. 25/01/2021- Action Plans submitted to HSE. Notice to stay as red on the tracker for now until feedback is received from HSE. 19/03/2021- Health & Safety Manager confirmed HSE will are happy for all MBs to be closed. Formal letter from HSE should be received next week. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021.
MB9	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Mental Health MB9	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB9	High	You should undertake a suitable and sufficient assessment of the risks to all employees and others (e.g.. Agency staff) within the Mental Health teams involved with the transportation of patients and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.	May-20 Jul-20 Jan-21	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020. 07/09/2020- HSE Granted extension to 29/01/2021. 02/11/2020- H&S Assurance Committee paper does not make clear if this will be implemented by January 2021. Rec to remain red (behind schedule) until clarification received from H&S team. 25/01/2021- Action Plans submitted to HSE. Notice to stay as red on the tracker for now until feedback is received from HSE. 19/03/2021- Health & Safety Manager confirmed HSE will are happy for all MBs to be closed. Formal letter from HSE should be received next week. MB to stay red until formal confirmation received. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021.
MB4	Oct-19	Health and Safety Executive	Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Prince Phillip Hospital MIU / AMAU MB4	Legislative requirements	Open	N/A	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	MB4	High	You should undertake a suitable and sufficient assessment for all employees and others (e.g.. Agency staff) within Prince Phillip Hospital MIU / AMAU who are required to work alone and make arrangements for their protection from exposure to violence where this is reasonably foreseeable.	May-20 Jul-20 Jan-21	Dec-21	Red	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 is extended to 31/07/2020. 07/09/2020- HSE Granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-PAMOVA training has been identified as a priority action. Training with regards to safe holding is in place but is unfortunately currently disrupted due to COVID-19 restrictions. Timescale stated as just the year 2021, therefore December 2021 assumed as implementation date. 25/01/2021- Action Plans submitted to HSE. Notice to stay as red on the tracker for now until feedback is received from HSE. 19/03/2021- Health & Safety Manager confirmed HSE will are happy for all MBs to be closed. Formal letter from HSE should be received next week. MB to stay red until formal confirmation received. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021.

19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Immediate Improvement Plan	Open	N/A	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	19097IA_004	High	R4. The Health Board is required to provide HIW with details of the action it will take to ensure that: Fire doors are fitted to the entrance of ward 7 in line with the requirements of the Enforcement notice issued by the Mid and West Wales Fire and Rescue Service to ensure the Health Board adequately protects patients, staff and the general public in the event of fire. We were informed that the doors to the entrance of ward 7 were not fire doors. An Enforcement Notice was issued by the Mid and West Wales Fire and Rescue Service requiring action to fit fire doors by the 30th November 2019. We were informed the doors were due to be replaced in September 2020 at the earliest as part of phase 2 of improvement work.	Aug-21	Aug-21	Amber	25/02/2021 One immediate recommendation remains at Withybush General Hospital (WGH) Ward 7, relating to fire safety doors at the entrance to ward. This has not gone beyond the timescale for completion (August 2021) which is in line with the fire safety work programme being undertaken by Estates.
20068	Dec-20	HIW	Glangwili Hospital (Towy Ward)	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	20068_001	High	R1. We recommend that an updated action plan for falls and pressure and tissue damage is submitted 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 on the ward.	Jan-21	Jan-21 May-21	Red	22/01/2021- Update from Hospital HON- Training commenced in 27/11/2020. Suspended due to Ward COVID outbreak. 15/02/2021- Meeting with Hospital HON, Nurse Manager and Ward sister. Weekly training is held on Wednesdays where staff are encouraged to attend in order to complete the frailty teaching session, but not all staff have yet been able to complete as a result of Covid-19 pressures. 19/02/2021- Aim to complete 28/05/2021 (depending on COVID-19 restrictions). 09/03/2021- HONs is confident this will be achieved by the end of May 2021. 24/05/2021- requested confirmation by 07/06/2021 that this recommendation is complete.
20068	Dec-20	HIW	Glangwili Hospital (Towy Ward)	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	20068_002	High	R2. We recommend that an updated action plan for completion of mandatory training is submitted to HIW within three months of the quality check so that we can assess progress made to improve compliance with mandatory training.	Feb-21	Feb-21 Aug-21	Red	22/01/2021- Update from Hospital HON- In-house training currently suspended due to COVID-19. 15/02/2021- Meeting with Hospital HON, Nurse Manager and Ward sister. Where possible, courses have been made available virtually for staff to attend and complete, however elements do require face to face training in areas such as fire safety and manual handling, which in the current climate is not possible. 19/02/2021- Aim to complete 27/08/2021 (depending on COVID-19 restrictions). 09/03/2021- HONs is confident this will be achieved by 27/08/2021.
20068	Dec-20	HIW	Glangwili Hospital (Towy Ward)	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	20068_002	High	R2. We recommend that an updated action plan for completion of mandatory training is submitted to HIW within three months of the quality check so that we can assess progress made to improve compliance with mandatory training.	Jan-21	Jan-21 Aug-21	Red	22/01/2021- Update from Hospital HON- Awaiting confirmation of training dates from Resus Officer and Fire Safety Officer. E-mail chaser sent 22/01/2021. 15/02/2021- Meeting with Hospital HON, Nurse Manager and Ward sister. A written document regarding cardiac arrest scenarios has been shared with staff, however as previously discussed the face to face elements of the training are currently undeliverable. 19/02/2021- Aim to complete 27/08/2021 (depending on COVID-19 restrictions). 09/03/2021- HONs is confident this will be achieved by 27/08/2021.
20271	Mar-21	HIW	Mass Vaccination Centre	Improvement Plan	Open	N/A	Public Health	Bethan Lewis	Director of Public Health	20271_012	High	The health board must review the standard operating procedures for each mass vaccination centre and ensure they accurately describe the agreed processes for each centre.	May-21	May-21	Amber	
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_001	High	The health board is required to provide HIW with details of the action taken to better inform patients visiting the department of current waiting times	Jun-21	Jun-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_002	High	The health board is required to inform HIW of the action taken to provide information to patients of their replies to surveys, with actions taken on feedback	Jun-21	Jun-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_003b	High	The employer must ensure that a review of the employer's written procedure relating to pregnancy enquires is undertaken. This is to ensure that there is sufficient detail on the process to be followed by staff, for all types of patients they may encounter. Additionally, this review should include how gender diversity is considered and managed.	Jun-21	Jun-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_004b	High	The employer must ensure the review of DRLs is carried out within the timeframe specified in the employer's procedure	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_005	High	The employer must ensure that the audit programme and associated documentation includes timeframes and frequency for the audits, how the findings were shared and how recommendations were actioned. In addition, there must be reference to when re-audit was required following the implementation of change.	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_006	High	The employer must ensure that training, competency and scope of practice is checked prior to entitlement to ensure this reflects the duty holder's role, including staff external to radiology	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_007	High	The employer must ensure that duty holders are informed of their entitlement and are aware of their specified scope of practice by for example a letter or certificate	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_008	High	The employer must ensure that the medical director is aware of their entitle role within theatres and this is further clarified and added to the theatre employer's procedure	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.

20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_009	High	The employer must ensure that all employer's procedures, policies and protocols that are overdue for review be reviewed and updated. This must ensure they are up to date, version controlled, reviewed in a timely manner and reflect practices and arrangements in place, including addressing the issues highlighted in the procedures and protocols section of this report	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_010a	High	The employer must ensure that a detailed analysis is completed, including themes and trends of accidental or unintended exposures including near misses. This should include what actions had been taken to enable shared learning and identify what changes were implemented in practice to improve patient safety	Apr-22	Apr-22	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_010b	High	The employer must ensure that a detailed analysis is completed, including themes and trends of accidental or unintended exposures including near misses. This should include what actions had been taken to enable shared learning and identify what changes were implemented in practice to improve patient safety	Jul-21	Jul-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_011	High	The employer must ensure that the relevant written procedures relating to accidental or unintended exposures are updated to accurately reflect current guidance and HIW incident reporting process requirements	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_012	High	The employer must ensure that the employers procedures for theatres are updated to include how benefit and risk information is communicated to patients prior to the exposure.	May-21	May-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_013a	High	The health board must ensure that all members of staff within the department are trained in basic life support and source the necessary training provider without delay	Apr-21	Apr-21	Red	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Improvement Plan	Open	N/A	Radiology	Amanda Evans	Director of Therapies	20255_013b	High	The health board must ensure that all members of staff within the department are trained in basic life support and source the necessary training provider without delay	Jun-21	Jun-21	Amber	20/04/2021- HIW confirmed they are happy with the improvement plan submitted, updates on implementation of these recommendations will be requested from the service during the next bi-monthly service summary email to be sent early June 2021.
20136	Apr-21	HIW MHLD	Quality Check: Morlais Ward, GGH	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Natasha Mitchell	Director of Operations	20136_001b	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	Mar-22	Mar-22	Amber	19/05/2021 New system delayed, although the C4C work identified is being progressed and capital funding has been approved work is likely to be completed November 21.
20136	Apr-21	HIW MHLD	Quality Check: Morlais Ward, GGH	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Natasha Mitchell	Director of Operations	20136_002a	High	The health board must review the training data and provide assurance that staff have up to date skills and knowledge to provide safe and effective care as well as reviewing the training data to ensure the reports provide an accurate and current compliance figure.	In line with easing of Covid restrictions	In line with easing of Covid restrictions	Amber	19/05/2021 Awaiting WG relaxation of current of social distancing rules to be approved prior to face to face training being recommenced.
20136	Apr-21	HIW MHLD	Quality Check: Morlais Ward, GGH	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Natasha Mitchell	Director of Operations	20136_003d	High	The health board must review and further analyse the restraint data submitted to HIW and provide more detail/analysis of the incidents	May-21	May-21 July-21	Red	19/05/2021 Ward Manager has confirmed: Results presented to the Ward Managers Forum. To be part of the next chairs report to MH&LD QSEG believed to be June/July.
20091	Apr-21	HIW MHLD	Quality Check: 10 Church Close, Begelly	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Tracey Lloyd	Director of Operations	20091_001a	High	The health board must ensure that any future DoLS applications are submitted in a timely manner once it is known that an application is necessary.	Jul-21	Jul-21	Amber	25/05/2021 Ward Manager confirmed we have completed five of the seven CoP applications and have a series of meetings with our solicitors to finalise in readiness for submission.
20136	Apr-21	HIW MHLD	Quality Check: Morlais Ward, GGH	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Natasha Mitchell	Director of Operations	20136_001a	High	The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced	May-21	May-21	Amber	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.
HDUHB1718-35	Apr-18	Internal Audit - HDUHB	Theatres Directorate	Internal Audit Report	Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_001	High	R4. The practice of claiming enhanced hours for the whole period of an on-call shift should be officially reviewed, as a matter of urgency, with appropriate personnel involved in the process. Any decision made on the future payment of enhanced provision should be made in line with the Agenda For Change On-Call Agreement. The decision should be fully documented and appropriately approved for use.	Jun-18	Sep-21	Red	The recommendations cannot be addressed until grievance process is complete. Recommendation currently with Director of Operations. 02/03/2021- Director of Operations confirmed implementation of grievance outcome should be completed by end of Q2 2021/22..
HDUHB_1920_40	Mar-20	Internal Audit - HDUHB	IM&T Assurance – Follow Up	Internal Audit Report	Open	Reasonable	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB_1920_40_001	High	R1. The Health Board should consider a wider security awareness programme. To facilitate this the Assistant Director of Informatics should identify individuals with jurisdiction to implement the recommendation	Feb-20	May-21	Red	03/09/2020- Recommendation to be picked during wider security work by Estates/H&S tem. H&S advisors to pick up security awareness as they go around each area and record this as part of their review process. 01/10/2020-H&S advisor to request at H&S team meeting if this recommendation can be included as part of the

HDUHB-1718-34	Feb-18	Internal Audit - HDUHB	National Standards for Cleaning in NHS Wales	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	HDUHB-1718-34_001	High	R4 • C4C audit methods and practices should be actioned by all Domestic Supervisors to ensure C4C are consistently thorough across all sites. • Audits should be planned ahead and noted on schedules and rotas to ensure audits are completed and do not get overlooked if a member of staff is away or on secondment. • If a member of staff is absent during the 48 hours following an audit, an alternative Domestic Supervisor should be deployed to check that the action plan arising from the cleaning audit has been completed in the functional area. • PMS should be asked to remap the rooms on the software and make amendments to the system so it accurately reflects the functional areas being audited. This will mean that the C4C system will be more user friendly and audits will be less time consuming to undertake.	Jun-18	Mar-22	Red	As required the audit check list is amended to the current use on the Estate. Any additional elements are added so that the area is scored as if it was already on the system. The information on the existing system has been amended to reflect the functional use of areas to make more user friendly/less time consuming. Some areas have now moved priority ratings from Very High to High Risk and vice versa as the use of areas has now changed. The full remap of areas would be part of the updated system which is still pending. 04/12/2020- Still awaiting updated system, recommendation outside gift of UHB to implement. 04/02/2021- Internal Audit currently undertaking follow up. 04/03/2021-Director of Estates, Facilities and Capital Management confirmed that in the last couple of weeks that new software SYNBIOTIX to replace current C4C system has been agreed. Implementation is planned to take place Q3/4 of 2021/22. 10/05/2021- There are concerns with a possible delay in IT implementing the new software, Assistant Head of Operational Facilities Management to check with IT for update.
HDUHB 1819-32	Oct-19	Internal Audit - HDUHB	Radiology Directorate	Internal Audit Report	Open	Reasonable	Radiology	Amanda Evans	Director of Operations	HDUHB1819-32-002	High	R8: It should be ensured that staff work on call or overtime hours in addition to their basic hours and not instead of. The full number of basic hours should be worked prior to receiving any payments for additional hours.	Apr-19	Aug-20 Dec-21	Red	Further meetings have been held with leads from the programme management office in an effort to maintain momentum Another is scheduled to happen in August . In addition discussions in July have been held with Workforce and Organisational Development regarding the bespoke leadership training for the radiology site leads. Any changes to current staging rotas have taken into consideration new ways of working There however has been no opportunity to present developments to date or the revised staffing models to the executive team due to the response to Covid-19 . 24/08/2020- revised date of December 2021 date as this relies on a new system, substantial more staff and a whole radiology transformation. Update to be provided to ARAC in February 2021. 04/02/2021- Head of IA to check the detail of the recommendation to see if the original recommendation has been addressed. 26/02/2021- Update to ARAC Feb2021 meeting reports recommendation 8 as outstanding. This recommendation is connected to the historic arrangements for the radiography out of hours provision. 25/03/2021- Reporting officer provided a revised date of December 2021 for the new rota system to be embedded
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_004	High	R4. The organisation should maintain oversight of the extent to which IM&T satisfies obligations (regulatory, legislation, common law, contractual), internal policies, standards and professional guidelines. A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for reporting status upwards via the Digital Sub-Committee and IGSC.	Jun-21	Jun-21	Amber	15/12/2020- Scoping exercise to begin March 2021, with an aim to report in June 2021. 02/03/2021- On track, scoping exercise to begin this month (March 2021). 11/05/2021- Should be on track to hit June 2021 timescale.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_006	High	R6 .Schedules and results of uninterruptible power supply tests should be held and monitored by Informatics, providing assurance that power can be switched to the supply without any significant effect on business operations.	Mar-21	Mar-21 Oct-21	Red	04/02/2021- recommendations to be reviewed in follow up report to be undertaken by Internal Audit. 02/03/2021- We have monthly generator tests and our Data Centre UPS management platform alerts us to any issues. As for the rest of the estate we have 100's of UPS so we have no resources to complete this at this time. Once network upgrades are completed then we will move onto UPS but the priority at the moment has to be end of life switches. Digital Business Manager to review and provide revised timescale for completion. 05/03/2021- Digital Business Manager provided update- We have monthly generator tests and our Data Centre UPS management platform alerts us to any issues. As for the rest of the estate we have 100's of UPS so we have no resources to complete this at this time. Once network upgrades are completed then we will move onto UPS but the priority at the moment has to be end of life switches. More realistic deadline of October 2021 provided. 11/05/2021- should be in a good position to complete by October 2021 deadline.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_010	High	R10. Once in post, the health board cyber security staff should carry out periodic testing of system security to determine adequacy of system protection.	Aug-21	Aug-21	Amber	15/12/2020- report states August 2021 deadline is dependent on a suitable candidate being appointed in March 2021. 02/03/2021- Band 7 Cyber Security Senior Specialist has been appointed, starting on 12th April. Once they start recommendation will form part of their workplan. Their first set of tasks once induction has been completed will be to implement the available solutions to enable these 6 monthly network scans. We would expect the first scans to be able to undertaken by the end of May 2021. 11/05/2021-New Cyber Security Senior Specialist will be writing a paper on this to IGSC in June 2021.
HDUHB-2021-22	Nov-20	Internal Audit - HDUHB	WCCIS Project (Ceredigion Locality)	Internal Audit Report	Open	Reasonable	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-22_001	High	R1. The Health Board needs to complete the work needed to identify appropriate local outcome measures which can then be baselined to demonstrate the realisation of identified benefits. The project benefits register should then be reviewed to ensure that it is complete and up to date, once this is done a baseline should be taken to allow for future benefits monitoring and realisation of this project and the wider deployment of the WCCIS across the Health Board.	Jun-21	Jun-21	Amber	04/02/2021-Digital Business Manager confirmed this recommendation is on track. 11/05/2021- Benefits tracker is now in place, awaiting confirmation from Internal Audit if this recommendation can be closed.
SSU-HDU-1920-02	Jun-20	Internal Audit - SSU	Glangwili Hospital Women & Children's Development Phase 2	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_006	High	R6: In accordance with the NEC contract, the external advisers should provide a detailed assessment report of the delays to date (to include contributing factors, programme and cost implications, acceptance / rejection etc.)	Jul-20	Jul-20 N/K	Red	Complete-PM is undertaking this on a monthly basis and incorporating into monthly report on an ongoing basis. CEIM&T report in July 2020 provides retrospective position 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Partially Addressed - A full review of delays awarded was reported to PPPAC in August 2020 and the Project Group now receives incremental updates on the delays to date. To fully action the above, a formal report should be prepared by the advisers to include: •delays claimed; • delays awarded (including detailed events, rationale and relevant contractual clause); • rejected claims for delays (including rationale and relevant clauses); and • delays not yet covered by claims. It has been agreed that this will now be produced at the end of the current phase to cover all delays accepted/ rejected to date. Revised Responsibility and Timescale is Project Director / Immediate. Assurance and risk officer to clarify with Planning colleagues when this recommendation will be completed. 28/05/2021- Head of Capital Planning confirmed PM will produce a detailed retrospective assessment once the work on Section 1 and 2 of the scheme is complete. Completion date for Section 2 has been delayed. No revised timescale received.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_001	High	R1. PBC's should include appropriate funding strategies and plans to manage maintenance and backlog maintenance which will arise over the life cycle of the new (or repurposed) assets.	Sep-21	Sep-21	Amber	13/01/2021- Director of Estates, Facilities and Capital Management confirmed timescale of September 2021, however this will be subject to Welsh Government feedback/approval and the UHB's ability to progress the business case. 04/03/2021- Process is in place, work will be needed as PBC programme develops. Sept-21 should be achievable however will depend on how quickly PBC progresses. 06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses.

BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Harverfordwest, SA61 2PG	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00113573_003	High	R3. Compartmentation / Dampers Reinstate the fire resistance in the following location: • The ventilation system will need to be inspected and repaired as necessary to ensure all its inherent fire safety devices are functioning in line with its design specifications and manufacturer's instructions. According to the action plan dated 02 December 2019 V2 these ongoing works are to be completed in the timescale of this Enforcement Notice	~~Oct-20~~ ~~Feb-21~~ ~~Dec-21~~ Apr-22	Dec-21 Apr-22	Amber	This work is part of the stage 2 WGH Fire Enforcement Programme. Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). Revised completion date issued on 24/08/2020 by MWWFRS of 21/12/2021. This is remedial works required to complete by February 2021 for priority works (advanced works) remaining works in Phase 1. 17/12/2020- Detailed work to review the delivery program being undertaken with a view to comply with the original date.
BFS/KS/SJM/00114719-/KS/890/02	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_02_001	High	R1. Compartmentation – All Vertical Escape Routes. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Vertical 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.	Sep-20 Jan-21	Jan-21 Feb-21 Jun-21	Red	This work is part of the Advanced Works WGH Fire Enforcement Programme. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021 for this advanced works. 17/12/2020- on track for end of January 2021 completion. 04/02/2021- Works completion date forecast mid February 2021. This small delay has been discussed with MWWFRS and they are fully satisfied with this progress and will amend the FEN when requested. 04/03/2021- Director of Estates, Facilities and Capital Management confirmed this work has been completed. Recommendation closed. 21/05/2021 - correspondence received from MWWFRS stating that they were not content that recommendation
BFS/KS/SJM/00114719-/KS/890/02	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_02_002	High	R2. Fire Damper Systems - Maintenance Ensure that the fire damper systems are properly tested and maintained. Following completion of testing of these systems, documentation needs to be sent to my office confirming this. Fire damper systems should be tested as per British Standard 5588-9 Code 9, with a maximum testing interval of two years.	Sep-20 Jan-21	Jan-21 Feb-21 Jun-21	Red	Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021 for this advanced works. 17/12/2020- This work has been completed. 21/05/2021 - correspondence received from MWWFRS stating that they were not content that recommendation had been fully actioned and therefore re-issued KS890/02, with a 28 day period to fulfil requirements. Report therefore re-opened and recommendation turned from green back to red.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Legislative requirements	Open	N/A	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.	Aug-21 Dec-21 Apr-22	Dec-21 Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2022 as agreed in the programme for Phase 1 Works (presented to them on the 02 October 2020). 04/03/2021-on track as per agreed programme of work. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.	Aug-21 Dec-21 Apr-22	Dec-21 Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2022 as agreed in the programme for Phase 1 Works (presented to them on the 02 October 2020). 04/03/2021-on track as per agreed programme of work. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date.
BFS/KS/SJM/00114719-KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/04	Legislative requirements	Open	N/A	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.	Apr-22 Apr-25	Dec-24 Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. Commencement of work to take place in May 2022. This will be a large piece of work involving entering individual wards and decanting of services as required. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 04/03/2021-on track as per agreed programme of work. 06/05/2021-still on track, UHB meeting with WG 07/05/2021 to establish when to start the work on ward areas.
BFS/KS/SJM/00107739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_001	High	R1. The areas visited in this inspection should be included into the current Compartmentation survey (areas listed at end of schedule)	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- On track. Contractors have been procured to undertake surveys at the end of January 2021. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021- Contractors have been requested to complete work, surveys will be completed by end of March 2021. 24/03/2021- Assistant Head of Operational Facilities Management believes this is complete but awaiting full confirmation on this. They may need to go back just to finish off a few areas where there was limited access. 06/05/2021- There are a some additional blocks remaining, which will be completed when contractors have been appointed at the end of May 2021 - Completion June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KS/SJM/00107739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_001	High	R1. Ensure the holes in the ceiling within the area mentioned are repaired to reinstate the fire resistance of this room (Block 3 FF RM 36 IT Room)	Feb-21 Aug-21	Feb-21 Apr-21 Jun-21	Amber	17/12/2020- On track. Contractors have been engaged. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Feb-21. 04/03/2021- Contractors will be completed work next week. 24/03/2021- Assistant Head of Operational Facilities Management confirmed this recommendation is still outstanding, revised timescale April 2021. 06/05/2021- There are a some additional blocks remaining, which will be completed when contractors have been appointed at the end of May 2021 - Completion June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.

BFS/KS/SJM/001 07739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_002	High	R2. Ensure that the means of escape is kept free from fire and smoke for a minimum period of 30 minutes by ensuring that: Padlocks / slide bolts should be removed from gates that are part of exit from Blocks 18B & A	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- Being delivered, on track for Feb-21. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021- Quote received and orders placed- will be completed by end of March 2021. 06/05/2021-Awaiting contractor to attend and complete works, revised timescale of June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KS/SJM/001 07739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_002	High	R2. Ensure that the means of escape is kept free from fire and smoke for a minimum period of 30 minutes by ensuring that: All Redlam panic bolts fitted to exits should have the hammer fitted in case of emergency on inspection these were missing within Block 4 FF, SF, TF	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- Being delivered, on track for Feb-21. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021- on track for end of March 2021. 06/05/2021- Hammers have been delivered to main stores on the 18/03/21, awaiting fixing. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KS/SJM/001 07739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_002	High	R2. Ensure that the means of escape is kept free from fire and smoke for a minimum period of 30 minutes by ensuring that: Ensure that the hold open device and door both work as one unit, within Ceri ward the sub compartment doors by rooms 11 & 20 had to be pushed further passed its 1st held open position to attach to the magnetic hold open device, meaning that in position 1 if the alarm activates this door will not close automatically	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- Being delivered, on track for Feb-21. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021- on track for end of March 2021. 06/05/2021- Awaiting contractors, revised timescale June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KS/SJM/001 07739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_006	High	R6. Provide a device complying with BS 5839 part 1 and linked to the existing fire alarm system in the following locations: 1. Add a Manual call point in Block 24 Rm 18 by final exit. 2. Move Manual call point in corridor within Block 28 as it is hidden by a held open door. 3. Extend the detection to cover Rm 48 Block 4 TF as it is now a Hazard room. As mentioned in the previous EN letter a number of Detector heads were seen to be outdated, this was also noted within the risk assessments, the fire detection needs to be updated in accordance with BS 5839 part 1. This was noted in: Block 1, Block 3, Block 18 a,b,d. The changes should be carried out and commissioned by a competent person	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- Being delivered, on track for Feb-21. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021-only block 4 left to complete, will be completed by end of March 2021. 06/05/2021- Items 1 & 2 of rec complete, item 3 to be completed June 2021. 06/05/2021- Awaiting contractors, revised timescale June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KS/SJM/001 07739	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00107739_Aug2020_007	High	R7. Manage all waste on site responsibly. Block 18B the storage of bins is in an area that is not enclosed or at a safe distance from the building. The bins can remain in the area as long as a locked structure is erected around them. If not carefully managed and controlled, rubbish stacked in a haphazard fashion in unsightly piles outside premises can lead to more rubbish being dumped or fly tipped. Graffiti, vandalism and arson may then follow in quick succession. When there is no segregated bin storage, wheeled bins should be chained together and to an immobile object, such as a metal stake, at least 10 metres away from any building.	Feb-21 Aug-21	Feb-21 Mar-21 Jun-21	Amber	17/12/2020- Being delivered, on track for Feb-21. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Mar-21. 04/03/2021- quote has been received and order placed, will be completed by end of March 2021. 06/05/2021-Order placed awaiting contractors to attend site to carry out the works, revised timescale June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021.
BFS/KBJ/SJM/001 13573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Legislative requirements	Open	N/A	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.	Mar-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 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. 04/03/2021- on track.
BFS/KBJ/SJM/001 13573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices)	Legislative requirements	Open	N/A	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.	Mar-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 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. 04/03/2021- on track.

BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Legislative requirements	Open	N/A	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.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Legislative requirements	Open	N/A	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.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be the preferred safer option, it was explained to me that this was due to the residents being able to smoke within the premises before the smoking ban to reduce the false alarm calls. • It was noted that there was a detector being covered at time of inspection within the kitchen of the Pembroke county block (First floor flat F block). You must ensure that this practice is not repeated, information must be given to the occupants explaining the severity of this action. • Due to the Server within the Means of escape an additional detector within the area of the device is required (due to the lintel between the detector and the server) noted within the Pembroke county and St Thomas block (but this should include all blocks if server is on escape route in the same way). The changes should be carried out and commissioned by a competent person.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. 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.
KS/890/07	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/07	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	KS/890/07_01	High	R1. Compartmentation – All Vertical Escape Routes. (Agreed Advanced works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Vertical Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Advanced 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.	Oct-20 Feb-21 Aug-21	Aug-21	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/890/07 to be completed by 31/08/2021 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for Aug-21 completion. 04/03/2021- still on track for August 2021, figure has been submitted to WG for advanced work for GGH, expect quick turnaround response in next couple of weeks. 06/05/2021- on track.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Legislative requirements	Open	N/A	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.	Oct-20 Feb-21 Jul-22	Jul-22	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for July 2022 completion. 04/03/2021- on track. 06/05/2021- Currently on track, subject to detailed assessment as part of the BC work.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	KS/890/08_02	High	R2.Compartmentation – All Vertical Breaches and / or Penetrations. To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Glangwili Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 2nd Oct 2020). Fire resisting structures are to continue to slab/ upper floor level/roof level and pass through any false ceiling provided.	Oct-20 Feb-21 Jul-22	Jul-22	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for July 2022 completion. 04/03/2021- on track. 06/05/2021- Currently on track, subject to detailed assessment as part of the BC work.

KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Legislative requirements	Open	N/A	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.	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. 17/12/2020- Director of Estates, Facilities and Capital Management confirmed 'All Vertical Escape Routes' included in the notice (schedule section) in error. 04/03/2021-On track. 06/05/2021- work has not commenced yet but within timescale for the programme of work by August 2024.
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_001	High	Article 8 Item 1 - Fire doors: 1. A 'number of' fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_001	High	Article 8 Item 1 - Fire doors: 2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired or replaced so that the doors close completely into their rebates.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_001	High	Article 8 Item 1 - Fire doors: 3. Fire doors should only be kept open by magnetic devices that releases when the fire alarm operate.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_001	High	Article 8 Item 1 - Fire doors: 4. All self-closing devices are to be regularly inspected and maintained.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_001	High	Article 8 Item 1 - Fire doors: 5. Cupboard doors under the staircases should be kept locked shut.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_002	High	Article 8 Item 2 - Structural Separation: 1. The staircases leading from the 2nd floor to the ground floor should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_002	High	Article 8 Item 2 - Structural Separation: 2. All openings in the walls, floors, partitions and ceilings throughout the premises that are provided for the passage of service piping, ducts or cables, are to be sealed or bushed to at least 30-minute standard of fire resistance.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_002	High	Article 8 Item 2 - Structural Separation: 3. All elements of structure, including doors, windows and glazing that are within 9 metres vertically below or 1.8 metres horizontally of an external fire escape stairway, are to be half hour fire resisting, with any frames fixed shut. All fire resisting construction is to conform to British Standard 476: Part 21-24, or the equivalent European Standard.	Aug-21	Aug-21	Amber	

General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_002	High	Article 8 Item 2 - Structural Separation: 4. An assessment should be undertaken to ensure that all areas identified with insufficient compartmentation need to be provided with fire resisting construction.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_003	High	Article 8 Item 3 - Oxygen Cylinders Storage: The oxygen cylinders should be in a secure location and in a 30 minutes fire compartment.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_004	High	Article 13 Item 1 - Fire Alarm System: 1.The automatic fire alarm system does not meet the current standard. The system is to be upgraded to meet a category L1 system., As specified in the British standard: Part 1 - "Fire Detection and Alarm Systems in Buildings", or the equivalent European Standard.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_004	High	Article 13 Item 1 - Fire Alarm System: 2.An assessment should be undertaken to ensure that all break glass call points are in working order.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_004	High	Article 13 Item 1 - Fire Alarm System: 3. It is good practise to remove the key from the fire panel so it cannot be tampered with.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_005	High	Article 14 Item 1 - Escape Route from Main Ward: A suitable and sufficient protected escape route is required from Ward L1/11.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_006	High	Article 14 Item 2 - Emergency Lighting: An assessment should be carried out to ensure that escape routes within the hospital are illuminated by emergency lighting that will operate if the local lighting circuit fails. The system should conform to BS 5266 or the equivalent European standard.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_007	High	Article 14 Item 3 - Door Fastening: Ensure that the doors exiting the boiler room, storage building and the Mortuary can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_008	High	Article 14 Item 4 - Signage: 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.	Aug-21	Aug-21	Amber	

General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_009	High	Article 14 Item 5 - Combustible Materials and Ignition Sources: An assessment should be undertaken to remove all ignition sources and combustible materials from the means of escape.	Aug-21	Aug-21	Amber	
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Legislative requirements	Open	N/A	Estates	Rob Elliott	Director of Operations	General/00111720_010	High	Article 15 Item 1 - Evacuation Procedure: A review of the current evacuation procedures should be revised to incorporate the current issues and procedures within the hospital.	Aug-21	Aug-21	Amber	

Appendix 2 - In Progress and Overdue Recommendations June 2021

Reference Number	Date of report	Report issued by	Report Title	Type of Plan	Status of report	Assurance Rating	Service / Directorate	Responsible Officer	Director	Recommendation Reference	Priority Level	Recommendation	Recommendation Owner	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/ Reason overdue
WAO_infoBack Up	Mar-18	Audit Wales	Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress	Improvement Plan	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	WAO_InfoBackUp_006	Not stated	Disaster Recovery & Business Continuity. R8. Design and implement a schedule of regular back-up media and disaster recovery testing to provide assurance that applications and data can be successfully restored in the time required after the loss of a system.		N/K	Mar-21 Apr-21 Jun-21	Red	Currently undertaken at local level but not national. Processes are in place and asset group is back up and running following COVID-19. Business Continuity plans are also in place. 07/01/2021- Digital Business Manager update- work is no taking place nationally (NWIS) with a cloud based approach. Should be on track for the March 2021 date. 04/02/2021- Audit Wales reviewed recommendation and commented: 'if evidence of local arrangements in place can be provided, then Audit Wales will be happy for this recommendation to be closed'. Digital Business Manager to review and provide evidence if available. 02/03/2021- The implementation of the Health Board's new backup environment is going well and 40% of data and workloads has been migrated. We aim to complete this by the end of March and will provide necessary documentation by the end of April 2021. 13/05/2021- Back up completion is now at 80%. Would be looking at a revised completion date of June 2021. Reason for delay is due to performance issues with the BT circuits.
175A2019-20	Apr-19	Audit Wales	Clinical coding follow-up review	Improvement Plan	Open	N/A	Digital and Performance	Anthony Tracey / Gareth Beynon	Director of Finance	WAO_ClinicalCoding_001e	Not stated	R1. Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	Assistant Director of Informatics / Deputy Director of Operations	Aug-20	Dec-20 Jun-21	Red	22/10/2020 - update provided to ARAC as follows: An action plan has been developed via the Health Records Group. The Tracking of Records will be the focus of the Health Records Group for the next 6 months with a review at the end of this period along with lessons learned. The work plan suggests a number of phases to the work, ensuring that there are feedback loops and reviews. Timescale – 16 months, based around 4 x 4 month PDSA cycles. The first PDSA cycle was undertaken and lessons learned have been feed into the next PDSA cycle, which unfortunately was paused due to the COVID outbreak. Progress has been delayed significantly due to the COVID pandemic (6-9 months). The audits are now programmed to begin November 2020. 03/12/2020- Informatics Business Manager confirmed revised timescale of June 2021. 07/01/2021 Digital Business Manager update- hopeful for group to meet in February/March 2021, this has been delays due to Covid. 04/02/2021- Audit Wales reviewed recommendation and commented: ' Recommendation was directed towards all staff not just coding staff- there is a policy for tracking records. Raising awareness with all staff that access records. If audit has started and is showing improvement this recommendation can be closed. '. Digital Business Manager to review and provide evidence if available. 02/03/2021- No audits are taking place at the moment, a meeting of the Health Records Group will be scheduled for March/April (Group haven't been meeting due to Covid) to agree and implement the audit work. 11/05/2021- Digital Business Manager confirmed she will check for an update.
Eye Care Services in Wales Follow Up	Jan-20	CHC	Eye Care Services in Wales Follow Up	Improvement Plan	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Carly Buckingham / Stephanie Hire / Keith Jones	Mar-21	Mar-21 Sep-21	Red	By the middle of quarter 2 (August 2020) will have better idea of the waiting lists due to COVID and will review this recommendation at this time to establish if March 2021 deadline is still feasible. 26/11/2020- Update from SDM- No change since last update. We are continuing with the community schemes in relation to glaucoma and cataracts, and a consultant is reviewing these patients to ensure that anyone with an urgent condition is offered a hospital appointment. We are exploring digital opportunities with our community optometrist practices for AMD referrals. We will have a better idea of timescales for implementation by January 2021. 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.
Eye Care Services in Wales Follow Up	Jan-20	CHC	Eye Care Services in Wales Follow Up	Improvement Plan	Open	N/A	Scheduled Care	Carly Buckingham	Director of Operations	EyeCareServices002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Carly Buckingham / Stephanie Hire / Keith Jones	Mar-21	Mar-21 Sep-21	Red	See update in recommendation 1- due to current COVID situation only those with greatest risk of sight loss now been given priority on the pathway. Recommendation to be reviewed in August 2020 to establish if March 2021 deadline is still feasible. 26/11/2020- Update from SDM- Continue to work with community optometrist practices to explore the opportunities for multi disc team working in community settings, for example the digital work mentioned above is a current project we are scoping. 26/03/2021- Updates have been requested from the reporting officer however due to operational pressures and annual leave no update has been received as of 26/03/2021. 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.
All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Mar-19	Delivery Unit	All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Angela Lodwick / Sarah Burgess	Director of Operations	AWAR_PCCAMHS_005	N/A	R5. The HB should undertake an engagement exercise with GPs to improve liaison and a shared understanding of CAMHS pathways.	Angela Lodwick	Nov-19	Dec-20 Jun-21	Red	Training for GP's will be delivered via MS Teams advise this change to 6 months to enable above. 19/02/2021. No progress since last update. 22/03/2021 Primary Mental Health Lead appointed and work plan will be to progress training sessions with GP s provide the written criteria in English and welsh and close this action by June 2021 . 18/5/2021 Action Complete The Primary Mental Health Lead has commenced engagement with GP Leads across the HB footprint discussing and planning the training required. GP letters complete and available in English and Welsh and will be sent out to all GPs along with the SCAMHS Service Specification on 1/6/2021. to be confirmed end of June.
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio002	N/A	R2:Ensure that all administrative record keeping – both electronic and within the medical records – are maintained to the highest of standards.		Aug-19	Oct-20 Dec-20 Aug-21	Red	Unable to progress due to COVID priorities reviewed date for completion is now September 2020. 02/10/2020- reporting officer confirmed It has not been possible to complete the planned monthly audits of outcomes forms at Cardiology Clinics as face to face Clinics have been suspended over the summer months due to COVID. Currently in the process of re-starting clinics now and will look to achieve monthly audits of outcome forms over the next few months. This will then allow us to present a % compliance. New timescale of December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- reporting officer update- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. With increasing numbers of face to face clinics reinstated in coming months, plan to undertake this audit in August 2021.
All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio003	N/A	R3b: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): b. clinical agreement that all referrals sent to tertiary service clearly include the clinically determined PSD and current adjusted PSD, including a standardised referral form which is consistent across HDUHB.		Dec-19	Dec-20 May-21	Red	Unable to progress due to COVID priorities reviewed date for completion is now December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- Update from reporting officer- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. Plan to re-audit this compliance over the next few weeks. 24/05/2021- Requested update if this rec will be completed by end of May 2021, no response as of 28/05/2021.

All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	May-19	Delivery Unit	All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Paul Smith	Director of Operations	DelUnitCardio003	N/A	R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.		May-19	Dec-20 Jun-21	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.
All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Jul-17	Delivery Unit	All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services July 2017	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Mel Evans	Director of Operations	AWR_QCTP_002	N/A	R2. A bespoke training programme to support the improvement of CTPs should be introduced to ensure that mental health and learning disability staff are, and remain, skilled in formulating CTPs and in enhancing the involvement and experience of service users in the process.	Sara Rees / Mel Evans	Mar-23	Mar-23	Amber	02/10/2020 Requested update - delayed due to COVID-19, first task and finish group of four due to take place early November, membership includes HB staff, 3rd sector and carer rep, it is anticipated that draft training package will be ready early in 2021. 10/12/20 Task and finish group has started and agreement over how the training should be delivered has been reached – continued sessions to take place in January 2021 with implementation to begin in an estimated timeframe of April. The training will be delivered by carers to enhance the impact and importance of crisis planning and support to carers re: risk assessment and joint planning of CTP. 19/02/2021 No progress no change to previous comment . 13/05/2021 Issue raised by DU in HB last 90 day review, DU have requested HB present what steps to have taken to address this and discuss at our next meeting. DU will then respond, either formally closing or with more clarity with regards to what further actions they expect to see. Date of that not confirmed but it is either end of May, beginning June 2021.
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Improvement Plan	Open	N/A	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_014	N/A	R14:The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.		Oct-19	Dec-20 Jun-21	Red	Senior Nurse currently working alongside Senior Nurse for Medicines Management to devise training package. Will form part of wider HB approach to addressing training needs for all practitioners in relation to oxygen administration. Suspended due to Covid-19 pandemic. To rearrange for October 2020. 22/01/2021- Hospital HON confirmed she will check with clinical Directors that this was discussed with medical staff and will check training status. 19/02/2021- Hospital HON confirmed she will discuss with Dr. Ward to undertake audit of O2 prescribing. 26/03/2021- update from Consultant Respiratory -'the project should be complete within the next 2 months. Hopefully sooner. It may take a bit longer to organise an educational session, so a rough timescale of 2-3 months'. Revised timescale of June 2021.
19127	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Improvement Plan	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Operations	19127_003	N/A	The health board must ensure that: Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards Notice boards containing information about staff on duty are updated at every shift change Notice boards are reviewed to provide health promotion information Information throughout the unit is made available bilingually.	Julie Jenkins Lesley Owen	Mar-20	Dec-20 Apr-21 Aug -21 Sept-21	Red	Letters available bilingually. Notice boards have been updated however further update will be following COVID 19 pandemic. To be reviewed Dec 2020. 27/07/2020 requested update, chased and meeting to update organised 6/08/2020. Update received-Signage completed, letters completed. On hold due to Covid 19 as staff relocated, full implementation to be reviewed possible Dec 2020. 18/09/2020 Request for update issued: Response received HoM Actions partially completed clinic letters completed. Further review of bilingual requirements to be completed. 20/11/2020 issued for update: Delayed due to Covid until new unit is completed and re-alignment of service signage for all maternity Services. 26/01/2021 Delays on Phase 2 work, due to the impact of Covid new date proposed August 2021. 02/03/2021 CB checked with Rob Elliott date confirmed Aug-21 correct. 26/05/2021 Signage maybe delayed due to delays in the Phase 2 end of Sept 2021.
19258	Jul-20	HIW	PACU and Cilgerran Wards, Glangwili General Hospital	Improvement Plan	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	19258_009	N/A	R9: The health board must ensure the following: Consider the provision of additional storage space	Nick Davies/ Assistant Major Capital Development Manager	Mar-21	01/03/2021 Jan-22	Red	20/11/2020 issued for update: Service response: Met with Capital Estates Manager waiting for costs to consider how to finance this work. 03/02/2021 Planning for new storage area being led by Tracey Bucknell. 19/03/2021 Issued email requesting update interim Manager recently taken over. 07/04/2021 escalated via DSN awaiting update. 26/05/2021 The issue of storage is delayed due to other areas already underway need to be completed before work can be start and it is an access and emergency route to the plant rooms. Likely to be 9-10 months-Jan 2022.
19258	Jul-20	HIW	PACU and Cilgerran Wards, Glangwili General Hospital	Improvement Plan	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	19258_015	N/A	R15: The health board must ensure that required staff are provided with up-to-date level two fire safety training.	Fire Officer for face to face training	Aug-21	Aug-21	Amber	18/09/2020 Request for update issued: Response: All fire training is completed via ELearning on ESR. 20/11/2020 issued for update: Service response: Due to Covid restrictions and social distancing the fire officer has agreed that fire safety training level 2 is to be completed via ELearning on ESR. 03/02/2021 DSN to check and establish any gaps in the training within the areas. 07/04/2021 escalated via DSN awaiting update. 27/05/2021 Face to face training reliant on relaxation of WG guidelines.
19259	Jul-20	HIW	Puffin Unit / PACU, Withybush General Hospital	Improvement Plan	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	19259_002	N/A	R2: The health board must ensure that the paediatric sepsis pathway/guideline is developed and implemented as a priority and all staff are provided with relevant training.	Paula Evans	Nov-20	Nov-20 Jan-21 Apr-21 Jun-21	Red	18/09/2020 Request for update issued: 25/09/2020Response received Work is ongoing and will be ratified in Oct 2020. 20/11/2020 issued for update: Service response: In the October documentation group the sepsis pathway was agreed in principle with minor changes – this will go through global consultation in Dec for final approval. 03/02/2021 – Awaiting next document group for approval – delayed due to lack of medical approval at meeting . Requested new date when action will be completed. 10/02/21 DSN working group involving other HB's in process of standardising SEPSIS pathway. Due to be completed April 2021. 07/04/2021 DSN update Paediatric Sepsis Guideline has been approved and is going out for wider HB consultation, New date confirmed June 2021. 27/05/2021 Sepsis pathway – internally approved and has gone for global consultation.
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	National Review	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_004	N/A	Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes	Julie Jenkins	Jun-21	Jun-21 Sept-21	Amber	15/03/2021 - this recommendation while raised in the initial report has not been included in the required template for completion by HIW (see p25 of original report) 19/03/2021 report included as part of normal scheduled request for updates. 30/03/2021 Currently due to covid, there are no partners outside labour ward setting. Planned improvement - Phase 2 is converting a room for birthing partner to stay overnight. 26/05/2021 Phase 2 delayed end of Sept 2021.
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	National Review	Open	N/A	Women and Children's Services / Public Health	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_006	N/A	Consider the introduction of smoking cessation leads	Julie Jenkins / Joanna Dainton	Mar-22	Mar-22	Amber	15/03/2021 - draft responses provided. 19/03/2021 report included as part of normal scheduled request for updates. 29/03/2021 issued to Public Health-Head of Commissioning and Partnerships no response. 30/03/2021 Head of Midwifery & Women Services is to work in partnership with Public Health (Head of Commissioning and Partnerships) and set up a meeting. 21/05/2021 Email issued to PH - no response.
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	National Review	Open	N/A	Women and Children's Services / Public Health	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_007	N/A	Consider working with Public Health Wales to further promote healthier living and lifestyles	Julie Jenkins / Joanna Dainton	Feb-22	Feb-22	Amber	15/03/2021 - draft responses provided. 19/03/2021 report included as part of normal scheduled request for updates. 29/03/2021 issued to Public Health-Head of Commissioning and Partnerships no response. 30/03/2021 Head of Midwifery & Women Services is to work in partnership with Public Health (Head of Commissioning and Partnerships) and set up a meeting. 21/05/2021 Email issued to PH - no response.

National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	National Review	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_017	N/A	Ensure that a clutter free and safe environment is maintained across units	Julie Jenkins	Jul-21	July -21	Amber	15/03/2021 - draft responses provided. 18/03/2021 - approved for HIW submission 19/03/2021 Report included as part of normal scheduled request for updates. 19/03/2021 Monthly assurance audits spot checks established and Band 7 co-ordinators walk arounds in place. Phase 2 and Dinefwr ward building work continuing to be monitored. 26/05/2021 Clutter free environment monitored due to Phase 2 and Dinefwr ward building work continuing.
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	National Review	Open	N/A	Women and Children's Services	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_029	N/A	Consider the introduction of live stream CTG monitoring in all units.	Julie Jenkins	Jul-21	Jul-21	Amber	15/03/2021 - draft responses provided. 18/03/2021 - approved for HIW submission 19/03/2021 Report included as part of normal scheduled request for updates. 19/03/2021 On track for July completion, however the system relies on phase two completion and training. 26/05/2021 System purchased, IT commissioned all set up - Completed. Awaiting new build handover.
190417	Aug-17	HIW MHLD	Cwm Seren / Low Secure Unit (LSU) and Psychiatric Intensive Care Unit (PICU), 14-16 January 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	190417_010	N/A	The health board must repair or replace the damaged flooring within the whole unit as this causes a risk to patient safety	Assistant Site Operations Manager/Building Officer	Dec-20	Dec-20 Mar-21 Apr-21 May-21	Red	Clarification provided by Maggie Annison- PICU flooring already completed. LSU flooring funding approved. Site operational teams to implement flooring works to Step Down corridor, Section 136 room and 3 bedrooms by end of year. 04/12/2020 update requested, 14/12/2020 Maggie Annison confirmed LSU flooring funding approved. Site operational teams to implement flooring works to Step Down corridor, Section 136 room and 3 bedrooms by end of year. 29/12/2020 Site Estates Manager confirmed a new multi quote exercise is required as the previous quote is no longer valid. Mid Feb 2021. 18/02/2021 Discussed with Nevin LSU flooring is underway and will be completed no later than end of March 2021. 14/04/2021 Project Manager reported that this is being planned with Ward Manager, Estates Site Manager and Contractor. Awaiting of confirmation of new date for completion. 26/04/2021 chased up the expected date of completion awaiting a response. 24/05/2021 Response received from Ward that the step down corridor has been completed and work is underway on the first bedroom floor. Final completion to be confirmed end of May.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_21	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Angela Lodwick	Dec-19	Dec-20 Mar-21 Sept -21	Red	The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England and the Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services. 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed Transition Lead moving back into post April 2021 and work plan will be prioritised and the Transition Policy will be reviewed and updated and signed off at written control group – on track for Sept . 18/5/2021 On Track Transition Lead has resumed post and has a workplan established to meet actions identified in HIW action Plan.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_21	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Angela Lodwick	Dec-19	Dec 20 March 21 Sept -21	Red	Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed the Transition Policy will be reviewed and updated and signed off at written control group – on track for Sept . 18/5/2021 On track The revised Policy will be sent to the written control group once complete.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_21	N/A	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Angela Lodwick	Dec-19	Dec 20 March 21 Sept -21	Red	Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services . 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed Transition Lead moving back into post April 2021 and work plan will be prioritised . Transition Policy will be reviewed and updated and signed off at written control group – on track for Sept and Transition Lead will arrange 2 x workshops for above to engage adult staff. 18/05/21 Transition Lead has established local transition groups with identified staff from the Adult Mental Health teams to focus on developing the workshops and disseminate good practice in respect of Transition.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_22	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	Angela Lodwick	Aug-19	Dec 20 March 21 Sept -21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically. Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed that Head SCAMHS will set up a Transition steering group May 21. 18/05/2021 On Track, Head of Service has established a multi disciplinary /agency Transition Steering Group and the first meeting will be 25/6/2021
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_22	N/A	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	Sara Rees / Angela Lodwick Senior Nurse QAPD Team	Aug-19	Dec 20 March 21 Sept -21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically . Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services . 19/02/2021. No progress since last update. 22/03/2021 Head of Service confirmed that the Head SCAMHS will set up a Transition steering group May 21. 18/5/2021 On Track, Head of Service has established a multi disciplinary agency Transition Steering Group and the first meeting will be 25/6/2021 to include management actions.

How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_26	N/A	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	Angela Lodwick	Sep-19	Dec 20 June 21 Sept- 21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated . The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services. 19/02/2021. No progress since last update. 22/03/2021 Transition Lead moving back into post April 2021 and work plan will be priority 18/5/2021 On Track, Updated Transition Policy will have Young Persons Passport documents embedded. Training will be provided on use of document across SCAMHS and AMHS. Audit of process will include views and experiences of young people.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_27	N/A	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	Angela Lodwick	Sep-19	Dec 20 June 21 Sept-21	Red	16/12/2020 Time frame realistic and dependant on all above actions being implemented. 19/02/2021. No progress since last update. 22/03/2021 Transition Lead moving back into post April 2021 and work plan will be prioritised. 18/5/2021 On track, Referral form is contained within Transition Policy and use of form will be audited 12 monthly.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Mental Health & Learning Disabilities	Sara Rees / Angela Lodwick	Director of Operations	Theme_YMH_32	N/A	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.	Angela Lodwick	Sep-19	Mar 21 Sept 21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post. No update August 2020. 02/10/2020 Requested update - Change completion date to Sept 2021 due to training pack needing to be developed by the transition worker and training set up on MST. 16/12/2020 Time frame realistic and dependant on all above actions being implemented. 19/02/2021. No progress since last update. 22/03/2021 Head of Service confirmed Training sessions will be organised. 18/5/2021 On track .Training Plan being developed for rolling programme over next 12 months
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Women and Children's Services	SDM W&C Tracey Bucknell	Director of Operations	Theme_YMH_29	N/A	Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.	Tracey Bucknell	Sep-19	Feb-22	Red	4/12/2020 Senior Nurse Community Children's Services a request has been submitted to ROALD DAHL charity to fund a Transitional Epilepsy Specialist Nurse. Email received from the charity on the 25/11/2020 stating that they are inundated and that they will provide an outcome asap. 27/01/2021 Charity has notified the Service that they were unsuccessful in their bid for funding, feedback has been requested. Directorate to develop and submit a Business Case to support a new post. 19/03/2021 Directorate SDM to develop and submit a Business Case to support a new Epilepsy Specialist Nurse post. 25/05/2021 SDM confirmed meeting to finalise JD 26th June 2021, the post should be in place by Sept 2021.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Women and Children's Services	SDM W&C Tracey Bucknell	Director of Operations	Theme_YMH_30	N/A	Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.	Tracey Bucknell	Sep-19	Feb-22	Red	4/12/2020 Senior Nurse Community Children's Services a request has been submitted to ROALD DHAL charity to fund a Transitional Epilepsy Specialist Nurse. Email received from the charity on the 25/11/2020 stating that they are inundated and that they will provide an outcome asap. 27/01/2021 Charity has notified the Service that they were unsuccessful in their bid for funding, feedback has been requested. Directorate to develop and submit a Business Case to support a new post. 19/03/2021 Recommendations 29 & 30 are linked a transitional Nurse is in post. Directorate SDM to develop and submit a Business Case to support a new Epilepsy Specialist Nurse post. 25/05/2021 SDM confirmed meeting to finalise JD 26th June 2021, the post should be in place by Sept 2021.
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	Improvement Plan	Open	N/A	Operations Directorate	Andrew Carruthers	Director of Operations	Theme_YMH_31	N/A	Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.	Director of Operations	Sep-19	Dec-20 Jun-21	Red	14/09/2020 - chaser e-mail sent to Mandy Rayani for updates in time for HIW update deadline of 9th October. Awaiting clarification if Director of Operations will lead on this recommendation. 02/03/2021-Update from Director of Operations- Improvement plan from assessment addresses the recommendation. Improvement plan going to QSEAC in June 2021, recommendation can therefore be closed in June 2021. 05/03/2021- Director of Operations confirmed this recommendation will be closed once the improvement plan goes to QSEAC in June 2021 as the assessment has been undertaken.
HDUHB1718-35	Apr-18	Internal Audit - HDUHB	Theatres Directorate	Internal Audit Report	Open	Reasonable	Scheduled Care	Stephanie Hire / Diane Knight	Director of Operations	HDUHB1718-35_002	Medium	R10. The practice of providing unnecessary 'rest days' to staff at BGH should be promptly reviewed. Any future agreement on rest time, following a period of on-call, should be in line with the A4C NHS terms and conditions of service.		Nov-17	Sep-21	Red	The recommendations cannot be addressed until grievance process is complete. Recommendation currently with Director of Operations. 02/03/2021- Director of Operations confirmed implementation of grievance outcome should be completed by end of Q2 2021/22.
HDUHB-1920-10	Jun-20	Internal Audit - HDUHB	Business Continuity	Internal Audit Report	Open	Reasonable	Public Health	Sam Hussell	Director of Public Health	HDUHB-1920-10_001	Medium	R1. The Director of Public Health should review training processes currently in operation within the Health Board and ensure this is accurately reflected in the Business Continuity Planning Policy.	Claire Conroy	Nov-20	Nov -20 Jun- 21	Red	Final version received at August 2020 ARAC. 27/11/2020 emailed requesting update 10/12/2020 Business Continuity Officer updated: The delay is due to Covid19, unable to give a predicted date as to when this will be completed. 05/02/2021 issued for update- Requested to check with Audit to see if the recommendation can be closed. Response received from audit all recommendations still require completion. Emailed CC - no response. 22/03/2021 Response received. Business Continuity Planning Policy reviewed and has been discussed the recommendations, added to, and updated the Policy. Policy to go to the People, Planning & Performance Assurance Committee. 23/03/2021 Head of Health Emergency Planning new date June 21.
HDUHB-1920-10	Jun-20	Internal Audit - HDUHB	Business Continuity	Internal Audit Report	Open	Reasonable	Public Health	Sam Hussell	Director of Public Health	HDUHB-1920-10_002	Medium	R2: Management should ensure the Business Continuity Planning Policy is reviewed and updated to reflect current processes and procedures before being submitted for approval at the People, Planning & Performance Assurance Committee	Claire Conroy	Nov-20	Jun-21	Red	Final version received at August 2020 ARAC. 27/11/2020 emailed requesting update 10/12/2020 Business Continuity Officer updated: The delay is due to Covid19, unable to give a predicted date as to when this will be completed. 05/02/2021 issued for update- Requested to check with Audit to see if the recommendation can be closed. Response received from audit all recommendations still require completion. Emailed CC - no response. 22/03/2021 Response received. Business Continuity Planning Policy reviewed and has been discussed the recommendations, added to, and updated the Policy. Policy to go to the People, Planning & Performance Assurance Committee. 23/03/2021 Head of Health Emergency Planning new date June 21.

HDUHB-1920-10	Jun-20	Internal Audit - HDUHB	Business Continuity	Internal Audit Report	Open	Reasonable	Public Health	Sam Hussell	Director of Public Health	HDUHB-1920-10_006	Medium	R6: The Emergency Planning Team should review the feasibility of uploading and maintaining all business continuity plans on the intranet. Where changes are identified, this should be reflected in the Business Continuity Planning Policy, otherwise all directorate, service and department plans should be shared online.	Claire Conroy	Nov-20	Nov -20 Jun- 21	Red	Draft Internal Audit reported to ARAC April 2020 with no management response included. Final version received at August ARAC. 27/11/2020emailed requesting update Response received 10/12/2020 Business Continuity Officer confirmed : The delay is due to Covid19, unable to give a predicted date as to when this will be completed as this recommendation is reliant on IT assistance . 05/02/2021 issued for update- Requested to check with Audit to see if the recommendation can be closed. Response received from audit all recommendations still require completion. Emailed CC - no response. 22/03/2021 Response received. Business Continuity Planning Policy reviewed and has been discussed the recommendations, added to, and updated the Policy. Policy to go to the People, Planning & Performance Assurance Committee. 23/03/2021 Head of Health Emergency Planning new date June 21.
HDUHB-1920-04	Jun-20	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	HDUHB-1920-04_003	Medium	R3: Management should liaise with directorates and services to ensure that arrangement currently in place meet the requirements set out in the Health & Safety Policy.	Head of Health, Safety & Security	Aug-20	Oct-20 Sep-21	Red	The dept. H&S Co-ordinator/Champion role has not been implemented to date due to the work undertaken for the H&S team with the HB response and management of COVID-19 pandemic. The H&S Training programme that has been established will be utilised to provide training to these staff. The Pilot course is being held on the 16th & 23rd October 2020. 23/10/2020- requested update from reporting officer that recs 2, 3 and 4 have now been implemented. Awaiting response. 26/01/2021- Internal Audit are planning scope of next Health & Safety IA report with H&S team, to be reported to ARAC in April 2021 (if it does not make February 2021 agenda). 25/03/2021- draft report to ARAC shows this recommendation as partially completed. Establishment of Departmental Health and Safety Champions/Co-ordinators has not been completed due to our departmental contribution to COVID-19 commitments. However, H&S Induction Training for Managers has progressed with approximately 150 staff completing the course since October 2020. Departmental Audits commenced in March 2020 with a planned annual programme in place. This recommendation will be completed as part of improvements to departmental management and ownership of health and safety by September 2021.
HDUHB_1920_40	Mar-20	Internal Audit - HDUHB	IM&T Assurance – Follow Up	Internal Audit Report	Open	Reasonable	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.	Assistant Director of Informatics	May-19	May-21 Aug-21	Red	04/12/2020- Delays in software solution therefore looking at shift patterns and other ways of working. 07/01/2021- Digital Business Manager confirmed newly developed shift patterns are going through checks and then will go through consultation with staff across the 3 sites. Should be on track for July 2021 date. 04/02/2021- Digital Business Manager confirmed currently working with staff to change rota, issue with night/weekend lone working which has been exacerbated by covid issues, social distancing requirements,etc. 8 new bank staff are to be trained and will be included in the new rota. 02/03/2021- there is currently still lone working on evenings and weekends. New rota being looked at in consultation with staff. Consulting with staff now on change in working practice, advise to be sought from HR if any contract changes required. This has been delayed by Covid, and OCP work is re-starting but now has target date of July 2021. 18/03/2021- There is currently still lone working on evenings and weekends. There has been a recent push by the Assistant Director of Digital Services to implement the new switchboard system across the 3 counties by May 2021, which will enable switchboards to switch to different sites. The new system will resolve this recommendation and negate the need for an OCP to be undertaken with staff. 11/05/2021-Digital Business Manager update- the new solution is not yet in place due to delays in some of the technical elements. We are meeting as a senior team to assess what is required and move at pace to get this completed. Working to get new system working alongside the current solution in the next couple of weeks. 4 sites now all under the same management. Revised date of August 2021 provided for both systems to be in place and testing to take place.
HDUHB1819-33	Feb-19	Internal Audit - HDUHB	Records Management	Internal Audit Report	Open	Limited	Digital and Performance	Patrycja Duszynska	Director of Finance	HDUHB1819-33_001	Medium	R1. Management should ensure the Corporate Records Management Strategy and Policy are submitted to the Business Planning & Performance Assurance Committee for approval.	Head of Information Governance	Sep-19	Sept-20 Jan-21 Mar-21 Apr-21 Jun-21	Red	Apr 20 ARAC update: Due to COVID outbreak, the work associated with many of the recommendations has been delayed by at least 3-4 months. A revised policy was due to be considered at the March 2020 IGSC, however this was postponed due to current outbreak. A meeting had been scheduled with the Information Governance Team to progress this work, but due to the pandemic, two meetings have been cancelled. An extension until September 2020 would be appreciated to allow time agree an approach and action the work required. 01/10/2020- Informatics Business Manager to check with Head of Information Governance that she is now the responsible officer for implementing this recommendation. Revised date to be sought. 22/10/2020 - Update provided to October ARAC: A revised policy will be considered at IGSC in January 2021 following clarification of roles and responsibilities. 29/10/2020- recommendation owner changed from Head of Corporate Office to Head of Information Governance. 08/12/2020- Health Records Manager- Corporate Records Management Strategy and Policy will be reviewed for consideration by IGSC in March 2021, prior to submission to PPPAC. 04/02/2021- Structured review of Records Management to be included in 2021/22 IA plan. 15/03/2021- Head of Information Governance confirmed this policy will be taken to IGSC in April 2021. 13/05/2021- Digital Business Manager obtained update from Head of Information Governance - the policy is in draft at the moment and will be reported to the next IGSC in June 2021.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_001	Medium	R1. The digital maturity measurement methodology should be further developed to give a more rounded view of the organisations capabilities.	Anthony Tracey, Assistant Director of Digital Services	Dec-21	Dec-21	Amber	15/12/2020-Commission independent review by December 2021. 11/05/2021- Digital Business Manager update- On track, project due to start in May/June 2021, being taken forward by Assistant Director of Digital Services and Head of Systems and Informatics Projects.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_002	Low	R2. The organisation should develop a communication plan covering the required messages, target audiences, communication mechanisms/channels and schedules. Departmental leads or champions should be identified and included in the communication of the strategy, acting as a point of contact they will aid ownership of the strategy.	Anthony Tracey, Assistant Director of Digital Services	Mar-21	Mar-21 Apr-21 N/K	Red	02/03/2021- There is overarching plan on what communication channels will be used, Digital Business Manager to share with Assurance & Risk Officer. Digital champions across the UHB that meet quarterly. Any comms, new developments etc. go to that group to disseminate to their teams. Also digital partners in the hospital sits and Digital Senior teams established corporately. Once Assurance & Risk Officer received documents this recommendation may be able to close. 05/03/2021- Digital comms documentation will be reported to IGSC on 13/04/2021 for approval. Once this is reported Internal Audit have confirmed they will be happy for the recommendation to be closed. 11/05/2021- Digital comms paper submitted to IGSC in April 2021 has been shared with Internal Audit, awaiting approval for this recommendation to be closed.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_003	Medium	R3. Terms of reference should be updated in order to assign the responsibility of monitoring the Digital related internal and external audit reports and findings.	Anthony Tracey, Assistant Director of Digital Services	May-21	May-21 Jun-21	Red	15/12/2020- May 2021 deadline is reflective of the current review period. At their September 2020 meeting IGSC approved their new Terms of Reference and agreed that a further review would be undertaken in 6 months. 11/05/2021- TORs to be included on IGSC agenda on 08/06/2021.

HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_005	Low	R5. Consideration should be given to providing reports to the Digital sub-committee identifying risks that are not scored to escalation level due to low likelihood, however contain a severe worst case scenario. In doing so, the Digital sub-committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.	Anthony Tracey, Assistant Director of Digital Services	Dec-20	Dec-20 Feb-21 May-21 Jul-21	Red	07/01/2021- Digital Business Manager update- Digital Agile Working Group due to meet bi-monthly, any projects in the interim will be reported to that group. Assistant Director of Digital Services looking at structure for reporting going forward, this has been delayed due to prioritising other work as a result of Covid-19. Revised date of February 2021. 02/03/2021-02/03/2021- Now called Digital Agile Working Group which is meeting on 05/03/2021, Digital Business Manager to send TORs to Assurance & Risk Officer and check workplan to see if this recommendation can then be closed. 05/03/2021- Digital Business Manager confirmed the risks will not be going to the Agile Business Group, but another operational group is due to be set up shortly and this will report to the Finance Committee. Revised timescale of May 2021 provided. 11/05/2021-Digital Business Manager update- Group hasn't been established yet but should be set up soon. Digital Business Manager to check. Revised timescale of July 2021 provided.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_008	Medium	R8. The Health Board should consider leveraging the national cyber security training, either for all staff or targeted groups.	Anthony Tracey, Assistant Director of Digital Services	Feb-21	Feb-21 Oct-21	Red	15/12/2020- report states 'Communication / Implementation Options to be considered at the November 2020 IGSC Meeting with a rollout plan and phased improvement targets to be agreed'. Assurance and risk officer to clarify timescale with reporting officer. 07/01/2021- Digital Business Manager update- IGSC Jan 2021 meeting cancelled due to large number of apologies, now meeting taking place in early February 2021. 02/03/2021- On ESR but not mandatory. The mandatory training group has not met, when they next do will request this is included as mandatory, Digital Business Manager to check and provide approximate date for completion. 05/03/2021- Update from Digital Business Manager- this has been discussed, but can only be made mandatory in the Health Board if it is an All Wales Mandatory requirement. Currently looking at buying additional licensing to make it available to all staff in the Health Board and promoting the completion of it through a communications plan. Revised timescale of October 2021 provided. 11/05/2021- this is part of the new Cyber Security Senior Specialist's workplan, working on making this mandatory on ESR.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_009	Medium	R9. The Health Board CAB Terms of Reference should be reviewed to ensure they reflect current practices.	Anthony Tracey, Assistant Director of Digital Services	Nov-20	Oct-20 Mar-21 May-21	Red	07/01/2021- Digital Business Manager to check if this is completed. 02/03/2021- Revised Change Advisory Board TORs will be available by the 12th March. 13/05/2021- The TORs have been updated and will be going to the next CAB meeting on 19/05/2021.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_011	Medium	R11. The incident management process should be strengthened by updating the Health Board IT Incident Management Procedure document to reflect current practices.	Anthony Tracey, Assistant Director of Digital Services	Dec-20 Feb-21	Dec-20 Feb-21 Mar-21 May-21 Aug-21	Red	07/01/2021- Digital Business Manager confirmed procedure will be looked at but this has been delayed due to Covid. New date of Feb-21 provided, training and awareness should be undertaken by then. 02/03/2021- Revised Incident Management Procedure will be available by the 12th March. 13/05/2021- Digital Business Manager confirmed this is now being reviewed along side the implementation of FreshWorks which is a replacement of the current Service Desk system. Revised completion date of August 2021.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_012	Medium	R12. Consideration should be given to allocating budget on need to ensure that the trajectory for strategy delivery is maintained.	Anthony Tracey, Assistant Director of Digital Services	Mar-21	Mar-21	Amber	15/12/2020- report states deadline 'As part of budget setting round for 2021/2022'. Assurance and risk officer to clarify timescale with reporting officer. 07/01/2021- Digital Business Manager confirmed timescale of March-21. 02/03/2021- Assistant Director of Digital Services in conversation with Director of Finance regarding the budget. Digital Business Manager to check for update. 05/03/2021- This is currently taking place and will be ready for the new financial year. 11/05/2021- Digital Business Manager update-Conversations have taken place between the DOF and Assistant Director of Digital Services, and a commitment has been made for the next 5 years. The Digital response has been reported to Board. Awaiting confirmation from Internal Audit if this report can now be closed.
HDUHB-2021-20	Nov-20	Internal Audit - HDUHB	IM&T Control and Risk Assessment	Internal Audit Report	Open	N/A	Digital and Performance	Anthony Tracey	Director of Finance	HDUHB-2021-20_013	Medium	R13. The department should regularly seek out opportunities for knowledge sharing, succession planning, staff backup, cross-training and job rotation initiatives to minimise reliance on individuals performing critical job functions.	Anthony Tracey, Assistant Director of Digital Services	Sep-21	Sep-21	Amber	11/05/2021- Digital Business Manager putting together a report for the DOF on the Digital academy approach taking place, including collaborative working with colleges and universities. Digital Business Manager to share report once written with assurance and risk officer in the hope that Internal Audit will then be happy to close this recommendation.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_001	N/A	Developing a protocol pack for future events that require similar arrangements, to swiftly implement the required measures. For example, building on approved procedures currently in place within the Health Board formally review and re approve establish meeting etiquette, membership, platform to use, meeting arrangements.	Board Secretary	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_004	N/A	Building on the current established process develop guidance for the level of information required to be documented in the Decision Log may be helpful, particularly where a large number of items or expenditure is being approved in one decision. This can be used for future mobilisation of the process, in the event of potential future peaks of the pandemic.	Board Secretary	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_006	N/A	Development of a Finance Directorate Business Continuity Plan in line with the Health Board's policy.	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_007	N/A	Building on the current established process develop guidance for the level of information required to be documented in the Decision Log may be helpful, particularly where a large number of items or expenditure is being approved in one decision.	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_009	N/A	Assess learning form the recruitment process to establish if that can enhance the efficiency of the routine process for the future.	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_010	N/A	Ensure there is a fully updated record of staff movement / redeployments.	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_011	N/A	Updating policy to include the expenditure of grant funds and the receipting and handling of donated assets (highlighted in separate Internal Audit Report).	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Internal Audit Report	Open	Advisory	Governance	N/A	Board Secretary	HDUHB2021-11_012	N/A	Additional specific guidance in relation to staff working at home including, the need to maintain privacy when using video conferencing and the storage of any hard copy documents.	N/K	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC.

HDUHB-2021-05	Apr-21	Internal Audit - HDUHB	Mass Vaccination Programme	Internal Audit Report	Open	Advisory	Public Health	Bethan Lewis	Director of Public Health	HDUHB-2021-05_001	N/A	Consider whether data relating to vaccine wastage, DNAs and reserve lists is included within current planning activity, appropriately monitored and reported.	N/K	N/K	N/K	Amber	
HDUHB-2021-05	Apr-21	Internal Audit - HDUHB	Mass Vaccination Programme	Internal Audit Report	Open	Advisory	Public Health	Bethan Lewis	Director of Public Health	HDUHB-2021-05_002	N/A	Establish arrangements to ensure minutes of the Bronze Vaccine Delivery Group are retained as an accurate record and audit trail	N/K	N/K	N/K	Amber	
HDUHB-2021-05	Apr-21	Internal Audit - HDUHB	Mass Vaccination Programme	Internal Audit Report	Open	Advisory	Public Health	Bethan Lewis	Director of Public Health	HDUHB-2021-05_003	N/A	Develop standard risk log templates for use by operational project groups with guidance on risk management which are aligned to the Health Board's Risk Management Strategy & Policy	N/K	N/K	N/K	Amber	
HDUHB-2021-05	Apr-21	Internal Audit - HDUHB	Mass Vaccination Programme	Internal Audit Report	Open	Advisory	Public Health	Bethan Lewis	Director of Public Health	HDUHB-2021-05_004	N/A	Assess aspects of the COVID-19 vaccination rollout that have worked particularly well and consider whether they can form part of future vaccination and immunisation arrangements, for example, the Influenza Vaccination Campaign	N/K	N/K	N/K	Amber	
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_001	Medium	R1. Management should ensure that the Health and Safety Policy is amended to reflect the change of executive lead for health and safety to the Director of Nursing, Quality and Patient Experience.	Head of Health, Safety & Security	Jul-21	Jul-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_002	Medium	R2. Management should review the Women and Child Health Quality & Safety Group agenda to ensure health and safety is a standing item, and to ensure the attendance of a Health and Safety Team representative at future meetings.	Head of Health, Safety & Security	Jul-21	Jul-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_003	Medium	R3. The Health and Safety Team should submit their annual audit programme and approach taken to the Health & Safety Assurance Committee for discussion.	Head of Health, Safety & Security / Health, Safety and Security Officer	Jul-21	Jul-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_004	Medium	R4. Management should introduce key performance indicators to enable the organisation to measure and monitor health and safety performance.	Head of Health, Safety & Security	Sep-21	Sep-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_005	Medium	R5. Management should ensure there is a clear reporting structure from the county partnership forums through to the Health & Safety Assurance Committee.	Head of Health, Safety & Security	Jul-21	Jul-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_006	Medium	R6. Management should ensure a summary update of issues, risks and actions arising at directorate and service level is reported through to the Health & Safety Assurance Committee within the Health and Safety Update Reports.	Head of Health, Safety & Security	Jul-21	Jul-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-01	Apr-21	Internal Audit - HDUHB	Health & Safety	Internal Audit Report	Open	Reasonable	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality & Patient Experience	HDUHB-2021-01_007	Medium	R7. Management should ensure that training compliance figures are reported at directorate/service quality and safety meetings and the Health & Safety Assurance Committee to allow for the identification of risks, trends and actions.	Head of Health, Safety & Security	Sep-21	Sep-21	Amber	25/05/2021- Report presented to ARAC on 05/05/2021. Assurance & Risk Officer will be requesting confirmation that recommendation is on track for completion as part of the next be-monthly service email in early July 2021.
HDUHB-2021-22	Apr-21	Internal Audit - HDUHB	Digital Modelling (EDAPT)	Internal Audit Report	Open	Substantial	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB-2021-22_001	Low	Ownership of the modelling tool and its code should be established and communicated to stakeholders.	Assistant Director of Digital Services	Jul-21	Jul-21	Amber	11/05/2021- Digital Business Manager confirmed recs are on track
HDUHB-2021-22	Apr-21	Internal Audit - HDUHB	Digital Modelling (EDAPT)	Internal Audit Report	Open	Substantial	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB-2021-22_002	Medium	The organisation should consider options to share the knowledge necessary for the upkeep of the tool, they should ensure that staff have time to share expertise with colleagues and consider developing a knowledge repository such as GitHub to document any future changes (GitHub is a code hosting platform for collaboration and version control of software developments).	Assistant Director of Digital Services	Sep-21	Sep-21	Amber	11/05/2021- Digital Business Manager confirmed recs are on track
HDUHB-2021-22	Apr-21	Internal Audit - HDUHB	Digital Modelling (EDAPT)	Internal Audit Report	Open	Substantial	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB-2021-22_003	Low	The above changes should be agreed with management and actioned to remove any potential confusion or ambiguity on the dashboards.	Assistant Director of Digital Services	Jun-21	Jun-21	Amber	11/05/2021- Digital Business Manager confirmed recs are on track
HDUHB-2021-22	Apr-21	Internal Audit - HDUHB	Digital Modelling (EDAPT)	Internal Audit Report	Open	Substantial	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB-2021-22_004	Low	As business as usual returns, for added assurance the Health Analytics Team should request assistance from the Information Governance Team to perform a retrospective Data Protection Impact Assessment (DPIA). Consideration should also be given to establish if there is a requirement under the General Data Protection Regulation (GDPR) for the modelling tool to appear as an information asset on the health boards information asset register and an appropriate owner and administrator assigned.	Assistant Director of Digital Services	Aug-21	Aug-21	Amber	11/05/2021- Digital Business Manager confirmed recs are on track
HDUHB-2021-10	May-21	Internal Audit - HDUHB	Brexit Risks and Actions Advisory Review Final Report	Internal Audit Report	Open	Advisory	Finance	Sam Hussell / Rhian Davies	Director of Finance	HDUHB-2021-10_001	N/A	The EU Settlement Scheme and its potential impact of maintaining services for affected EU employees should be considered when developing business continuity plans	N/K	N/K	N/K	Amber	No information provided within the advisory report as to recommendation owner nor timescale for completion
HDUHB-2021-10	May-21	Internal Audit - HDUHB	Brexit Risks and Actions Advisory Review Final Report	Internal Audit Report	Open	Advisory	Finance	Sam Hussell / Rhian Davies	Director of Finance	HDUHB-2021-10_002	N/A	Outstanding Information Asset Owners must be reminded of their responsibility to communicate their Information Asset Register work plans promptly to the Information Governance Team in order to identify all data flows between the UK and EU	N/K	N/K	N/K	Amber	No information provided within the advisory report as to recommendation owner nor timescale for completion

HDUHB-2021-10	May-21	Internal Audit - HDUHB	Brexit Risks and Actions Advisory Review Final Report	Internal Audit Report	Open	Advisory	Finance	Sam Hussell / Rhian Davies	Director of Finance	HDUHB-2021-10_003	N/A	Data sharing and retention risks that are currently recorded on the Information Governance Teams local system should be transferred to directorate and service risks registers in order to retain control of residual issues and risks following the closure of the corporate risk entry	N/K	N/K	N/K	Amber	No information provided within the advisory report as to recommendation owner nor timescale for completion
HDUHB-2021-10	May-21	Internal Audit - HDUHB	Brexit Risks and Actions Advisory Review Final Report	Internal Audit Report	Open	Advisory	Finance	Sam Hussell / Rhian Davies	Director of Finance	HDUHB-2021-10_004	N/A	A clear trail to ensure key actions raised at the BSG meetings, prior to the group disbanding in March 2021, should be evidenced as being 'closed off'	N/K	N/K	N/K	Amber	No information provided within the advisory report as to recommendation owner nor timescale for completion
SSU-HDU-1920-02	Jun-20	Internal Audit - SSU	Glangwili Hospital Women & Children's Development Phase 2	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_004	Medium	R4: Costs will be agreed as a matter of priority for the remaining change costs	Project Director	Jun-20	Jul-20 N/K	Red	Completed. 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Of two Project Manager Instructions (PMI) awaiting contractual cost agreement at the prior audit, one, relating to the LV switch room (formerly assessed at £100,000) is recorded at the January 2021 cost report as still being "Open" (i.e. cost awaiting resolution). The second, relating to a roof walkway is recorded as resolved at Compensation Event (CE) CE059b in value of £59,890. However the associated CE remains to be evidenced". Revised responsibility and Timescale is Project Director / Immediate. Recommendation remains with Planning. 28/05/2021- Head of Capital Planning confirmed this was closed off in January and June 2020. Information has been sent to Audit to enable this recommendation to be closed off. Awaiting confirmation from Internal Audit before this recommendation is turned to green.
SSU-HDU-1920-02	Jun-20	Internal Audit - SSU	Glangwili Hospital Women & Children's Development Phase 2	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_008	Medium	R8: Reporting to the Project Group should be extended to include: * mitigating factors e.g. Compensation Events; * early access to phases * extended programmes for individual phases; * economies generated from overseeing phases; * the impact of delays from prior phases and forward impact on remaining phases; * remaining potential for phase over-lap; and * delay damages arising.	Project Director	Jun-20	Jul-20 Jun-21	Red	Complete- Completed for June and July 2020 report and incorporated monthly going forward. 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Partially Actioned While there remained need for a report outlining overall project commentary on time and cost to date and forecast (recommendation 6 above), key project time impacts including issues relating to the major Compensation Events were seen to be routinely reported to the Project Group as they arose. As such, incremental delay was well reported. However, an analysis of unagreed delay, between time pending review, and other delay was not identified. Management have advised that a summary of time spent on each phase compared to budget will be added to reporting." Revised responsibility and timescale is Project Director / Immediate. Assurance and risk officer to clarify with Planning colleagues when this recommendation will be completed. 28/05/2021- Head of Capital Planning confirmed this is will be captured in monthly PM report from June 2021.
SSU-HDU-1920-02	Jun-20	Internal Audit - SSU	Glangwili Hospital Women & Children's Development Phase 2	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_010	Medium	R10: Noting that limited action can be taken at this project, management should include commercially assessed delay damages within future contracts in accordance with national framework guidance	Director of Estates	At future projects	Mar-21 N/K	Red	16/09/2020- Assistant Major Capital Development Manager update- We currently have two projects in the pipeline: Cross Hands Health and Wellbeing Centre which is at OBC Stage, and fire improvement works at Withybush General Hospital which is currently at SOC Stage. Consultants and SCP Teams have historically supplied Activity Schedules at OBC and FBC Stages, so this action relates to Stage 4 (Construction) activities. We will obtain clarification of NWSSP-SES expectations in respect of Stage 4 Activity Schedules for the project that advances quickest (this should be fire improvement works in Withybush which is due to finish March 2021). 04/02/2021- Reporting officer currently in discussions with Director of Estates, Facilities and Capital Management for follow through to sign off. 05/03/2021- Update from Planning Project Manager- Delayed damages on future projects will be based on advised received by Shared Services on a scheme by scheme basis. 21/04/2021-Planning Project Manager confirmed this recommendations can be closed- HB will access delayed damages in future schemes in line with Shared Services advice to progress. 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Delay damages have been set at £0 at this contract in respect of all phases. While phase completion dates have been included within the contract, these similarly have £0 damages for any delay. The Health Board sought clarification from NWSSP-SES on the expectations in respect of delay damages for future projects. Management advised at the prior audit that: "The value of the delay damages was set in the Call-Off Contracts supplied by NWSSP to the Health Board. The Health Boards were not asked to make their own assessment for delay damages." NWSSP:SES advised that: "The Liquidated and Ascertain Damages (LAD) rate would ..be based upon a pre-estimation of loss that could arise, as calculated by the Health Board in its capacity as the Contracting Authority, for insertion into the contract clause when the contract is refreshed on issue of a Confirmation Notice at completion of FBC. Responsibility for completing Contract Data Part 1 (which would include for Delay Damages) rests with the Health Board as the Employer". Revised responsibility and timescales is Director of Estates / At future projects. 10/05/2021- advice being sought from Internal Audit on the closure of this recommendation.
SSU-HDU-1920-02	Jun-20	Internal Audit - SSU	Glangwili Hospital Women & Children's Development Phase 2	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_011	Medium	R11: A reconciliation should be undertaken of identified/remaining project risks, affirming both the programme and available contingency, and reported to the Project Group through to project completion	Project Director	Jul-20	Jul-20 Jun-21	Red	05/05/2021 - 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Partially actioned Agreed management action in response to the recommendation stated at the prior report: "The risk register will be updated regularly (at least every two months), and at key project stages, to the end of the contract". While management advised that there was general review of the level of risk register inclusions, project minutes and risk register inclusions showed that detailed update had not taken place.". Revised responsibility and timescale is Project Director / June 2021. 28/05/2021- Head of Capital Planning confirmed regular reviews of the Risk Registers have occurred. The next full review of the Risk Register will be at the end of Section 2, however an intermediate review has been undertaken in May 2021.
SSU Capital Governance	Dec-20	Internal Audit - SSU	Capital Governance Arrangements	Internal Audit Report	Open	Advisory	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU Capital Governance_005	N/A - Advisory Review	R5. There is an opportunity to standardise and define expected UHB governance arrangements within procedures, including for example, standardised terms of reference for Project Boards/ Groups etc.	Not stated in report	May-21	Jul-21	Red	04/02/2021- Planning Project Manager discussing recommendations with Head of Capital Planning and will inform Assurance & Risk Officer of updates/timescales in due course. 04/03/2021- On track. 14/04/2021- Planning Project Manager update- Review and update on procedures it still being undertaken. Revised completion date July 2021.
SSU Capital Governance	Dec-20	Internal Audit - SSU	Capital Governance Arrangements	Internal Audit Report	Open	Advisory	Strategic Development and Operational Planning	Paul Williams (Planning)	Director of Strategic Development and Operational Planning	SSU Capital Governance_008	N/A - Advisory Review	R8. The UHB's established capital governance and control arrangements will be reviewed and enhanced, together with its existing procedural documentation, to comprehensively document the control framework.	Not stated in report	May-21	Jul-21	Red	04/02/2021- Planning Project Manager discussing recommendations with Head of Capital Planning and will inform Assurance & Risk Officer of updates/timescales in due course. 08/02/2021- Planning Project Manager confirmed this recommendation is in progress. 04/03/2021- On track. 14/04/2021- Planning Project Manager update- Review and update on procedures it still being undertaken. Revised completion date July 2021.
HDUHB-2021-15	Aug-20	Internal Audit - SSU	Standards of Behaviour	Internal Audit Report	Open	Reasonable	Governance	Alison Gittins	Board Secretary	HDUHB-2021-15_002	Medium	Management should ensure that the staff declaration of interest register is updated to include all individuals with 'Nil Returns' for completeness and ease of reference.	Alison Gittins	May-21	May-21	Amber	09/10/2020 - Confirmation that a new process for the submission of Declaration of Interest forms is in progress via ESR, with communication to be sent over October / November to staff to raise awareness of this process. A register of Declaration of interests will be presented to ARAC based on this information in May 2021.

SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_003	Medium	R3. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Urgent but un-related works arising subsequently in the same time frame.	Director of Estates, Facilities & Capital Management	Sep-21	Sep-21	Amber	13/01/2021- Director of Estates, Facilities and Capital Management confirmed timescale of September 2021. 04/03/2021- Process is in place, work will be needed as PBC programme develops. Sept-21 should be achievable however will depend on how quickly PBC progresses. 06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_004	Low	R4. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Co-located issues (known, or discovered following invasive works).	Director of Estates, Facilities & Capital Management	Sep-21	Sep-21	Amber	13/01/2021- Director of Estates, Facilities and Capital Management confirmed timescale of September 2021. 04/03/2021- Process is in place, work will be needed as PBC programme develops. Sept-21 should be achievable however will depend on how quickly PBC progresses. 06/05/2021- should be achievable, however is dependent on how quickly the PBC progresses to the next stage, this is currently with WG for consideration. Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_005	Medium	R5. Management should provide assessment of the likely non-acute backlog requirements (financial and labour resource).	Director of Estates, Facilities & Capital Management	May-21	May-21	Amber	13/01/2021-Head of Property Performance is writing a paper for the next CEIM&T Committee on how this will be managed going forward. 04/03/2021- On track- report will be going to CEIM&T in May 2021. 06/05/2021- Report going to CEIM&T on 24/05/2021.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_006	Medium	R6. Management will conclude the current exercise of reviewing the true clinical risk, and optimum funding allocation.	Assistant Director of Strategic Planning	Mar-21	Mar-21	Red	04/03/2021- another workshop set by Assistant Director of Strategic Planning scheduled for 15/04/2021. Planning Project Manager to obtain update from Assistant Director of Strategic Planning. 06/05/2021- Head of Property Performance has requested confirmation from Assistant Director of Strategy & Planning if this recommendation has been implemented, awaiting response.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_007	Medium	R7. Variance reporting summaries should be provided to relevant committees, to include at minimum, an annual summary of schemes planned (funded) v schemes delivered.	Head of Property Performance	May-21	May-21	Amber	04/03/2021- On track for May, report to be written. 06/05/2021- Report going to CEIM&T on 24/05/2021.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_008	Medium	R8. Management should report the relation between urgent statutory works, and risk profiled backlog.	Head of Property Performance	May-21	May-21	Amber	04/03/2021- On track for May, joint report to be written by Head of Property Performance and Assistant Head of Operational Facilities Management. 06/05/2021- Report going to CEIM&T on 24/05/2021.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_009	Medium	R9. Management should confirm an appropriate range of reporting, notably in relation to causality and drivers of backlog.	Head of Property Performance	Oct-21	Oct-21	Amber	04/03/2021- October 2021 should be achievable. 06/05/2021- on track for October 2021 at present.
SSU-HDU-2021-08	Dec-20	Internal Audit - SSU	Backlog Maintenance	Internal Audit Report	Open	Reasonable	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_010	Medium	R10. Management should consider the type and coding of data loaded to the CAFM system to ensure the ability to produce required reports e.g. labour resource, and backlog origin.	Head of Property Performance in liaison with the Assistant Head of Operational Facilities Management	Dec-20	Dec-20 Oct-21	Red	13/01/2021- Assistant Head of Operational Facilities Management believes the timescale of December 2020 noted in the report is incorrect and will be clarifying this with the Internal Audit team. 04/03/2021- timescale should be October 2021, CAFM doesn't go live until April 2021, only then recommendation can be progressed. Assistant Head of Operational Facilities Management having another conversation with Internal Audit and feedback to Assurance & Risk Officer. 18/03/2021-Assistant Head of Operational Facilities Management confirmed Internal Audit will not revise date on report, therefore this recommendation remains red. December 2020 timescale was included in the report in error, the correct timescale for this recommendation is October 2021. 06/05/2021- on track for October 2021 at present. There could be a potential delay if the rollout of CAFM is delated, which is currently with Digital Services to progress.
HDUHB-2021-28	Jan-21	Internal Audit - SSU	Quality and Safety Governance	Internal Audit Report	Open	Reasonable	Nursing	Sian Passey / Cathie Steele	Director of Nursing, Quality and Patient Experience	HDUHB-2021-28_001	Medium	R1. Management should ensure current and draft Quality and Safety Governance Group terms of reference for directorates are consistent in their approach and reflect the organisation's agreed quality and safety governance arrangements.	Assistant Director of Nursing	Apr-21	Apr-21	Red	08/03/2021- Reporting officer confirmed recommendations are on track for April 2021. 25/05/2021- Chaser email sent to reporting officer requesting update by 28/05/2021, no response received.
HDUHB-2021-28	Jan-21	Internal Audit - SSU	Quality and Safety Governance	Internal Audit Report	Open	Reasonable	Nursing	Sian Passey / Cathie Steele	Director of Nursing, Quality and Patient Experience	HDUHB-2021-28_002	Medium	R2. Management should ensure risk registers are a standing item on directorate and service Quality and Safety Governance Group agendas.	Assistant Director of Nursing	Apr-21	Apr-21	Red	08/03/2021- Reporting officer confirmed recommendations are on track for April 2021. 25/05/2021- Chaser email sent to reporting officer requesting update by 28/05/2021, no response received.
HDUHB-2021-28	Jan-21	Internal Audit - SSU	Quality and Safety Governance	Internal Audit Report	Open	Reasonable	Nursing	Sian Passey / Cathie Steele	Director of Nursing, Quality and Patient Experience	HDUHB-2021-28_003	Medium	R3. Management should implement the good practice demonstrated by the Scheduled Care directorate by ensuring the progress and actions of specialty and department risks are captured and regularly reported to the Quality and Safety Governance Groups.	Assistant Director of Nursing	Apr-21	Apr-21	Red	08/03/2021- Reporting officer confirmed recommendations are on track for April 2021. 25/05/2021- Chaser email sent to reporting officer requesting update by 28/05/2021, no response received.
SSU_HDA_1920_01.1	Feb-21	Internal Audit - SSU	Capital Assurance- Follow Up	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams / Rob Elliott / Anthony Tracey / Julian Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_001	Medium	R1. Cardigan Integrated Care Centre (original R1): Clarification should be provided to differentiate between the Project Group quorum, members and attendees.	Head of Capital Planning	May-19	~~Jul-21~~ Oct-21	Red	23/02/2021 - as per this new follow up report (follow up of SSU_HDA_1920_01.2), recommendation outstanding as follows: Management advised that due to the impact of Covid on the availability of service leads this has not yet been undertaken. It is anticipated the PPE will be undertaken during the summer. This recommendation was previously considered as actioned per updates received from the service (SSU_HDA_1920_01.2_001). Recommendation has been re-opened as part of this more recent follow up review, and noted that the recommendation owner is now Head of Capital Planning and not Project Director as per previous report. 04/03/2021- on track for July 2021 date. 14/04/21- Planning Project Manager update- Post project Evaluation for Cardigan ICC has been delayed due to COVID-19. It has been agreed with WG that the Cardigan PPE/Gateway 5 Review will now be undertaken in October 2021.
SSU_HDA_1920_01.1	Feb-21	Internal Audit - SSU	Capital Assurance- Follow Up	Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Paul Williams / Rob Elliott / Anthony Tracey / Julian Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_002	Medium	R4: Bronglais Front of House: The planned post project evaluation (PPE) exercise for the Bronglais Front of House development will consider the issues raised in the prior Bronglais audit reports as follows: • An evaluation of the adequacy of design solution for the development; • Confirmation (or otherwise) that the original business case assumptions remain valid, or implications will be assessed; and • performance against the targets of the business case will be assessed.	Project Director	Sep-19	Mar-21 Sept-21	Red	23/02/2021 - as per this new follow up report follow up of SSU_HDA_1920_01.2), recommendation outstanding as follows: The Project Director will lead the completion of the PPE by March 2021. The recommendation was previously considered to be outstanding from the previous follow up report. 04/03/2021- more realistic date of September 2021 provided, this work has been delayed due to other work prioritised due to Covid-19. 14/04/21- Planning Project Manager update- Post project Evaluation for BGH Front of House has been delayed due to COVID-19. It has been agreed with WG that the FOH will be an internal PPE and a date needs to be agreed with the County Team.

SSU_HDU_1920_01.02	Feb-21	Internal Audit - SSU	Estates Assurance Follow Up	Internal Audit Report	Open	Substantial	Estates	Rob Elliott / Simon Chiffi / Heather Williams / Paul Evans	Director of Operations	SSU_HDU_1920_01.02_003	Medium	R6: A robust, and consistent, site access control system should be implemented across all sites that ensures: Daily sign in / out of ALL contractors Uniquely identifiable badges issued and recorded on the sign in/out register Robust process for management of contractors out of hours A sign in/out system should be in place at each community site, using measures appropriate to the site, with ALL contractors required to action daily. (from Control of Contractors report).	Interim Head of Operations	Sep-20	May-21	Red	23/02/2021 This recommendation has previously been reported as actioned under previous report SSU_HDU_1920_01.01, but newly issued follow up report states the following: Partially implemented Management provided a copy of the Contractor Attendance Register which is in operation at each of the UHB's acute sites. The attendance register is referenced as a control procedure to ensure that all contractors employed by the UHB are fully aware of the safety protocols adopted by the Estates department. There is the expectation that contractors address the key questions included in the attendance register before proceeding with any work activity and before a contractor's badge can be issued. The procedure for managing contractors out of hours is documented in the Control of Contractor policy i.e. contact with the on-call engineer upon arrival and departure from site. Whilst management acknowledge the process is managed, they accept there is currently no central recording of this information [noting that it13% of the contractor call-outs in the past three months had been out of hours. With regard to the management of contractors at community sites, management advised that training sessions have been provided to community managers / responsible officers regarding expectations for when a contractor is on site. It is noted that Covid restrictions has impacted the completion of these training sessions. Noting the action management has taken to date to address the agreed recommendation, the priority rating has been reassessed as medium. 04/03/2021- on track for May 2021. 17/05/2021- Requested confirmation by 28/05/2021 that this recommendation is complete. As of 28/05/2021 update has not been provided.
SSU_HDU_1920_01.02	Feb-21	Internal Audit - SSU	Estates Assurance Follow Up	Internal Audit Report	Open	Substantial	Estates	Rob Elliott / Simon Chiffi / Heather Williams / Paul Evans	Director of Operations	SSU_HDU_1920_01.02_005	Medium	R10: Management will consider the viability of accommodation both with and without SIFT monies. (from Residential Accommodation report).	Director of Operations	Jun-19	Mar-21 N/K	Red	23/02/2021 - progress update in Feb-21: Outstanding. At the time of issuing this report, supporting information had not been received from the UHB. Therefore, in the absence of information to provide assurances that this recommendation had been addressed, it remains outstanding. 04/03/2021-Audit & Risk Officer to check if update has been obtained from Director of Operations. 05/03/2021- Director of Operations to have conversation with Medical Director to resolve this issue.
SSU_HDU_2021_07	Mar-21	Internal Audit - SSU	Management of Fire Enforcement Notices	Internal Audit Report	Open	Substantial	Estates	Rob Elliott / Paul Evans / Gareth Lloyd	Director of Operations	SSU_HDU_2021_07_002	Low	R2. A terms of reference should be prepared for the Project Board, confirming responsibilities, reporting lines and membership (including quorate requirements)	Director of Estates, Facilities & Capital Management	May-21	May-21	Amber	06/05/2021- on track to be completed by the end of May. TORs being reported to two project boards (GGH & WGH) on 19/05/2021, comments will be requested and amendments made by end of May 2021.
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_005	Medium	Management should report projected SCP cash flows with reconciliation to the position forecast out-turn at project reports, and associated commentary.	Lisa Humphrey	May-21	May-21 Jun-21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 Next Cost advisor report due June 2021 should address this issue .
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_006	Medium	Future Action - Management should conclude the intended lessons learnt exercise, reporting the conclusions and resulting action to the CEIM&T	Lisa Humphrey	Jul-21	Jul-21 Aug-21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 This work is currently being undertaken with report to CEIM&T in July and PPPAC in August.
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_007	Medium	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.	Lisa Humphrey To request of NWSSP:SES	Jul-21	Jul-21	Amber	26/05/2021 no update.
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_008	Medium	Management will obtain NWSSP:SES advice (and legal advice as required) on issuing and agreeing Covid related costs.	Lisa Humphrey	May-21	May-21 N/K	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 NWSSP-SES have been given the information and are working with PM and TCA on reviewing the claims received from Tilbury Douglas
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_009	Medium	Management will confirm that assumptions are appropriately detailed at Covid related Compensation Events.	Lisa Humphrey	May-21	May-21 N/K	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 Advice from NWSSP-SES is that, in accordance with PMI 104 (attached) CEN 116 costs should be "agreed by the Project Manager (with assistance from the Cost Advisor), when the full time and cost particulars of the event can be determined". PM will make an assessment of direct costs incurred at the end of each phase. This will be ongoing for the remainder of the scheme
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_010	Low	Signed agreement should be obtained from the Supply Chain Partner with regard any variation in contractual terms	Lisa Humphrey	May-21	May-21 N/K	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 Currently outstanding.
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_011	Medium	Specific Covid funding risks will be highlighted and regularly reported to relevant committees	Lisa Humphrey	May-21	May-21 Aug-21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 Covid funding risks are being reported to CEIM&T/PPPAC and Finance Committee as part of the regular reports being prepared
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Internal Audit Report	Open	Limited	Women and Children's Services	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_013	Medium	The proposed work in respect of the Labour Ward staff room will be implemented and reported in compliance with local procedures and Welsh Government approval letter conditions (13/01/2017).	Lisa Humphrey	May-21	May-21 N/K	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 This is included in Cost Advisor's report and will be reported as part of the overall scheme expenditure.
Glangwili Neonatal Unit Peer Review Report	Aug-19	Peer Review	Glangwili Neonatal Unit Peer Review Report	Peer Review Report	Open	N/A	Women and Children's Services	Paula Evans	Director of Operations	PeerReview-GGH003	N/A	R6. Training and education Only 55% of nurses are Qualified in Specialty (QIS). 6 out of the 7 consultants and 87% of nursing staff are NLS compliant.	Karen Jones	Dec-23	Dec-23	Amber	02/12/2020 Service Response: Recruitment remains a challenge. On-going campaigns are being added to social media. Senior Nurses will be attending RCN virtual job fair in January 2021. 04/02/21 Senior nurse and unit manager attended RCN virtual job fair- no applications for vacancies yet. Recruitment continues to be a challenge but 1 QIS appointed and 1 paediatric nurse. Successful recruitment of 2 newly qualified nurses via adult streamlining, due to start in March 2021. 2 nurses have completed part 1 of neonatal training. 19/03/2021 issued for update no response. 13/05/2021 Minimal change in staffing situation and recruitment continues to be a challenge. We have appointed into the Practice educator post (B6)- start date of end of May. Aware of a few nurses who qualify in September who would like to work in SCBU- hoping to recruit via streamlining. 2 nurses have enrolled in Intensive Care module this year. No NLS courses have been available due to COVID however there are starting again in May 2021.
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Open	N/A	Out of Hours	David Richards	Director of Operations	PeerReview-OOH001	N/A	R1. Enhanced Clinical Leadership and Support Address border free working 24/7 and produce SOPs for this purpose, which all clinicians and operational staff need to adhere to.	David Richards	Dec-19	Dec-21	Red	09/02/2021- update from new SDM- We have improved boarder free working amongst the clinicians and this has reduced the need to have an enhanced clinical leadership on shift in the short to medium term. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Meetings have begun with the clinicians from across Hywel Dda. These meetings cover multiple topics including OOH working practices such as border free working. These meetings will continue over the next 2-3 months. Further updates will be available following the meetings and 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.

Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Open	N/A	Out of Hours	David Richards	Director of Operations	PeerReview-OOH003	N/A	R3. Multi-Disciplinary Workforce Physician Associates to also be considered as part of the longer term strategy.	David Richards	Mar-20	Dec-21	Red	09/02/2021- update from new SDM- After assessment physician associates are not for immediate deployment in Out of Hours but will be considered as part of the longer term Multi-disciplinary team. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- A multi-disciplinary team continues to be a high priority of the OOH workforce plan. Recently the new SDM and OOH management team with the Workforce Development team have reconvened to continue with work that began pre Covid-19. This evaluation of the OOH workforce and development of future workforce models is underway with plans and actions set. The use of Physicians Associates will be considered within this work.
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Open	N/A	Out of Hours	David Richards	Director of Operations	PeerReview-OOH006	N/A	R6. Wider Workforce Planning The clinical competencies framework need to be considered for supporting ACP's, UCP, HCSW etc. and should now drive the future workforce planning	David Richards	Dec-19	Dec-21	Red	Initial meetings with Assistant Directors of Nursing have taken place and frameworks will be assessed within the nursing directorate. Senior Workforce Development Manager is assisting in mapping out workforce requirements as a part of TCS agenda, delayed significantly by COVID. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- New SDM now in place to drive this work forward. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Similar to the multi-disciplinary team action the wider workforce plan will form part of the work recently reconvened between OOHs and the Workforce Development team. Stakeholders are being identified and will be invited to participate in the evaluation and design of the OOH workforce.
Out of Hours Peer Review 21-22nd October 2019	Nov-19	Peer Review	Out of Hours Peer Review 21-22nd October 2019	Peer Review Report	Open	N/A	Out of Hours	David Richards	Director of Operations	PeerReview-OOH014	N/A	R14. Specific Operational Issues Executive members to meet staff and clinical leads in OOHs on a quarterly basis and be clear about expectations and behaviours aligned to Health Board values	David Richards	Jan-20	Mar-20 Oct-20 Dec-21	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- recommendation still delayed due to Covid, however in the meantime any significant issues are reported to the Director of Operations. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021-The Clinical Lead and Service Delivery Manager are planning to meet all the OOH workforce to discuss issues and seek a team approach 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.
201905316	#########	Public Service Ombudsman (Wales)	10076	Ombudsman Report	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	201905316_008	N/A	R8. The Health Board will submit evidence of completion of all these measures to the Ombudsman.		Oct-20	Oct-20 N/K	Red	18/11/2020- Timescale currently unknown. 26/01/2021-Ombudsman Liaison Manager update- Awaiting evidence of organisational improvements from service leads. Though they have been made aware of the necessity to submit I cannot give you a timescale. Ombudsman is aware. 15/03/2021- this recommendation cannot be turned to green until all other recommendations are implemented. 22/03/2021- Requested clarity on timescale, Ombudsman Liaison Manager responded -I can't speculate how quickly 17006 will be complete as this will depend on the resolution of the claim. I don't think the end of August would be realistic but will at least attempt to get the clinical changes introduced by then. 24/03/2021- Assurance & Risk Office requested the Ombudsman Liaison Manager to obtain a revised timescale from the service, as requested by the Director of Operations, no response as of 26/03/2021. 28/05/2021- Evidence of learning from events team meeting submitted. Awaiting further confirmation from PSOW Investigation officer regarding any outstanding evidence.
202000482	Jan-21	Public Service Ombudsman (Wales)	16667	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	202000482_002	N/A	The Health Board reviews to what degree a first mental health screening and risk assessment takes place with a patient not known to the CMHT.	Kay Isaacs	Jul-21	Jul-21	Amber	05/03/2021- Ombudsman Liaison Manager confirmed recommendation is on track for July 2021. 28/05/2021- still on track for July 2021.
202000482	Jan-21	Public Service Ombudsman (Wales)	16667	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	202000482_003	N/A	The Health Board reviews the process of support and clinical supervision by senior clinical staff at the CMHT, particularly in decisions to involve outside agencies (such as the police).	Kay Isaacs	Jul-21	Jul-21	Amber	05/03/2021- Ombudsman Liaison Manager confirmed recommendation is on track for July 2021. 28/05/2021- still on track for July 2021.
202000482	Jan-21	Public Service Ombudsman (Wales)	16667	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	202000482_004	N/A	The Health Board is invited to remind members of CMHT staff to communicate to the patient the outcome of any assessment, even when this includes closing the referral without accepting the patient for services.	Kay Isaacs	Jul-21	Jul-21	Amber	05/03/2021- Ombudsman Liaison Manager confirmed recommendation is on track for July 2021. 28/05/2021- still on track for July 2021.
202000482	Jan-21	Public Service Ombudsman (Wales)	16667	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	202000482_005	N/A	The Health Board is invited to reflect on its process for complying with SARs when the requestor is already involved with its Complaints Department.	Kay Isaacs	Jul-21	Jul-21	Amber	05/03/2021- Ombudsman Liaison Manager confirmed recommendation is on track for July 2021. 28/05/2021- still on track for July 2021.
202003187	Mar-21	Public Service Ombudsman (Wales)	202003187	Ombudsman Report	Open	N/A	Scheduled Care	Lydia Davies	Director of Operations	202003187_004	N/A	I recommend that in four months of the date of the final report, the first health board reviews the pathway for referring acute hand injuries to the Second Health Board to prevent any future unnecessary referral delays.	Lydia Davies	Jul-21	Jul-21	Amber	New PSOW report received 19/03/2021. 28/05/2021- Assistant Director confirmed evidence was submitted in April 2021. There is one piece of evidence outstanding regarding team reflection. The case is being discussed at a team event in June 2021 - the minutes will need to be sent to the PSOW following this to confirm it has been undertaken.
201902007	Mar-21	Public Service Ombudsman (Wales)	12941	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	201902007_004	N/A	I recommend that within 6 months of the date of this report, the Health Board reviews its referral processes by carrying out a learning exercise to identify what happened in Mr X's case and change its process to avoid repetition, if required.	Kay Isaacs	Sep-21	Sep-21	Amber	
201902007	Mar-21	Public Service Ombudsman (Wales)	12941	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	201902007_005	N/A	I recommend that within 6 months of the date of this report, the Health Board ensures the OT service develops auditable assessment processes, with targets, to ensure initial assessments and assessments post discharge are completed in a timely fashion.	Kay Isaacs	Sep-21	Sep-21	Amber	
201902007	Mar-21	Public Service Ombudsman (Wales)	12941	Ombudsman Report	Open	N/A	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	201902007_006	N/A	I recommend that within 6 months of the date of this report, the Health Board ensures OTs at the Unit receive training/supervision in assessment and treatment planning. Further that consideration is given to adopting a standardised assessment tool for initial assessments e.g. MOHOST.	Kay Isaacs	Sep-21	Sep-21	Amber	

National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_002a	N/A	The fragility and sustainability of the service must be addressed as a priority. At the time of the visit, the service was unable to deliver core measures such as four MDT appointments. Capacity challenges across several disciplines has resulted in staff members working substantially in their personal time to deliver core and expected care. Whilst the efforts of team members are to be highly commended and the outcomes celebrated, the reliance on goodwill is unsustainable in the longer term. There must also be consideration of succession planning to ensure the progress made is maintained.	Tracey Bucknell	Aug-21	Aug-21	Amber	Identified on IMTP, discussed in Q&S. 19/03/2021 Report verified and discussed with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 SDM confirmed: Financial information has been gathered. Discussions are in place with the SDM are diabetic service around recruitment. 25/05/2021 SDM confirmed funding for 0.6 currently working with Finance. Possibly in place by Sept 2021.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_002b	N/A	The fragility and sustainability of the service must be addressed as a priority. At the time of the visit, the service was unable to deliver core measures such as four MDT appointments. Capacity challenges across several disciplines has resulted in staff members working substantially in their personal time to deliver core and expected care. Whilst the efforts of team members are to be highly commended and the outcomes celebrated, the reliance on goodwill is unsustainable in the longer term. There must also be consideration of succession planning to ensure the progress made is maintained.	Tracey Bucknell & Dietetic Lead	Aug-21	Aug-21	Amber	19/03/2021 Report verified and discussed with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. SDM to liaise with dietetics re progress. emailed HOS 02/03/2021. 09/04/2021 SDM confirmed a response has been received from Dietetics – further consideration required from SDM. 25/05/2021 SDM confirmed funding for post led by Dietetics service appoint asap.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_002e	N/A	The fragility and sustainability of the service must be addressed as a priority. At the time of the visit, the service was unable to deliver core measures such as four MDT appointments. Capacity challenges across several disciplines has resulted in staff members working substantially in their personal time to deliver core and expected care. Whilst the efforts of team members are to be highly commended and the outcomes celebrated, the reliance on goodwill is unsustainable in the longer term. There must also be consideration of succession planning to ensure the progress made is maintained.	Local Programme Director, Tracey Bucknell	Jun-21	Jun-21	Amber	19/03/2021 Report verified and discussed with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. SDM to discuss with Clinical Lead Dr Fountain Polley and SDM P&N. 09/04/2021 SDM confirmed a meeting is arranged with Dr Fountain-Polley for WC 12/04/2021. 25/05/2021 SDM confirmed being explored.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_004a	N/A	Dietetic and psychology provisions are insufficient, leading to lengthy intervals for follow up and restrictions on the availability of additional interventions for both teams. The team are unable to offer four MDT appointments per year. This lack of provision is having a significant impact on colleagues as well as for the outcomes of children, young people and their families and must be addressed as a priority.	Tracey Bucknell & Dietetic Lead	Aug-21	Aug-21	Amber	SDM community to liaise with dietetics for outcomes emailed HOS 02/03/2021 for a response. 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 Response received from dietetics – further consideration required from SDM. 25/05/2021 SDM confirmed funding for post led by Dietetics service appoint asap..
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_005	N/A	At the time of the visit, dietetic expertise was predominantly applied to the management of diabetes technologies due to a lack of capacity. It is acknowledged an additional dietitian joined the team the week of the peer review visit, thereby increasing available resource. The peer review team encouraged the team to take this opportunity to reclaim the role of dietitian and drive forward the dietetic profile.	Tracey Bucknell & Dietetic Lead	Aug-21	Aug-21	Amber	Report verified with SDM SDM community to liaise with dietetics for outcomes emailed HOS 02/03/2021 for a response. Explore recruitment of 0.4 WTE Dietician 09/04/021 Response received from dietetics – further consideration required from SDM 25/05/2021 SDM confirmed funding for post led by Dietetics service appoint asap..
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_007	N/A	The service is strongly encouraged to explore the establishment of a parent representative link to integrate patient and parent voice within the activities of the MDT: this may include representatives being invited to participate in part of the MDT meeting.	Tracey Bucknell & Diabetes Lead	Jul-21	Jul-21	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. SDM to chase Diabetes Lead PDSN for progress. 09/04/02021 SDM meeting arranged with PDSN WC 12/04/2021 25/05/2021 SDM working with Assistant Director of Patient Engagement possibly be completed by Dec 21.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_009a	N/A	Future scoping and capacity planning must reflect the additional resourcing required to effectively support the use of diabetes technologies. Whilst there are valuable advantages for children, young people and their families – as well as clinicians – technologies bring additional duties and responsibilities which must be undertaken to realise the benefits.	Tracey Bucknell & Diabetes Lead	Aug-21	Aug-21	Amber	Report verified with SDM Identified on IMTP, discussed in Q&S 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 Financial information has been gathered. Discussions in place with SDM are diabetic service around recruitment. 25/05/2021 SDM confirmed funding for 0.6 currently working with Finance. Possibly in place by Sept 2021.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_009c	N/A	Future scoping and capacity planning must reflect the additional resourcing required to effectively support the use of diabetes technologies. Whilst there are valuable advantages for children, young people and their families – as well as clinicians – technologies bring additional duties and responsibilities which must be undertaken to realise the benefits.	Clinical Director, Paediatric Diabetes Lead	Jun-21	Jun-21	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 SDM has communicated the requirement to CD/CL/and SDM. 25/05/2021 For consideration in future appointments.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_009d	N/A	Future scoping and capacity planning must reflect the additional resourcing required to effectively support the use of diabetes technologies. Whilst there are valuable advantages for children, young people and their families – as well as clinicians – technologies bring additional duties and responsibilities which must be undertaken to realise the benefits.	Tracey Bucknell & Dietetic Lead	Aug-21	Aug-21	Amber	Report verified SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 Response received from dietetics – further consideration required from SDM 25/05/2021 SDM confirmed funding for post led by Dietetics service appoint asap.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_009e	N/A	Future scoping and capacity planning must reflect the additional resourcing required to effectively support the use of diabetes technologies. Whilst there are valuable advantages for children, young people and their families – as well as clinicians – technologies bring additional duties and responsibilities which must be undertaken to realise the benefits.	Tracey Bucknell & Diabetes Lead	Jun-21	Jun-21	Amber	Report verified SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 SDM meeting arranged with Dr Fountain-Polley for WC 12/04/2021 25/05/2021 SDM confirmed being explored.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_011a	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expeditated to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Paediatric & Adult Clinical	N/K	N/K	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 26/05/2021 initial discussions started ongoing.

National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_011b	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expeditated to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Tracey Bucknell	Aug-21	Aug-21	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 25/05/2021 No update
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Improvement Plan	Open	N/A	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_014b	N/A	Ward staff training must be formalised, and attendance robustly recorded. This will provide children, young people and their families with high quality specialised care whilst on the ward and an early introduction to positive diabetes management strategies. This will also alleviate pressure on the PDSNs.	Senior Paediatrician - Diabetes	Apr-22	Apr-22	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	Hazel Davies	Mar-21	Mar-21 Mar-23	Red	This is part of a wider site plan and progress was being made across key areas but now, is necessarily on hold, due to Covid. Acute stroke is the only one where day rate tariff is now in place. 25/01/2021- Responsible officer confirmed this is a part of the BGH Clinical Strategy work which will be completed by March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_001	N/A	1.2 Improve networking and collaboration with other sites and health boards	Exec and Site Senior Team	Mar-21	Mar-21 Mar-23	Red	As above, as part of wider site plan. Working collaboratively with SC in regard to reinstatement of scheduled activity (Covid plan) which is working well. Also exploring options for local site management representation for SC. 25/01/2021- Responsible officer confirmed this is a part of the BGH Clinical Strategy work which will be completed by March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_001	N/A	1.6 Improve networking and collaboration with other sites and health boards	Hazel Davies	Apr-21	Apr-21	Red	12/10/2020- this is not a single Action against which to report – it is a large piece of work in progress. A significant amount has been achieved but it isn't effectively represented in this action plan. Telemedicine has been enhanced and progress escalated due to Covid. Many clinical services are using technology extensively to reduce risk and enable patients to access care, where appropriate via virtual means. Attend Anywhere and other software are being trialled by the Scheduled Care Directorate, who manage OPD. They have produced an SBAR which gives dates etc. for implementation. BGH team (HD is Mid Wales lead for telemedicine) are providing an update to the November 2020 Mid Wales Board re telemedicine. Due to Covid we have established a fruitful primary care operations group for Ceredigion (meets bi weekly) BGH are progressing a dedicated telemedicine suite for the site (Spring 2021 approx.) which will enable tertiary interface and patient consultations, including for in patients. 25/01/2021- Responsible officer confirmed good progress being made with telemed but this will be a work in progress linked to the strategy for some time. Though some elements can be considered completed. Recommendation to remain amber for the time being, to be further reviewed in March 2021. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm if this recommendation is implemented, and if not and the recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_004	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	Graham Boswell, Educational Lead	Dec-20	Dec-20 N/K	Red	On hold due to Covid. 25/01/2021- Responsible officer confirmed this remains on hold due to Covid. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm if this recommendation is implemented, and if not and the recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. If this is not part of Clinical Strategy then a revised timescale will be required. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_004	N/A	4.5 Develop new teaching and qualification opportunities for trainees and specialty doctors	General Manager	Mar-21	Mar-21	Red	In progress – some delay due to Covid and the need to identify funding. 25/01/2021- Responsible officer confirmed Physician Associates has increased to 4, with a plan to increase to 6 which is currently subject to funding. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm if this recommendation is implemented, and if not and the recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. If this is not part of Clinical Strategy then a revised timescale will be required. Reporting officer out of office until 29/03/2021. 07/04/2021- Reporting Officer confirmed this is almost complete- just about to recruit 2 further PAs for site with the potential for a 3rd in planned care. 11/05/2021-Assurance and risk officer emailed reporting officer to check if this recommendation has been completed.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Hilary Edwards / John Evans	Sep-22	Sep-22	Amber	12/10/2020- PGC Development on the BGH site in progress. Completion to be confirmed but 2021/22. Programme of improvement to under and post graduate site accommodation is in hand – completion by June 2020. School of Health Sciences with incorporated School of Nursing is in the accreditation process at present with a plan for completion and first intake September 2022. 25/01/2021- Responsible officer confirmed in progress for September 2022 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Hilary Edwards / John Evans	Sep-22	Sep-22	Amber	12/10/2020 – PGC development. Works completion due 2021/22. 25/01/2021- Responsible officer confirmed in progress for September 2022 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.

RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	County Director, HoN & GM	Dec-21	Dec-21	Amber	Part of above 25/01/2021- Responsible officer confirmed in progress for December 2021 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_005	N/A	5.4 Develop the postgraduate education centre, including clinical skills and simulation equipment	Jayne Noble / Hazel Davies	Mar-23	Mar-23	Amber	On track. 25/01/2021- Responsible officer confirmed in progress for March 2023 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_005	N/A	5.5 Develop the postgraduate education centre, including clinical skills and simulation equipment	Jayne Noble / Hazel Davies	Jul-20	May-21	Red	In hand. Monies allocated to improve accommodation on site. 29/10/2020- requested revised timescale and progress update from Director of Secondary Care. 25/01/2021- Responsible officer confirmed accommodation improvement on track, additional 20k now allocated and work should be completed by May 2021. Original completion date of July 2020 was stated in error. SIFT monies now identified – recent meeting with Assistant Director (Medical Directorate) who has a plan for sites in hand subject to agreement with the DoF. 25/03/2021- This recommendation is currently being progressed by the Assistant Director (Medical Directorate) and the Director of Finance.
RCP 2019	Sep-19	Royal College of Physicians	RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report	Improvement Plan	Open	N/A	Unscheduled Care (BGH)	Hazel Davies	Director of Operations	RCP2019_006	N/A	6.3 Ensure training posts are attractive with time for research, teaching and quality improvement	Graham Boswell, Educational Lead	Mar-23	Mar-23	Amber	Long term plan. 25/01/2021- Responsible officer confirmed this could potentially take longer than March 2023 as it sits with the Deanery and is out of her hands. Recommendation will remain amber for now and to be reviewed closer to the original timescale date of March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	External Assessment	Open	N/A	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_005	Medium	CE+ 5: Six monthly network scans will allow progress on the points mentioned above to be measured over time, and give a clearer, ongoing picture of the Health Boards exposures. It will also allow efficient and effective deployment of IT resources.		N/K	Oct-21	Red	Reliant on NWIS National procurement of vulnerability scanning solution. In the interim local scans are taking place in the interim. 03/09/2020- No further update on national work, doing all we can at local level. 01/10/2020, 05/11/2020 & 07/01/2021- No further update on the national work. 05/03/2021- Update from Digital Business Manager. We successfully appointed to the Cyber Security role on the 19th February and employment checks have started. Their first set of tasks once induction has been completed will be to implement the available solutions to enable these 6 monthly network scans. We would expect the first scans to be able to undertaken by the end of May 2021. NWIS undertake the scans, but our staff will deal with the issues outlined in the scans. First scan to be completed in May 2021. October 2021 provisional date of completion. Due to update received recommendation no longer noted as 'external rec', i.e. outside the gift of the UHB to implement. 11/05/2021- Digital Business Manager confirmed this will form part of the paper to IGSC in June 2021 clarifying some of this work and timescales.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	External Assessment	Open	N/A	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_009	Medium	A.8.1: The asset register for technical items to be fully completed. Work to complete the IAR to be maintained so that it is complete by the time that GDPR comes into force.		Dec-20	Dec-20 Jan-21 Feb-21 Apr-21 Jun-21	Red	3/9/2020- almost completed, was delayed due to changeover of staff. New staff member now taking this forward and update on Asset Owner Group will be provided to IGSC in October 2020. 01/10/2020- On track for December 2020 timescale. 05/11/2020- Informatics Business Manager confirmed couple remain outstanding, hoping to be implemented by December 2020. Has been delayed due to problems with engagement but this is now 100%. 03/12/2020- Informatics Business Manager confirmed will be reported to IGSC in January 2021. 07/01/2020- Digital Business Manager update- IGSC January meeting postponed due to number of apologies, meeting now taking place in early February. 04/02/2021- Digital Business Manager confirmed this will be reported to IGSC on 11/02/2021. Awaiting outcome of meeting. 02/03/2021- Reported to IGSC in February 2021 as not fully completed, IGSC requested report for next meeting on 13th April. The mapping of servers to Information Asset owners is nearing completion and will be available for submission by the end of March. If not completed by end of March any issues highlighted will be escalated. 11/05/2021- Digital Business Manager confirmed report went to IGSC in April 2021 which confirmed a small number are outstanding. Revised date of June 2021 provided.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	External Assessment	Open	N/A	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_015	Medium	A.12.4:NWIS are purchasing the LogRhythm SIEM solution. Once the purchase and staff training has been completed its deployment to the various Health Boards should be expedited.		N/K	Jun-21	Amber	Reliant on NWIS national procurement of LogRhythm solution. Awaiting a response from NWIS. 03/09/2020- No further update on national work. 01/10/2020, 05/11/2020 & 07/01/2021- No further update on national work. 05/03/2021- Update from Digital Business Manager - We successfully appointed to the Cyber Security role on the 19th February and employment checks have started. Their first set of tasks once induction has been completed will be to implement the available SIEM solution. We would expect SIEM to be implemented by the end of June 2021.Due to update received recommendation no longer noted as 'external rec', i.e. outside the gift of the UHB to implement. 13/05/2021- Digital Business Manager confirmed rather than waiting on national work the UHB have gone with a new system (Splunk) which is currently being implemented and led by the cyber security specialist. An update on the progress of this work will be provided to IGSC in June 2021. The completion date will be reviewed following the paper to IGSC.

Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	External Assessment	Open	N/A	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_002	Not stated	CE+ 2: Removing old/unnecessary/unsupported software from the estate will reduce the potential attack surface as well as removing inherent vulnerabilities. Vendor software i.e. Adobe Reader and Adobe Flash Player on a large number of hosts requires patching to a supported level. Adobe Reader and Adobe Flash are standalone software applications that can normally be updated or patched with low impact on other applications or services.		N/K	~~Mar-21~~ ~~Jun-21~~ Jul-21	Red	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020. 03/09/2020- Job has been advertised and currently reviewing applicants. This recommendation cannot be progressed until this resource is in place. Assurance & Risk Officer will receive further update next month once interviews have taken place. 04/12/2020- Rebanding has been agreed and on Trac system, waiting for sign off then will be advertised. 07/01/2020- Digital Business Manager confirmed Job out for advert with deadline of next week, hopeful to get Band 7 in place. Recruitment has been an issue for all Health Boards. 04/02/2021- Digital Business Manager confirmed applicant shortlisting has taken place and interviews are to be scheduled. If successful in recruiting it is hopeful the person will be in post by June 2021. If successful candidate it not found they will be looking to request a current member of staff to undertake training to achieve the desired skillset required. 02/03/2021- As the vulnerability scans are completed we will have a report of unsupported software used by the Health Board and a report will be presented in IGSC in July 2021 on the status and the work required to mitigate. 11/05/2021- this recommendation will be part of the new Cyber Security Senior Specialist's workplan and an update will be reported to IGSC in June 2021.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	External Assessment	Open	N/A	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_003	Not stated	CE+ 3: On the HDUHB supported infrastructure, up to date Microsoft Windows security updates, patches for vendor software 7-Zip and VPN client Cisco AnyConnect should be implemented, and a more comprehensive patch management plan agreed for future updates.		Mar-21	~~Mar-21~~ ~~Jun-21~~ Jul-21	Red	No further progress as no Cyber security resources have been allocated to the department. Awaiting funding from Welsh Government to fund Band 6 post to take this work forward. It is envisaged that this will be fully implemented by March 2021, providing the post holder will be in place by September 2020. 03/09/2020- Job has been advertised and currently reviewing applicants. This recommendation cannot be progressed until this resource is in place. Assurance & Risk Officer will receive further update next month once interviews have taken place. 01/10/2020- job advertisement was unsuccessful. Job description being revised to a higher band in the hope it will attract suitable applicants. Timescale for this recommendation will be reviewed once suitable applicant is in post (approx. January 2021). 04/12/2020- Rebanding has been agreed and on Trac system, waiting for sign off then will be advertised. 07/01/2020- Digital Business Manager confirmed Job out for advert with deadline of next week, hopeful to get Band 7 in place. Recruitment has been an issue for all Health Boards. 04/02/2021- Digital Business Manager confirmed applicant shortlisting has taken place and interviews are to be scheduled. If successful in recruiting it is hopeful the person will be in post by June 2021. If successful candidate it not found they will be looking to request a current member of staff to undertake training to achieve the desired skillset required. 02/03/2021-As the vulnerability scans are completed we will have a report of unsupported software used by the Health Board and a report will be presented in IGSC in July 2021 on the status and the work required to mitigate. 11/05/2021- this recommendation will be part of the new Cyber Security Senior Specialist's workplan and an update will be reported to IGSC in June 2021.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Open	N/A	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_001	N/A	R1. The Health Board must conduct a review to check that appointment letters sent from other departments comply with standard 5 and act upon the results of the review.	Enfys Williams	Apr-20 Mar-21	Oct-20 Mar-21 N/K	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/2021 – Directorates have completed an assessment. Work has been done to ensure compliance. Due to current Covid pressure the information from the Operations directorate is incomplete. As a result of Covid and a cyber-attack on the WL Commissioner's office an extension has been granted on collating the remaining information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Open	N/A	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_002	N/A	R2. The Health Board must conduct a review to check that forms provided to the public by other departments comply with standard 36 and act upon the results of the review.	Enfys Williams	Apr-20 Mar-21	Oct-20 Mar-21 N/K	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/21 – Directorates have completed an assessment. Work has been done to ensure compliance. Due to current Covid pressure the information from the Operations directorate is incomplete. As a result of Covid and a cyber-attack on the WL Commissioner's office an extension has been granted on collating the remaining information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Legislative requirements	Open	N/A	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_003	N/A	R3. Hywel Dda University Health Board must provide sufficient written evidence to satisfy the Welsh Language Commissioner that it has carried out enforcement actions 1-2.	Enfys Williams	Apr-20 Mar-21	Oct-20 Mar-21 N/K	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/21 – An annual review meeting was held between the Health Board and the WL Commissioner's office on 26/01/21. It was agreed that we would provide the evidence already collated by the 19/03/2021 date and a new date will be set for the remaining Operations directorate information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021.

Reports Closed on the Audit Tracker since ARAC April 2021

Report name	Lead Executive/Director
Audit Wales: Effectiveness of Counter-Fraud Arrangements	Director of Finance
Audit Wales: Procuring and Supplying PPE for the COVID-19 Pandemic	Director of Finance
Delivery Unit: All Wales Review of Progress Towards Delivery of Eye Care Measures ***(moved to Strategic Log for monitoring)***	Director of Operations
Delivery Unit: Review of the Impact of Long Waits for Planned Care on Patients	Director of Operations
Health and Safety Executive: Material Breach – Notification of Contravention – Covid-19 arrangements dated 28/01/2021	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Notification of Contravention - Shielding. Letter dated 17/11/2020	Director of Nursing, Quality and Patient Experience
Internal Audit: Estates Directorate Governance Review	Director of Operations
Internal Audit: Finance Team Transformation	Director of Finance
Internal Audit: Contracting (Follow Up)	Director of Finance
Internal Audit: Quality Review of Consultant Job Plans (Advisory Review)	Medical Director & Director of Clinical Strategy
Internal Audit: Service Modernisation Project at Bronglais General Hospital - Front of house Scheme (Final Account 2020/21)	Director of Finance
Public Service Ombudsman (Wales): 8391	Director of Operations
Public Service Ombudsman (Wales): 9905	Director of Operations
Public Service Ombudsman (Wales): 12035	Director of Operations
Public Service Ombudsman (Wales): 13459	Director of Operations

Reports Opened on the Audit Tracker since ARAC April 2021

Report name	Lead Executive/Director	Final report received at
Audit Wales: Procuring and Supplying PPE for the COVID-19 Pandemic	Director of Finance	Circulated electronically to the Audit and Risk Assurance Committee, April 2021
Health Inspectorate Wales: Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Director of Therapies	Quality, Safety and Experience Assurance Committee, June 2021
Health Inspectorate Wales: Quality Check – 10 Church Close, Begelly	Director of Operations	Quality, Safety and Experience Assurance Committee, June 2021
Health Inspectorate Wales: Quality Check – Morlais Ward, Glangwili General Hospital	Director of Operations	Quality, Safety and Experience Assurance Committee, June 2021
Internal Audit: Brexit Risks and Actions Advisory Review Final Report	Director of Finance	Audit and Risk Assurance Committee, June 2021
Internal Audit: Digital Modelling (EDAPT)	Director of Finance	Audit and Risk Assurance Committee, May 2021

Internal Audit: Service Modernisation Project at Bronglais General Hospital - Front of house Scheme (Final Account 2020/21)	Director of Finance	Audit and Risk Assurance Committee, April 2021
Internal Audit: Governance Arrangement during the Covid-19 Pandemic (Advisory Review)	Board Secretary	Audit and Risk Assurance Committee, October 2020
Internal Audit: Health & Safety	Director of Nursing, Quality & Patient Experience	Audit and Risk Assurance Committee, May 2021
Internal Audit: Mass Vaccination Programme	Director of Public Health	Audit and Risk Assurance Committee, April 2021
Internal Audit: Patient Experience	Director of Nursing, Quality & Patient Experience	Audit and Risk Assurance Committee, April 2021
Internal Audit: Glangwili Hospital Women & Children's Development	Director of Operations	Audit and Risk Assurance Committee, May 2021
Internal Audit: Management of Fire Enforcement Notices	Director of Operations	Audit and Risk Assurance Committee, April 2021
Internal Audit: Withybush General Hospital Wards 9 & 10 Lessons Learnt	Director of Operations	Audit and Risk Assurance Committee, June 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	Director of Operations	To be received at Health and Safety Assurance Committee Meeting, July 2021
Mid and West Wales Fire and Rescue Service: Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital *(report has been re-opened in May 2021 after MWWFRS inspection confirmed further works required).*	Director of Operations	To be received at Health and Safety Assurance Committee Meeting, July 2021