



**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

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| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 24 August 2021 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Audit Tracker |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Joanne Wilson, Board Secretary |
| SWYDDOG ADRODD: REPORTING 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.

During COVID-19, the Audit Tracker report focussed specifically on high priority recommendations, understanding the significant pressures services were under during the pandemic. However, going forward, this paper will review and provide updates on the status of all recommendations on the Audit Tracker as the UHB returns to relative normality.

Asesiad / Assessment

Management of outstanding recommendations

Audit Tracker

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

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

Since June 2021, 15 reports have been closed or superseded, with 10 new reports received by the UHB. These are listed in Appendix 2.

As of 29th July 2021, there are 93 reports currently open. 45 of these reports have recommendations that have exceeded their original completion date, which has decreased from the 60 reports previously reported in June 2021.

There is an increase in recommendations where the original implementation date has passed from 93 to 102. The number of recommendations that have gone beyond six months of their original completion date has reduced from 52 to 51 as reported in June 2021. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

| | Open reports at ARAC June 21 | New reports since June 21 | Closed reports since June 21 | Open reports at ARAC August 21 | Open reports which are overdue* | Red recommendations** | Red recommendations overdue by more than 6 months |
|-------------------------|------------------------------|---------------------------|------------------------------|--------------------------------|---------------------------------|-----------------------|---|
| AW | 4 | 2 | 0 | 6 | 4 | 2 | 1 |
| CHC | 2 | 0 | 0 | 2 | 2 | 2 | 0 |
| CHC / HIW Contractors | 2 | 1 | 1 | 2 | 1 | 1 | 0 |
| Coroner Regulation 28 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DU | 3 | 0 | 0 | 3 | 3 | 3 | 3 |
| HEIW | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| HSE | 17 | 0 | 9 | 8 | 0 | 9 | 9 |
| HIW (Acute & Community) | 9 | 1 | 1 | 9 | 4 | 19 | 4 |
| HIW (MH&LD) | 6 | 0 | 1 | 5 | 4 | 10 | 8 |
| IA | 30 | 1 | 5 | 26 | 15 | 32 | 16 |
| MWWFRS | 11 | 5 | 0 | 16 | 0 | 7 | 2 |
| Peer Reviews | 3 | 0 | 0 | 3 | 3 | 4 | 4 |
| PSOW - S16 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PSOW - S21 | 7 | 0 | 0 | 7 | 5 | 1 | 0 |
| Royal Colleges | 2 | 0 | 0 | 2 | 2 | 4 | 2 |
| Other | 1 | 0 | 0 | 1 | 0 | 5 | 2 |
| WLC | 2 | 0 | 0 | 2 | 2 | 3 | 0 |
| TOTAL | 99 | 10 | 17 | 92 | 45 | 102 | 51 |

*Reports which have passed their original implementation date

**Original implementation date noted for the recommendation has passed, or will not be met

Appendix 1 provides a full list of 212 recommendations on the audit tracker that need to be implemented, of which 102 are red (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. Appendix 1 also includes 14 recommendations highlighted as an 'external recommendation' whereby the recommendation is outside the gift of the UHB to currently implement, for example reliant on an external organisation to implement. These are marked as 'External' in the RAG status column. These 'External' recommendations are not included in the figures below.

Appendix 1 also contains 53 recommendations which do not have revised timescales (30 reported at previous meeting) - this is where the date has passed and not known (N/K) is reported. This includes 19 recommendations from 4 Letters of Fire Safety Matters on flats at the BGH site. The action plan has now been shared with the assurance and risk team; therefore, the timescales will be reflected in the next audit tracker report to ARAC in October 2021. The N/K figures also include 3 advisory internal audit reports with a combined total of 17 recommendations that had no timescales included in the reports. The assurance and risk team are working with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented. The remaining 17 recommendations noted as N/K are as follows:

- 2 recommendations relate to the GGH Hospital Women & Children's Development Phase 2 (2019/20) Internal Audit report. Currently awaiting confirmation from Internal Audit whether the evidence provided is sufficient to close the recommendations. If Internal Audit advise these are not yet implemented, revised timescales will be requested from the service.
- 4 recommendations from the Glangwili Hospital Women & Children's Development (2020/21) Internal Audit report. Dates have been requested from the service.
- 3 recommendations from the Welsh Language Commissioner (WLC) report which have been delayed due to COVID-19. The assurance and risk team have requested a progress update from the service.
- 1 recommendation relating to SIFT money and accommodation, SBAR to be reported to Capital, Estates, and IM&T Sub-Committee to advise of the impact to the DCP.
- 2 recommendations relate to the Royal College of Physicians follow up report to BGH. These recommendations will be reviewed as part of the piece of work the assurance and risk team will be undertaking on the Strategic Log. Further discussions require to take place with the service on this.
- 1 recommendation from the HIW Quality Check: Morlais Ward, GGH report. The recommendation relates to face to face fire training which has been suspended as a result of COVID-19, the current position is being reviewed by the service.
- 4 recommendations from the Audit Wales Structured Assessment 2021: Phase 1 Operational Planning Arrangements. The management response is being submitted to ARAC in August 2021; therefore, the timescales will be reflected in the next audit tracker report to ARAC in October 2021.

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

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at August 2021. A rolling programme to collate updates from services on a bi-monthly basis is in place in order to report progress to the Committee. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager. Detailed analysis of movements and trends with regards to recommendations will be included in this report from October 2021 onwards to demonstrate any progress or changes in position from the previous ARAC report.

| Service | Open reports as at August 21 | Overdue reports as at August 21 | Total number of recommendations | Total overdue recommendations (red) | Recommendations overdue by more than 6 months | Comments |
|---|------------------------------|---------------------------------|---------------------------------|-------------------------------------|---|---|
| CEO Office (Welsh Language) | 2 | 2 | 3 | 3 | 0 | WLC investigation- 3 recommendations outstanding, delayed by COVID-19. No progress update from service. |
| Community and Primary Care- Carmarthenshire | 0 | 0 | 0 | 0 | 0 | N/A |
| Community and Primary Care- Ceredigion | 1 | 1 | 0 | 0 | 0 | AW report- 1 'External' recommendation. |
| Community and Primary Care- Pembrokeshire | 0 | 0 | 0 | 0 | 0 | N/A |
| Digital and Performance | 9 | 5 | 21 | 17 | 6 | 6 recommendations implemented. Several outstanding recommendations will be closed once IGSC has convened in October 2021. |
| Central Ops | 1 | 1 | 4 | 4 | 4 | Peer Review Out of Hours report – 4 recommendations with revised timescales to December 2021, delayed by COVID-19. |
| Estates | 21 | 2 | 63 | 10 | 5 | MWWFRS Enforcement Notices and Letters of Fire Safety Matters progressed through phase works at GGH and WGH, overseen by the HSC. 7 recommendations overdue - awaiting survey outcomes and extended delivery dates on specialist equipment/materials. |
| Finance | 1 | 0 | 4 | 0 | 0 | IA Advisory report supported by Public Health - clarification of timescales has been requested but not yet received. |
| Governance | 2 | 0 | 6 | 0 | 0 | IA advisory review supported by Finance and Workforce & OD directorates. A further IA report - all 3 recommendations implemented. |
| MH&LD | 10 | 7 | 17 | 9 | 7 | 1 HIW Quality Checks contains overdue recommendations. COVID-19 has impacted implementing recommendations raised in the HIW thematic review. |
| NQPE | 13 | 4 | 25 | 13 | 10 | Awaiting formal extensions on 6 recommendations from HSE. 2 IA reports – no progress received from service. |
| Pathology | 0 | 0 | 0 | 0 | 0 | N/A |
| Primary Care, Community and Long Term Care | 2 | 1 | 4 | 1 | 0 | 1 HIW UHB managed practice- progress recently provided to HIW. |
| Public Health | 3 | 1 | 3 | 3 | 3 | 1 IA report -3 recommendations slipped to December 2021. 1 IA and 1 HIW report- all recommendations implemented. |
| Radiology | 2 | 1 | 14 | 13 | 1 | HIW IRMER (PPH)- 12 recommendations |

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|--|-----------|-----------|------------|------------|-----------|--|
| | | | | | | overdue, no progress received from service. IA report- 1 recommendation revised date December 2021. |
| Scheduled Care | 3 | 3 | 3 | 3 | 0 | PSOW report- 1 recommendation overdue. CHC report- 2 recommendations delayed due to COVID-19. |
| Strategic Development & Operational Planning | 4 | 3 | 11 | 7 | 5 | 1 IA report- 2 PPE recommendations delayed due to COVID-19. Evidence submitted to IA for 2 recommendations to close. 1 IA report with 2 overdue recommendations- awaiting outcome of follow up report. |
| USC BGH | 1 | 1 | 4 | 3 | 2 | RCP follow up – recommendations to be evaluated as part of Strategic Log review. |
| USC GGH | 3 | 3 | 5 | 5 | 4 | 2 DU and 3 HIW recommendations overdue- no updates received due to unprecedented site pressures. |
| USC WGH | 2 | 1 | 1 | 0 | 0 | 1 PSOW report - awaiting closure. HIW report – 1 amber recommendation due for completion in August 2021. |
| Women & Children | 9 | 7 | 23 | 11 | 4 | 3 recommendations behind schedule – delayed by W&C's phase 2 work. HIW Thematic review- 2 recommendations delayed due to funding and recruitment requirements. |
| Workforce & OD | 2 | 1 | 1 | 0 | 0 | AW report- 1 amber recommendation. WLC report- 1 'External' recommendation. |
| Unscheduled Care | 1 | 1 | 0 | 0 | 0 | CHC report- 1 'External' recommendation. |
| Total | 92 | 45 | 212 | 102 | 51 | |

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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| Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor | 3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Not applicable. |

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| 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: | Not applicable |
| Rhestr Termiau: Glossary of Terms: | <p>ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CHC – Community Health Council DCP – Discretionary Capital Programme DU – Delivery Unit GGH – Glangwili General Hospital HEIW – Health Education and Improvement Wales HIW – Healthcare 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 SIFT – Service Increment for Teaching SSU – Specialist Services Unit UHB – University Health Board WLC – Welsh Language Commissioner WGH – Withybush General Hospital MH&LD – Mental Health & Learning Disabilities NQPE – Nursing, Quality & Patient Experience USC – Unscheduled Care IGSC – Information Governance Sub Committee Management & Technology Sub Committee. HSE – Health & Safety Committee W&C – Women & Children PPE – Post Project Evaluation RCP – Royal College of Physicians</p> |
| Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: | Board Secretary |

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

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on schedule) | Progress update/Reason overdue |
|--------------------------------------|----------------|------------------|---|---------------------|------------------|--|--|--------------------------------|--|--------------------------|----------------|--|--|---|--------------------------|--------------------------------------|--|---|
| 603A2018-19 | Jun-18 | Audit Wales | District Nursing: Update on Progress | Open (external rec) | N/A | Community and Primary Care (Ceredigion) | Community and Primary Care (Ceredigion) | Tracey Evans / Sharon Daniel | Director of Operations | WAO_DistrictNursing_001 | Not stated | R6. Workload varies between teams. The Health Board should use the all-Wales dependency tool when it becomes available to monitor and review the case mix between teams compared with team resources. | The Health Board said that it expects this issue to be definitively addressed through the publication of the All Wales dependency tool, currently expected in 2020. | | Jan-19 | Mar-20 Nov-20 Dec-21 | External | 24/11/2020: Community Head of Nursing confirmed the All Wales DN Workstream is progressing well with the development of a dependency and acuity tool and the first testing phase of the DN Welsh Levels of Care Acuity and Dependency tool is planned for March / April 2021. There is good representation on the national workstream from HDUHB and all DN teams will be engaging in the planned pilot phases of testing. Malinko scheduling system is also being rolled out across the community nursing teams in HDUHB which will further support the use of this tool. The plan is a 6 month pilot followed by review and then most likely a further 6 month testing phase. It is more likely that there will be a tool in use consistently in 2022 although we will have something to use from Spring 2021. Revised timescale December 2021. 16/07/2021- reporting officer requested to provide any updates by 28/07/2021. |
| 175A2019-20 | Apr-19 | Audit Wales | Clinical coding follow-up review | Open | N/A | Digital and Performance | 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. | All the clinical coding teams are asked to track case notes correctly using the Myrddin Patient Administration System. The Health Board's self-assessment indicated that this always happens, except for when case notes are collected from a ward in the morning and returned that afternoon. However, coding staff indicated that case note tracking is generally poor, except at Wyllybush Hospital. | Assistant Director of Informatics / Deputy Director of Operations | Aug-20 | Dec-20 Nov-21 Dec-21 | Red | 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. 30/06/2021- Digital Business Manager to provide evidence (procedure, etc) to Internal Audit to close this recommendation. 28/07/2021 - The Health Records Group was unable to meet during the initial COVID period, this group is currently being re-established and the work plan will include the auditing of case note tracking. Recommend to extend the deadline until December 2021, with a caveat of staff being able to access wards |
| WAO_infoBackup | Mar-18 | Audit Wales | Follow-up Information Backup, Disaster Recovery and Business Continuity, and Data Quality: Update on Progress | Open | N/A | Digital and Performance | 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. | No revised management response provided in this follow up report. | | N/K | Mar-21 Apr-21 Jun-21 Oct-21 | Red | 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. 30/06/2021- performance issues have been resolved and it is hopeful this can be closed. Digital Business Manager to obtain update from colleagues. 28/07/2021 - To date significant work has been undertaken to work towards this, with the implementation of the Health Board's new backup environment going well and 85% of data and workloads have been migrated. There have been some |
| 2443A2021-22 | Jun-21 | Audit Wales | Audit of Accounts Report | Open | N/A | Workforce and OD | Finance | Anmarie Thomas | Director of Workforce & OD | 2443A2021-22_001 | High | The Health Board should ensure that a more robust system is installed to readily, and accurately, monitor leave balances across the organisation at any one time. It is recommended that this is remedied before next year's audit. | The recommendation is accepted, we will review how we interface Intrepid and ESR and use this to determine our annual leave booked and yet to be taken at any point in time. | Anmarie Thomas | Oct-21 | Oct-21 | Amber | Agreed via email that this recommendation sits with W&OD and not Finance. 15/07/2021 update provided by Assistant Director of Workforce & OD. Meeting took place on 15th July 2021 to discuss the approach for the delivery of the recommendation. Baseline reports are being developed to report on annual leave booked and outstanding. A communications plan is being developed to reinforce the message HB wide in respect of the importance of accurate and timely use of our E-Systems (ESR and Intrepid) for recording and reporting of annual leave management. |
| 651A2015 | Feb-16 | Audit Wales | Hospital Catering and Patient Nutrition Follow-up Review | Open (external rec) | N/A | Nursing | Nursing | Sharon Daniel | Director of Nursing, Quality and Patient Experience | WAO_Catering001 | Not stated | R4b. We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems. | Introducing a computerised catering system will incur additional revenue costs as the inputting of live data is key to providing timely and accurate information. The costs associated with such systems would ordinarily need to be sourced from Capital funding. • A review of cost benefits will be undertaken during 2016 as part of the work on the Catering Business case development, with a view to including in the Outline Business case if the review demonstrates it to be appropriate to do so | | Dec-16 | N/K | External | The national IT catering Solution is now available via All Wales Procurement Framework. The system has been introduced in part to Aneurin Bevan and representatives from Hywel Dda visited to consider the benefits of procuring the system. The feedback received is that the benefits realisation has yet to be assured and for this reason a business case has not yet been progressed. Director of Nursing, Quality and Patient Experience currently considering if this recommendation will be implemented, or if it will not be taken forward. 04/12/2020- Director of Nursing, Quality and Patient Experience contacted to request if final recommendation and therefore report can be closed. No response received. 05/03/2021- Conversations currently taking place with Estates and decision to be made at Nutrition & Catering Group regarding this recommendation. |
| 2360A2021-22 | Jun-21 | Audit Wales | Structured Assessment 2021: Phase 1 Operational Planning Arrangements | Open | N/A | Strategic Development and Operational Planning | Strategic Development and Operational Planning | TBC | Director of Strategic Development and Operational Planning | 2360A2021-22_001 | Not stated | R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked. | | | N/K | N/K | Amber | 05/07/2021 - Recommendations added without management responses as not yet received. Management response to be submitted to ARAC August 2021. |
| 2360A2021-22 | Jun-21 | Audit Wales | Structured Assessment 2021: Phase 1 Operational Planning Arrangements | Open | N/A | Strategic Development and Operational Planning | Strategic Development and Operational Planning | TBC | Director of Strategic Development and Operational Planning | 2360A2021-22_002 | Not stated | R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members. | | | N/K | N/K | Amber | 05/07/2021 - Recommendations added without management responses as not yet received. Management response to be submitted to ARAC August 2021. |
| 2360A2021-22 | Jun-21 | Audit Wales | Structured Assessment 2021: Phase 1 Operational Planning Arrangements | Open | N/A | Strategic Development and Operational Planning | Strategic Development and Operational Planning | TBC | Director of Strategic Development and Operational Planning | 2360A2021-22_003 | Not stated | R3. The Quarters 3-4 Plan does not provide details of progress on actions arising in the preceding quarters, despite commitments to doing so. The Health Board should ensure that its future plans contain the necessary information to provide assurance of progress over time. | | | N/K | N/K | Amber | 05/07/2021 - Recommendations added without management responses as not yet received. Management response to be submitted to ARAC August 2021. |
| 2360A2021-22 | Jun-21 | Audit Wales | Structured Assessment 2021: Phase 1 Operational Planning Arrangements | Open | N/A | Strategic Development and Operational Planning | Strategic Development and Operational Planning | TBC | Director of Strategic Development and Operational Planning | 2360A2021-22_004 | Not stated | R4. The Health Board does not have processes in place to track the delivery of its actions set out in its operational plans. The Health Board should develop a mechanism for tracking progress against actions. In doing so, the Health Board should clarify responsibility for oversight at Board and Committee level for monitoring delivery of plans, including the 2021-22 Annual Plan. | | | N/K | N/K | Amber | 05/07/2021 - Recommendations added without management responses as not yet received. Management response to be submitted to ARAC August 2021. |
| Eye Care Services in Wales Follow Up | Jan-20 | CHC | Eye Care Services in Wales Follow Up | Open | N/A | Scheduled Care | Scheduled Care (ophthalmology) | 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 | Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding. | Carly Buckingham / Stephanie Hire / Keith Jones | Mar-21 | Mar-21 Sep-21 | 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: |

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|--|----------------|-----------------------------|--|---------------------|------------------|---------------------------------------|---------------------------------------|--------------------------------|--|--------------------------|----------------|---|---|---|--------------------------------------|----------------------------|--|---|
| Eye Care Services in Wales Follow Up | Jan-20 | CHC | Eye Care Services in Wales Follow Up | Open | N/A | Scheduled Care | Scheduled Care (ophthalmology) | 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 | Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home. | Carly Buckingham / Stephanie Hire / Keith Jones | Mar-21 | Mar-21 Sep-21 | 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 received from the reporting officer however due to operational pressures and annual leave no update has been received as of 26/03/2021. |
| Eye Care Services in Wales Follow Up | Jan-20 | CHC | Eye Care Services in Wales Follow Up | Open (external rec) | N/A | Scheduled Care | Scheduled Care (ophthalmology) | Carly Buckingham | Director of Operations | EyeCareServices005 | N/A | R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas. | EPR to be awarded to allow Health Board to progress | Carly Buckingham | Apr-20 | Jul-20 Apr-21 N/K | External | WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. |
| What's your NHS like for you? Hearing from people with a learning disability | May-18 | CHC | What's your NHS like for you? Hearing from people with a learning disability | Open (external rec) | N/A | Unscheduled Care | Unscheduled Care | Sian Passey | Director of Operations | NHSLikeForYou_001 | N/A | R5. All Wales Working Group currently developing standards of practice for annual health checks including training programmes for GPs. | • Once finalised the standards of practice to be implemented across the GP practices • GPs to participate on All Wales Training Programme | | Mar-19 | Apr-20 Aug-20 N/K | External | 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. |
| DU_QCTPAMH&LD | 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 | Open (External Rec) | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Mel Evans | Director of Operations | DU_QCTPAMH&LD_001 | N/A | R1. The Health Board and its local authority partners should, as a matter of priority, improve integration across health and social care in learning disability services. This should include the alignment of policies & protocols to support joint working, the sharing of assessments, and the production of multi-agency CTPs. | As this is a high level action it sits within the HB Programme of work under transformation. A transformation fund has been made available across the Region and within this there is an allocation for developing integration. There are also clear links to transforming clinical services and transforming mental health services. A CTP Policy is being developed which will articulate the required joint working arrangements. Through the development of the WCCIS(integrated information database for Wales) | Sara Rees / Mel Evans | May-19 | Mar-23 | External | 02/10/2020 Requested update - Response received 22/10/2020 - Any patients under secondary care, where a CTP is required have electronic records, care partner, Health and social care staff within CMHTs have access and utilise care partner. 4/12/2020 update requested, response received: WCCIS is the integrated information database for Health and Social Care and this is being delivered by NWS outside the gift of the HB. 19/02/2021 No progress no change to previous comment. 19/03/2021 this recommendation was set by the delivery unit in 2017. Sara/ Mel in discussions with the Delivery Unit and Mel is presenting a report to request an agreement from DU this should be closed, await outcome. 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. |
| DU_QCTPAMH&LD | 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 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Mel Evans | Director of Operations | DU_QCTPAMH&LD_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. | There is a Regional Workstream for Workforce Development and we are looking to ensure that this is aligned to work ongoing there. The TMH workstream is also taking this forward. Within LD a bid is currently being written for people who use services to help deliver and inform training and create be-spoke packages, this will include how we fund this work. | 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. |
| DU_RPCC&AMHS | 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 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Angela Lodwick / Sarah Burgess | Director of Operations | DU_RPCC&AMHS_005 | N/A | R5. The HB should undertake an engagement exercise with GPs to improve liaison and a shared understanding of CAMHS pathways. | GPs and Primary care staff will be provided with a Service Specification for referral to CAMHS LPMHSS | Angela Lodwick | Nov-19 | Dec-20 Jun-21 | Red | Training for GPs 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 GPs 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. 22/6/2021 Action partially complete - Primary Mental Health Lead is meeting with all GP Clusters, letter has been sent to all GP. Service Specification is being ratified in July then a copy of service specification will be forwarded to all GP clusters and action complete |
| All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review | May-19 | Delivery Unit | All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Paul Smith | Director of Operations | DeUnitCardio002 | N/A | R2:Ensure that all administrative record keeping – both electronic and within the medical records – are maintained to the highest of standards. | Monthly audits of outcome form to establish % compliance - feedback any non-compliances with Clinical lead to address non-compliance. | | 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 | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Paul Smith | Director of Operations | DeUnitCardio003 | 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. | For 100% of referral letters to have a PSD identified by November 2019 - audit undertaken in February 2020 demonstrates a 31% compliance. SDM Cardiology and Cardiology Service Support Manager to reinforce need of PSDs to referring clinicians and re-audit in 3 months. | | Dec-19 | Dec-20 May-21 Oct-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. 14/06/2021- Update from reporting officer on 22/01/2021, update not yet received. |
| All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review | May-19 | Delivery Unit | All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Paul Smith | Director of Operations | DeUnitCardio003 | N/A | R3f: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work. | HDUHB was in the process of working with IT to setup another SharePoint system to move towards the electronic referral of patients between Cardiology and Cardiac Surgery. However, this hasn't been progressed due to the All Wales Accelerating Cardiac Informatics work being progressed on Hospital to Hospital Referrals. Cardiology Service Delivery Manager currently in discussion with HDUHB Informatics and AWACI. | | May-19 | Dec-20 Jun-21 Mar-22 | Red | Unable to progress due to COVID review date December 2020. 29/01/2021- Update requested from reporting officer on 22/01/2021, update not yet received. 20/03/2021- Update from reporting officer- Pandemic pressures and more recently the Welsh Government priority to achieve a 35% reduction in the follow-up waiting list has compromised capacity to complete this audit. Clinical Lead/SDM plan to review the possibility of developing a more reliable SharePoint system to support referrals and discuss this with SBUHB counterparts with respect to have we might progress this. 24/05/2021- Requested update if this rec will be completed by end of June 2021, no response as of 28/05/2021. 11/06/2021 update -The Cardiology Service is currently undertaking a Pathway Transformation Project which will review the |
| LPI/HD/04102 019/06 | Oct-19 | Health and Safety Executive | Improvement notice - Incidents 02-11/07/19 IN6 | Open | N/A | Nursing | Nursing (Health and Safety) | Tim Harrison | Director of Nursing, Quality and Patient | 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. | Various actions noted under this measure. | | May-20 Jul-20 Jan-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 |
| LPI/HD/04102 019/06 | Oct-19 | Health and Safety Executive | Improvement notice - Incidents 02-11/07/19 IN6 | Open | N/A | Nursing | Nursing (Health and Safety) | Tim Harrison | Director of Nursing, Quality and Patient | 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. | Various actions noted under this measure. | | 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 |
| LPI/HD/04102 019/06 | Oct-19 | Health and Safety Executive | Improvement notice - Incidents 02-11/07/19 IN6 | Open | N/A | Nursing | Nursing (Health and Safety) | Tim Harrison | Director of Nursing, Quality and Patient | 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 | Various actions noted under this measure. | | May-20 Jul-20 Jan-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. |
| LPI/HD/04102 019/08 | Oct-19 | Health and Safety Executive | Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8 | Open | N/A | Nursing | Nursing (Health and Safety) | Tim Harrison | Director of Nursing, Quality and Patient | 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. | Various actions notes under this recommendation. | | 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. 15/07/2021- Health & Safety Manager confirmed still on track for September 2021 date. |
| LPI/HD/04102 019/08 | Oct-19 | Health and Safety Executive | Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8 | Open | N/A | Nursing | Nursing (Health and Safety) | Tim Harrison | Director of Nursing, Quality and Patient | 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. | Various actions notes under this recommendation. | | 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. 15/07/2021- Health & Safety Manager confirmed still on track for September 2021 date. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-ahead of schedule) | Progress update/Reason overdue |
|---------------------|----------------|-----------------------------|---|------------------|------------------|------------------------|-----------------------------|---------------------|---|--------------------------|----------------|--|---|---|--------------------------------------|--|--|---|
| JHET/HD/04102019/02 | Oct-19 | Health and Safety Executive | Improvement notice - Manual Handling 02-11/07/19 IN2 | Open | N/A | Nursing | Nursing (Health and 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; | See management response for recommendation 1 - not clear how the actions are split across the 5 recommendations | | May-20 Jul-20 Jan-21 Jun-21 | Dec-20 May-21 Jun-21 | Red | 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. |
| JHET/HD/04102019/02 | Oct-19 | Health and Safety Executive | Improvement notice - Manual Handling 02-11/07/19 IN2 | Open | N/A | Nursing | Nursing (Health and 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 | Critically review the Manual Handling Policy to ensure that it is fit for purpose. Request assistance of General Managers in achieving aims. Increase moving and handling risk assessments where required. Introduction of new Moving & Handling risk assessment paperwork to standardise nursing documentation across Wales. Link to Incident Investigation Control Group. | | May-20 Jul-20 Jan-21 Jun-21 | Oct-20 Dec-20 May-21 Jun-21 | Red | 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. |
| JHET/HD/04102019/02 | Oct-19 | Health and Safety Executive | Improvement notice - Manual Handling 02-11/07/19 IN2 | Open | N/A | Nursing | Nursing (Health and 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. | Full action plan held by H&S team. | | May-20 Jul-20 Jan-21 Jun-21 | Oct-20 Dec-20 May-21 Jun-21 | Red | 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. |
| JHET/HD/04102019/02 | Oct-19 | Health and Safety Executive | Improvement notice - Manual Handling 02-11/07/19 IN2 | Open | N/A | Nursing | Nursing (Health and 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. | Full action plan held by H&S team. | | May-20 Jul-20 Jan-21 Jun-21 | Oct-20 Dec-20 May-21 Jun-21 | Red | 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. |
| JHET/HD/04102019/02 | Oct-19 | Health and Safety Executive | Improvement notice - Manual Handling 02-11/07/19 IN2 | Open | N/A | Nursing | Nursing (Health and 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. | Full action plan held by H&S team. | | May-20 Jul-20 Jan-21 Jun-21 | Oct-20 Dec-20 May-21 Jun-21 | Red | 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. |
| LP1/HD/04102019/07 | Oct-19 | Health and Safety Executive | Improvement notice - Theatres, Bronglais Hospital 02-11/07/19 IN7 | Open | N/A | Nursing | Nursing (Health and 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: | Various actions noted under this measure. | | May-20 Jul-20 Jan-21 Jun-21 | Jul-20 Oct-20 Dec-20 May-21 Jun-21 | Red | 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. |
| 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 | Open | N/A | Nursing | Nursing (Health and 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. | Various actions notes under this recommendation. | | 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 be happy for all MBs to be closed. Formal letter from HSE should be received next week. |
| 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 | Open | N/A | Nursing | Nursing (Health and 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. | Various actions notes under this recommendation. | | 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 be happy for all MBs to be closed. Formal letter from HSE should be received next week. |
| 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 | Open | N/A | Nursing | Nursing (Health and 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. | Various actions notes under this recommendation. | | 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 be 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. |
| 18264 | Jun-19 | HIW | HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19 | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Owren 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. | Clinical Directors to discuss the need for improved prescribing of oxygen with medical staffing. To provide training for ward staff on the use of oxygen therapy and prescribing. | | 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 |
| 20068 | Dec-20 | HIW | Glangwili Hospital (Towy Ward) | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Owren 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. | All staff to attend frailty teaching session. | Senior Ward Sister/ Senior Nurse Manager | 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. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. |
| 20068 | Dec-20 | HIW | Glangwili Hospital (Towy Ward) | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Owren 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. | All staff to attend in-house training when available. There has been a reduced face to face in-house training programme due to COVID-19. | Senior Ward Sister/ Senior Nurse Manager | 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. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. |

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|---|----------------|------------------|--|---------------------|------------------|-------------------------------|-------------------------------|-------------------------------------|---|--------------------------|----------------|--|---|---|--------------------------|---|---|--|
| 20068 | Dec-20 | HIW | Glangwill Hospital (Towy Ward) | Open | N/A | Unscheduled Care (GGH) | Unscheduled Care (GGH) | Owen 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. | Develop and arrange ward based fire and cardiac arrest Scenario sessions to bridge the gap until face to face training sessions are available post pandemic. | Senior Ward Sister/ Senior Nurse Manager Fire Safety Advisor/Simulation and Resuscitation Advisor | 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. 16/07/2021- update requested by 28/07/2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. |
| 19097 | Jul-20 | HIW | Wards 7 & 11, WGH 04-05 Feb 20 | Open (external rec) | N/A | Unscheduled Care (WGH) | Unscheduled Care (WGH) | Janice Cole-Williams / Carol Thomas | Director of Operations | 19097_026 | N/A | R26: The Deprivation of Liberty Safeguards (DoLS) policy is updated to reflect the Liberty Protection Safeguards in line with the Mental Capacity (Amendment) Act 2019 | Protocol drafted for managing the MHA/MCA interface. Currently out for consultation. Final version to be approved by the MCA and Consent Group | Sieven Hughes, Deprivation of Liberty Safeguards Coordinator | Aug-20 | Aug-20 April-22 | External | 16/09/2020 Update received: SM advised A report on this is to be submit to the mental capacity and consent group next week for approval. It's been delayed as some of the key consultees in mental health haven't been available and the consent group hasn't met since February due to Covid response issues. If approved by the group next week it will still need to go for approval by the equivalent Mental Health scrutiny group, I'm not sure when they next meet. Further progress to be issued next week. 6/11/2020 update received from DOLS Co-ordinator. We have a DoLS policy that is within its review date. LPS will be completely new legislation and the DoLS policy will become obsolete on its introduction as it completely replaces DoLS. The work on the interface could be added to the current DoLS policy as an appendix detailing procedures to be followed, it can then be added to a future LPS policy as very similar issues will remain under the new legislation. Unable to provide a new date new LPS not expected before April 22. 11/03/2021 Recommendation currently outside the gift of the Health Board until new legislation is in place. |
| 19097 | Jul-20 | HIW | Wards 7 & 11, WGH 04-05 Feb 20 | Open | N/A | Unscheduled Care (WGH) | 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 2019. The Welsh Government are also fully engaged in this process and are | The Health Board has a fully structured plan for fire safety at WGH developed in response to the Mid and West Wales Fire and Rescue Service Enforcement Notice (MWWFRS). The plan presented to MWWFRS is a staged approach allowing us to undertake advance works very promptly with the substantive element of work progressed via a Business Case process. Within this plan all fire requirements to escape routes identified within the above Enforcement Notice will be undertaken at WGH between May 2020 and August of 2021. This programme is currently being considered by the MWWFRS and we are awaiting further clarity from them on the agreed timelines on this work. The Welsh Government are also fully engaged in this process and are | Director of Estates / Head of Fire Safety | Aug-21 | Aug-21 | Amber | 25/02/2021 One immediate recommendation remains at Worthybush 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. |
| 19258 | Jul-20 | HIW | PACU and Cilgerran Wards, Glangwill General Hospital | Open | N/A | Women and Children's Services | 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 | This is programmed in line with phase 2 work with estates to re build the storage facilities for the unit | Nick Davies/ Assistant Major Capital | Mar-21 | Mar-21 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. |
| 19258 | Jul-20 | HIW | PACU and Cilgerran Wards, Glangwill General Hospital | Open | N/A | Women and Children's Services | 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. | Currently on hold for face to face training due to COVID, consideration for E learning or electronic platforms to deliver training | Fire Officer for face to face training | Aug-21 | Aug-21 | 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, Worthybush General Hospital | Open | N/A | Women and Children's Services | 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. | Paediatric Sepsis Pathway is ongoing and awaiting input from the medical team. Once implemented a comprehensive plan on training and information sharing will be rolled out | Paula Evans | Nov-20 | Nov-20 Jan-21 Apr-21 Jun-21 Aug-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. 07/07/2021 Requested update, awaiting response. 16/07/21021 Senior Nurse Paediatrics confirmed the Sepsis pathway completed. Awaiting the final implementation plan for training to be rolled out. |
| 19127 | Jan-20 | HIW | Glangwill Hospital (Maternity), 7-9 October 2019 | Open | N/A | Women and Children's Services | 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. | Clinical lead to meet with Head of Welsh Language services to discuss appropriate information being available in Welsh | Julie Jenkins Lesley Owen | Mar-20 | Dec-20 Apr-21 Aug-21 Sept-21 Dec-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 reviewed-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. 12/07/2021 Delays on Phase 2 work, possibly completed by December 21. |
| National Review of Maternity Services - Phase 1 | Nov-20 | HIW | National Review of Maternity Services - Phase 1 | Open | N/A | Women and Children's Services | 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 | Phase 2 converting a room for birth partners to stay overnight. | Julie Jenkins | Jun-21 | Jun-21 Sept-21 | Red | 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. 12/07/2021 Changes to birth partners only restrictions, currently there are no partners overnight as WG guidance, allowed visiting slots during daytime hours. |
| National Review of Maternity Services - Phase 1 | Nov-20 | HIW | National Review of Maternity Services - Phase 1 | Open | N/A | Women and Children's Services | Women and Children's Services | Julie Jenkins | Director of Nursing, Quality and Patient Experience | NRMS_026 | N/A | Consider the implementation of a live PSAG display feed, to enhance patient handover | Process for handover is in place – copied and scanned on a daily basis. Explore an All Wales approach. WG Directive | Julie Jenkins | Mar-22 | N/K | external | 15/03/2021 - this recommendation while raised in the initial report has not been included in the required template for completion by HIW (see p43 of original report) 19/03/2021 Report included as part of normal scheduled request for updates. 19/03/2021 Process for handover is in place – records are copied and scanned on a daily basis. Explore an All Wales approach. HWG Directive (outside gift of HB) 26/05/2021 Manual processes in place at HB, this recommendation is changed to external as PSAG is being led by WG. 12/07/2021 No change to recommendation awaiting WG solution. |
| National Review of Maternity Services - Phase 1 | Nov-20 | HIW | National Review of Maternity Services - Phase 1 | Open | N/A | Women and Children's Services | 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. | *New Phase 2 development proposed to be open in late spring 2021 will have this facility and allow consultant obstetrician to review remotely when on call. In addition this facility allows external access to Bronllys and Worthybush General Hospitals providing additional clinical advice and support. | 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. 12/07/2021 Delays to Phase 2 still awaiting handover. System purchased, IT commissioned all set up - Completed |

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| National Review of Maternity Services - Phase 1 | Nov-20 | HIW | National Review of Maternity Services - Phase 1 | 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 | <ul style="list-style-type: none"> Integrated community and hospital smoking cessation service established in Hywel Dda in January 2020 and referral pathways from maternity services established Smoking cessation guideline ratified 01/12/20 Service improvement of MDT working with Public Health Co monitoring embedded during antenatal period Promotion across maternity services of the existing referral process in place across HDUHB where all pregnant women assessed as smoking are | 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. 12/07/2021 Collaborative working with Public Health is underway. Band 5 & 6 nurses appointed to work on the Women and Children agenda. Band 5 to work on the redesign of services and motivation in importance of healthy lifestyle(smoking |
| National Review of Maternity Services - Phase 1 | Nov-20 | HIW | National Review of Maternity Services - Phase 1 | 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 | <ul style="list-style-type: none"> Public Health Midwife job description formatted and awaiting approval with a vision for employing a Band 7 Public Health Midwife to address smoking cessation initiatives. Meet with HDUHB Health Improvement & Wellbeing Team to discuss links between the Public Health Midwife and Band 6 Senior Practitioner for Smoking and Wellbeing within the Public Health Directorate to further discuss joint initiatives in improving healthier 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. 12/07/2021 Collaborative working with Public Health is underway. Band 5 & 6 nurses appointed to work with Women and Children agenda. Band 5 to work on redesign of services and motivation in importance of healthy lifestyle(smoking cessation, weight management etc) W&C Strategy in place, Employ PH midwife to work with the HB team population health goals. Job Description is under development. |
| 21002 | Jun-21 | HIW Contractors | Tenby Surgery (UHB Managed Practice) | Open | N/A | Primary Care, Pharmacy (community), LTC & LVWS | Primary Care, Pharmacy (community), LTC & LVWS | Anna Swinfield / Sonia Luke | Director of Primary, Community and Long Term Care | 21002IA_005 | High | R5 (Immediate improvement plan). There was no evidence provided of a schedule for carpet or curtain cleaning despite a number of rooms being carpeted. This was not in line with the health board's policy. | <p>Flooring: actions will be as follows;</p> <ol style="list-style-type: none"> Inspection by team - 16/06/2021 (completed) Tender to be developed by 02/07/2021 Tender to be awarded by 09/07/2021 Replacement flooring to be fitted by 10/09/2021 <p>Photographs of completed works to be submitted as evidence by 10/09/2021</p> | Head of Operations | Sep-21 | Sep-21 | Amber | 29/06/2021 - progress update submitted to HIW stating "Action is due for completion in September 2021, and an update will be provided upon completion." |
| 21002 | Jun-21 | HIW Contractors | Tenby Surgery (UHB Managed Practice) | Open | N/A | Primary Care, Pharmacy (community), LTC & LVWS | Primary Care, Pharmacy (community), LTC & LVWS | Anna Swinfield / Sonia Luke | Director of Primary, Community and Long Term Care | 21002IA_007 | High | R7 (Immediate improvement plan). We were not assured that all staff were trained to an acceptable level in infection control and prevention. In the quality check call the practice manager advised that non clinical staff did not undertake infection control and prevention training at any level. They also confirmed that non clinical staff had not undertaken any training in donning and doffing PPE. This was despite a large number of these staff being a public facing role, who were required to undertake tasks such as cleaning and temperature checks. This was not in line with the health boards training position which requires all staff to be proficient in donning and doffing PPE and trained to level 1 infection control. | Standard Infection Prevention and Control Precautions are always practiced mitigating against cross infection risks and as taught in Level 1 and Level 2 mandatory training. | Senior Primary Care Nurse Advisor | Jun-21 | Jun-21 | Red | 29/06/2021 - progress update submitted to HIW showing this recommendation will be completed by 30/06/2021. Update to be requested during next service email scheduled for August 2021. 29/07/2021 - Awaiting confirmation from Director of Primary, Community and Long Term Care that recommendation is complete, then recommendation will turn green. |
| 21002 | Jun-21 | HIW Contractors | Tenby Surgery (UHB Managed Practice) | Open | N/A | Primary Care, Pharmacy (community), LTC & LVWS | Primary Care, Pharmacy (community), LTC & LVWS | Anna Swinfield / Sonia Luke | Director of Primary, Community and Long Term Care | 21002_001 | High | R1. The practice must ensure that they keep adequate records of staff agreement to the Standard Operating Procedure. | A Standard Operating Procedure for the cleaning of the premises is being introduced, alongside regular training and supervision. A record of the agreement of the cleaning staff to the SOP will be retained in a file. This record will be shared as evidence. | Hotel Facilities Supervisor Practice Manager | Jul-21 | Jul-21 | Amber | 12/07/2021 - letter received from HIW accepting improvement plan and requesting progress made against recommendations in three months time. Update to be requested during next service email scheduled for August 2021. |
| 21002 | Jun-21 | HIW Contractors | Tenby Surgery (UHB Managed Practice) | Open | N/A | Primary Care, Pharmacy (community), LTC & LVWS | Primary Care, Pharmacy (community), LTC & LVWS | Anna Swinfield / Sonia Luke | Director of Primary, Community and Long Term Care | 21002_002 | High | R2. The practice must ensure team meeting minutes are kept to ensure staff can access the discussions when needed. | Clinical team meetings take place weekly (chaired by the GP Lead), and admin team meetings are held fortnightly. Minutes/action notes will be documented and made available to staff electronically and as hard-copy in a file. A sample copy of Minutes/action notes will be shared as evidence. | Practice Manager | Jul-21 | Jul-21 | Amber | 12/07/2021 - letter received from HIW accepting improvement plan and requesting progress made against recommendations in three months time. Update to be requested during next service email scheduled for August 2021. |
| 20255 | Apr-21 | HIW IRMER | Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER) | Open | N/A | Radiology | 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 | Information board to be installed in reception area. Approximate wait times to be updated regularly for each modality | Head of Radiology | Jun-21 | Jun-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. |

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| 20255 | Apr-21 | HIW IRMER | Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER) | Open | N/A | Radiology | 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 | As above. Information board to include a 'you said... we did' section updated monthly. This will be rolled out in radiology departments across all four acute sites | Head of Radiology | Jun-21 | Jun-21 | 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) | Open | N/A | Radiology | 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. | To be reviewed and audited after a period of 3 months | Head of Radiology | Jun-21 | Jun-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) | Open | N/A | Radiology | 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 | DRL Review Programme to be revisited at RPG to ensure compliance | Consultant Clinical Scientist (Medical Physical & Clinical Engineering) | May-21 | May-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) | Open | N/A | Radiology | 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. | To be discussed and updated at the RPG in April 2021. All findings will be shared at the RPG and Radiology Quality Safety and patient Experience group | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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 | To be discussed and approved at RPG April 2021 following which it will be cascaded to relevant staff | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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 | Letter / certificate to be drafted and reviewed at the RPG for use after approval | Head of Radiology and Clinical Director of Radiology | May-21 | May-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) | Open | N/A | Radiology | Radiology | Amanda Evans | Director of Therapies | 20255_008 | High | The employer must ensure that the medical director is aware of their entitled role within theatres and this is further clarified and added to the theatre employer's procedure | Procedure to be reviewed, updated and presented for approval at RPG in April 2021, and then disseminated to appropriate staff. | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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 | All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic. | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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 | Annual review and analysis of all relevant incident submissions to be undertaken and presented to the RPG (the new Once for Wales Concerns Management System (OFWCMS) has improved concerns codes which will allow for capturing of radiology related incidents and theming of the learning). | Head of Radiology with assistance from the Quality Assurance and Safety Team | 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) | Open | N/A | Radiology | 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 | Quarterly reports of (relevant) incidents reported to be provided to the RPG | Quality Assurance and Safety Team | 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) | Open | N/A | Radiology | 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 | All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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. | All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic | Head of Radiology | May-21 | May-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) | Open | N/A | Radiology | 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 | The Resuscitation training department to be provided with a list of all outstanding staff requiring training | Head of Radiology | 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. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red- behind schedule, Amber- on schedule, Green- on schedule) | Progress update/Reason overdue |
|---|----------------|------------------|---|---------------------|------------------|---------------------------------------|---------------------------------------|----------------------------|------------------------|--------------------------|----------------|---|---|--|--------------------------|------------------------------|---|--|
| 20255 | Apr-21 | HIW IRMER | Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER) | Open | N/A | Radiology | 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 | Training to be scheduled to accommodate all outstanding staff | Head of Radiology / Resuscitation Department | Jun-21 | Jun-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. |
| HIW_JTRCMHT | Feb-19 | HIW MHL | Joint Thematic Review of Community Mental Health Teams 2017-2018 | Open (External Rec) | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Kay Isaacs | Director of Operations | HIW_JTRCMHT_021 | N/A | Health boards and local authorities need to work together to improve joint processes for driving the improvement of services. This includes the need for greater alignment of processes within CMHTs including integrated records and data collection | The MH/LD Directorate continues its commitment to co-producing the implementation of its Transforming Mental Health Programme. A data and evaluation work stream has recently been established to review data gathering processes and develop means of continuous quality improvement. The UHB are being assisted by Swansea University. Ensure information systems are updated with a move to Welsh Patient | Head of Clinical Innovation & Strategy MHLD Sara Rees / Kay Isaacs | Dec-22 | N/A | External | 4/12/2020 update requested, response received: WPAS migration has been completed however some issues between the interfaces of the systems are being ironed out. 19/02/2021 This recommendation is partially completed by the HB. The HB has agreed with the Delivery Unit to deliver a presentation on any outstanding actions. Outlining the thematic actions that are considered unachievable. (Outside of gift of the HB). |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | HDUHB will ensure there is an up to date Transition Policy in place for transition from 5-CAMHS to AMHS | 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 |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | This Policy will be formally ratified by the Written Policy Control Group and reviewed by the multi disciplinary group every 3 years or when national policy indicates. | Angela Lodwick | Dec-19 | Dec-20 Mar-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 |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | Transition workshop/s will be held across both services to provide training & awareness on transition and disseminate good practice including the Welsh Governments documents: -HDUHB Transition Policy /pathway -TACYP Good Transition Guidance for CAMHS | Angela Lodwick | Dec-19 | Dec-20 Mar-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. |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | HDUHB will develop a multiagency Transition Steering Group which will provide oversight and effective governance on transition | Angela Lodwick | Aug-19 | Dec-20 Mar-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. |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | The Steering Group will have clear Terms of Reference which include the following: - Monitor implementation of the Transition Policy - Review of the data on all transitions 6 monthly - Coordinate training on Transition & pathways | Angela Lodwick Senior Nurse QAPD Team | Aug-19 | Dec-20 Mar-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. |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | HDUHB will implement the Young Persons Passport to increase awareness of transition, increase their participation in the transition process and provide support. | 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. |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_27 | N/A | Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible. | A transition referral will be completed to formalise the handover of care as per Transition Policy. | 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. 22/6/2021 Action is on track and included in Transition Policy (6 months pre 18 birthday). |
| 19009 | Sep-19 | HIW MHL | St Caradog Ward & St Non Ward, Canolfan Bro Cerwyn WGH 10-12 June 2019 | Open (external rec) | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Neil Mason / Kay Isaacs | Director of Operations | 19009_007 | N/A | The Health Board must ensure that their policy/s on the interface between DoLS and MHA is compliant in law to ensure it does not diverge from the principle in law | Following reviews of current legislation, interface guidance between DoLS and MHA will be developed and draft will be sent to HB legal department for review prior to ratification. | Neil Mason/ Kay Isaacs | Jul-20 | Apr-22 | External | 22/10/2020 response received Head of AMH to request information from Sarah Roberts Administration Manager, as whilst new legislation not due we can use what is current. Internal DoLS policy currently being used until new legislation in April 2022. 4/12/2020 Recommendation outside gift of Health Board until new legislation is in place. |
| HIW_HAHSMNYO2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Sara Rees / Angela Lodwick | Director of Operations | HIW_HAHSMNYO2019_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. | Colleagues in adult mental health services will be provided with training to understand the developmental needs of young people and their families in accessing mental health services and the need for a individual systemic approach for some young people in accessing services. | 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. |
| 20136 | Apr-21 | HIW MHL | Quality Check: Morlais Ward, GGH | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Kay Isaacs | Director of Operations | 20136_001a | High | The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced | Morlais is classified within C4C as significant. The most recent audit was undertaken on the 25th February 2021. A detailed action plan is being compiled to identify the extent of repairs required and to establish a target cost, funding source and an achievable timescale for completion. The initial analysis will be undertaken by May 2021 with subsequent action (subject to funding approval) phased in following the bid and approval process. In the event capital funding is available the work will be completed by the end of the 2021/22 financial year. | Natasha Mitchell/Operations Manager and Assistant Operations Manager | May-21 | May-21 Nov-21 | Red | 19/05/2021 Operations Manager Confirmed: We commenced the redecoration work in the area on the 11/04/21, this work is due for completion on the 18/07/21. The bathroom refits required capital funding, which was approved last week 11/05/21 (Completed) Capital funding approved. We are in the process of completing a multi-quote to appoint a contractor for this element of the work. This type of sanitary wear tends to have a significant lead to delivery date, so we have allowed 8 weeks. Anticipated commencement on site 16th August 21 - completion 15th November 21. |
| 20136 | Apr-21 | HIW MHL | Quality Check: Morlais Ward, GGH | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Kay Isaacs | Director of Operations | 20136_001b | High | The health board must review the C4C audit and ensure any outstanding actions are completed and evidenced | Outside of this specific challenge within Morlais, The Estates team are phasing in a new Synbiotics system (already in place in other Health Boards) that will allow real time data, reaction and improvements in efficiency in cleaning standards. This system is being phased in throughout the 2021/22 financial year. | Operations Manager and Assistant Operations Manager | Mar-22 | Mar-22 | 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 MHL | Quality Check: Morlais Ward, GGH | Open | N/A | Mental Health & Learning Disabilities | Estates | Kay Isaacs | 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. | As a result of the Covid-19 pandemic, all face to face L2 fire safety training has been suspended until further notice. This position is being reviewed regularly as to when L2 face to face sessions can resume. | Director of Estates, Facilities and Capital Management | N/A | N/A | 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 MHL | Quality Check: Morlais Ward, GGH | Open | N/A | Mental Health & Learning Disabilities | Mental Health & Learning Disabilities | Kay Isaacs | 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 | The results of the review/analysis will be presented to the ward manager forum, this can then be captured in the chairs report to the MH/LD QSEG. | Natasha Mitchell | 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. |
| How are healthcare services meeting the needs of young people? Thematic Review 2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Mental Health & Learning Disabilities | 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. | There are transition pathways in place for a number of specific conditions. There are learning disability liaison nurses and there is information on supporting reasonable adjustments. By December 2020, the Health Board will be undertaking a comprehensive assessment of all Health Board CYP services to identify areas of improvement which will include reviewing transition arrangements and communication with adult services. | 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. |
| How are healthcare services meeting the needs of young people? Thematic Review 2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Women and Children's Services | 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. | Transition pathway in place for those CYP who have a continuing care package. Well-child Transitional Care nurse in post, application to a charity of a Transitional Epilepsy Specialist Nurse. | 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. |
| How are healthcare services meeting the needs of young people? Thematic Review 2019 | Mar-19 | HIW MHL | How are healthcare services meeting the needs of young people? Thematic Review 2019 | Open | N/A | Women and Children's Services | 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. | Transition pathway in place for those CYP who have a continuing care package. Well-child Transitional Care nurse in post, application to a charity of a Transitional Epilepsy Specialist Nurse. | 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. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-schedule) | Progress update/Reason overdue |
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| HDUHB-1920-05 | Oct-19 | Internal Audit - HDUHB | Welsh Language Standards Implementation | Open (external rec) | Reasonable | CEOs Office (Welsh Language) | CEOs Office (Welsh Language) | Enfys Williams | CEO | HDUHB-1920-05_001 | Low | R1. Management should consider introducing a Welsh Language Standards e-learning module as part of the ESR training programme to ensure staff and managers understand their roles and responsibilities in line with the Standards. | The Welsh Language Services Team has contributed to a national piece of work being co-ordinated by Betsi Cadwaladr UHB and Shared Services, in the Once for Wales spirit of partnership, and the outcome is an e-learning resource. Timescale for this is currently unknown, but we plan to roll out once launched. In the meantime, we are targeting focused training and awareness and cascading through key teams. | Enfys Williams | Oct-19 | Oct-20 Apr-21 N/K | External | 21/10/2020 update-Work is on-going at an All-Wales level to produce an e-learning module for all Health Boards. This has been delayed due to Covid-19, but the group plans to launch the new e-learning model in April 2021. It is anticipated that face-to-face corporate induction sessions will recommence within the next month (November 2020). Revised date of April 2021 provided. 28/01/2021 update-Work is progressing at an All-Wales level, with Hywel Dda UHB input, to produce an e-learning module for all Health Boards in Wales. This has been delayed due to Covid-19, but the group is on track to launch the new e-learning module in April 2021. |
| HDUHB1819-33 | Feb-19 | Internal Audit - HDUHB | Records Management | Open | Limited | Digital and Performance | 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. | Following internal discussions, the Corporate Office is leading the review and updating of the Corporate Records Management Strategy and Policy. This will require contributions and input from a number of teams across the UHB. Once reviewed, these will be submitted to the Business Planning & Performance Assurance Committee at the earliest opportunity. | Head of Information Governance | Sep-19 | Sep-20 Jan-21 Mar-21 Apr-21 Jun-21 Aug-21 | Red | 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. 30/06/2021 - Policy now being reported to IGSC in August 2021. 28/07/2021 - This work has been undertaken by Information Governance in collaboration with the Corporate team and the |
| HDUHB_1920_40 | Mar-20 | Internal Audit - HDUHB | IM&T Assurance – Follow Up | Open | Reasonable | Digital and Performance | Digital and Performance | Anthony Tracey / Sarah Brain | Director of Finance | HDUHB_1920_40_003 | Medium | R3. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to. | The business manager was able to supply a paper which was produced for the Executive Team in June 2019, this paper evidences that work is underway to address the non-compliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence | Assistant Director of Informatics | May-19 | May-21 Aug-21 Oct-21 | Red | 18/03/2021 - There is currently still some work 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 |
| HDUHB-2021-22 | Apr-21 | Internal Audit - HDUHB | Digital Modelling (EDAPT) | Open | Substantial | Digital and Performance | 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. | Agree – further investigations will be undertaken to establish how to commence the assignment of intellectual property of the model to Hywel Dda Health Board. | Assistant Director of Digital Services | Jul-21 | Jul-21 Sep-21 | Red | 11/05/2021 - Digital Business Manager confirmed recs are on track. 30/06/2021 - establishing guidance on how to progress with this, Assistant Director of Digital Services currently obtaining advice. 28/07/2021 - The Health Analytics Team are currently working through an IP rights document and considering the best model for IP protection. An example is that some IP models would require us outsourcing the IP management to Universities. Technically, anything developed on Health Board time is automatically the property of Hywel Dda, in which case the ownership |
| HDUHB-2021-22 | Apr-21 | Internal Audit - HDUHB | Digital Modelling (EDAPT) | Open | Substantial | Digital and Performance | 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). | Agree – the storage of programme / SQL code is an area which needs further discussion. A number of wiki sites have been created with the use of Microsoft 365, however this does not provide version control. The Digital Team with examine GitHub to ascertain whether it is suitable for the on-going development of programme coding. | Assistant Director of Digital Services | Sep-21 | Sep-21 | Amber | 11/05/2021 - Digital Business Manager confirmed recs are on track. 30/06/2021 - on track. 28/07/2021 - The Health Analytics Team have now introduced information sharing meetings within the Team to share the knowledge and technical issues. For example, an additional two members of the team have been trained in Python and Simulation. The Team have also set up a prototype GitHub, but we are discussing as a Digital Team whether this process if the most suitable for the Health Board. The Team are examining whether a basic SharePoint site, utilising Office 365 would be |
| HDUHB-2021-22 | Apr-21 | Internal Audit - HDUHB | Digital Modelling (EDAPT) | Open | Substantial | Digital and Performance | 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. | Agree – plans are advanced in making the changes noted above. | Assistant Director of Digital Services | Jun-21 | Jun-21 Aug-21 | Red | 30/06/2021-Digital Business Manager to send evidence to Internal Audit to close this down. 28/07/2021 - The change policy is currently being finalised. Recommend to extend the deadline until August 2021 to allow for approval of change process |
| HDUHB-2021-22 | Apr-21 | Internal Audit - HDUHB | Digital Modelling (EDAPT) | Open | Substantial | Digital and Performance | 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 | Agree – The Health Analytics Team will work with the Information Governance Team to undertake a retrospective Data Protection Impact Assessment (DPIA) to be presented to the Information Governance Sub-Committee (IGSC). | Assistant Director of Digital Services | Aug-21 | Aug-21 Sep-21 | Red | 11/05/2021 - Digital Business Manager confirmed recs are on track. 30/06/2021-Digital Business Manager to send evidence to Internal Audit to close this down. 28/07/2021 - The work associated with the development of the retrospective Data Protection Impact Assessment (DPIA) has not started. Recommend to extend the deadline until September 2021 |
| HDUHB-2021-20 | Nov-20 | Internal Audit - HDUHB | IM&T Control and Risk Assessment | Open | N/A | Digital and Performance | 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. | The Health Board has committed to use the industry standard HIMSS (Healthcare Information and Management Systems Society, along with a number of other tools to assess the wider organisations digital maturity. We will commission an independent review to assess our maturity against the HIMSS standard within the next year. This is further explored in the new "Our Digital Response – 2020-2025", which outlines an ambitious path where we | 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. 30/06/2021 - Assistant Director of Digital Services leading this work with Head of Systems and Informatics Projects, will be going out to procurement. Hopeful December 2021 date will be met. 28/07/2021 - The Digital Team have begun to undertake an internal assessment based on the Healthcare Information and |
| HDUHB-2021-20 | Nov-20 | Internal Audit - HDUHB | IM&T Control and Risk Assessment | Open | N/A | Digital and Performance | 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 | Agreed – The combined risk register for digital will be considered at required groups with the necessary reporting. | Anthony Tracey, Assistant Director of Digital Services | Dec-20 | Dec-20 Feb-21 May-21 Jul-21 | Red | 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. 30/06/2021 - Revised governance structure TORs is with DDF for approval. Once agreed this recommendation will go through |
| HDUHB-2021-20 | Nov-20 | Internal Audit - HDUHB | IM&T Control and Risk Assessment | Open | N/A | Digital and Performance | 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. | Agreed. The national cyber security training is currently optional, and is not part of mandatory training. Hywel Dda University Health Board has requested that this be reconsidered due to the importance of cyber security training. However, as part of the Health Board response to Cyber Security, the Information Governance Sub-Committee (IGSC) will be presented with a number of options on how this will be communicated across the Health Board in order to leverage | Anthony Tracey, Assistant Director of Digital Services | Feb-21 | Feb-21 Oct-21 | Red | 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. 30/06/2021-Request sent to Workforce&OD to make this mandatory but issue with licensing resulting in not looking to |
| HDUHB-2021-20 | Nov-20 | Internal Audit - HDUHB | IM&T Control and Risk Assessment | Open | N/A | Digital and Performance | 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. | Agreed – The completion of this recommendation is dependent on the appointment of the specific Cyber Security resource. Once appointed then they will utilise the national product (Nessus) to undertake a full vulnerability scan of the Health Board. | Anthony Tracey, Assistant Director of Digital Services | Aug-21 | Aug-21 Oct-21 | Red | 11/05/2021-New Cyber Security Senior Specialist will be writing a paper on this to IGSC in June 2021. 30/06/2021 - Paper to IGSC in June 2021 by the new Cyber Security Senior Specialist with forward planning included. Paper to be sent to Internal Audit for confirmation if this can now be closed. 28/07/2021 - Following the appointment of the Cyber Security Senior Specialist, our first set of scans was undertaken w/c 19th July 2021 and the Digital Team is in the process of reviewing the results. Following further tests scheduled for the coming months a full report will be provided to IGSC, however one should note that the vulnerability tests will be scheduled to run |
| HDUHB-2021-20 | Nov-20 | Internal Audit - HDUHB | IM&T Control and Risk Assessment | Open | N/A | Digital and Performance | 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. | Agreed – The incident process will be reviewed, and modified 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 Sep-21 | Red | 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. 30/06/2021 - Head of Digital Operations looking into this, still on track to complete by August 2021. 28/07/2021 - This will be completed as part of the implementation of our new Service Desk system, we envisage this being available in September 2021 |
| HDUHB-2021-22 | Nov-20 | Internal Audit - HDUHB | WCCIS Project (Ceredigion Locality) | Open | Reasonable | Digital and Performance | 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 | Agreed. Following the successful pilot within Ceredigion County a benefits tracker has been developed, which brings together the project benefits, proposed financial savings which will also encompass a risk stratification of the benefits and savings. The Benefits Tracker will be presented as part of the revised Business Case. | Anthony Tracey, Assistant Director of Digital Services | Jun-21 | Jun-21 Aug-21 | Red | 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. 30/06/2021 - Digital Business Manager to share evidence with Internal Audit to close off this recommendation. 28/07/2021 - Benefits trackers for each workstream are being developed along with the consolidated programme benefits tracker. Re-development of the full WCCIS business case is being undertaken and will include the updated, consolidated programme benefits. Further work is needed to include and align with DHCW work on WCCIS benefits which has |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_001 | N/A | R1. The project execution plan (PEP) applied at UHB projects should be reviewed by the Project Director and Project Board at individual schemes to ensure that the change control arrangements/guidance is adequately defined. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Project Director | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021 - Discretionary Capital Projects Manager confirmed this recommendation sits with the Project Director. Assurance and Risk Officer to establish contact for timescales and updates. 30/06/2021-Assurance and Risk Officer emailed Project Director for timescales and current position of recommendation. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_002 | N/A | R2. The practice of batching unassociated items of amendment within Architects Instructions/ Progress - Cost Variation Approval forms should be discontinued. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Discretionary Capital Projects Manager | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021 - Discretionary Capital Projects Manager confirmed this would apply to future projects as this was a lessons learnt exercise – final audit report was issued on 26th May 2021. Design team have been fully briefed and action would be deemed complete. This action would apply to all projects approved for 2021/22 Financial Year. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_003 | N/A | R3. Verbal Instructions should be minimised and firmed up immediately via formal Architects Instructions. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Discretionary Capital Projects Manager | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021 - Discretionary Capital Projects Manager confirmed this would apply to future projects as this was a lessons learnt exercise – final audit report was issued on 26th May 2021. Design team have been fully briefed and action would be deemed complete. This action would apply to all projects approved for 2021/22 Financial Year. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_004 | N/A | R4. Variations to the contract should be issued on a timely basis e.g. prior to the progression of the works and only when time/cost implications are fully determined | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Discretionary Capital Projects Manager | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021 - Discretionary Capital Projects Manager confirmed this would apply to future projects as this was a lessons learnt exercise – final audit report was issued on 26th May 2021. Design team have been fully briefed and action would be deemed complete. This action would apply to all projects approved for 2021/22 Financial Year. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_005 | N/A | R5. The delegated approval limits applied at UHB projects should be defined by the Project Director and Project Board at individual schemes. It is important that these are assessed on a project by project basis and agreed subject to the contract conditions and anticipated approval requirements. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Project Director | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021 - Discretionary Capital Projects Manager confirmed this recommendation sits with the Project Director. Assurance and Risk Officer to establish contact for timescales and updates. 30/06/2021-Assurance and Risk Officer emailed Project Director for timescales and current position of recommendation. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-schedule) | Progress update/Reason overdue |
|------------------|----------------|------------------------|--|------------------|-----------------------|--------------|-----------------------------|--------------------------------------|---|--------------------------|----------------|---|---|---|--------------------------|-------------------------|---|---|
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_006 | N/A | R6. Delegated approval limits should be fully complied with at future projects. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Project Director | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021: Discretionary Capital Projects Manager confirmed this recommendation sits with the Project Director. Assurance and Risk Officer to establish contact for timescales and updates. 30/06/2021: Assurance and Risk Officer emailed Project Director for timescales and current position of recommendation. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_008 | N/A | R8. Quantity Surveyors reports should be subject to regular scrutiny and discussion at project progress meetings. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Discretionary Capital Projects Manager | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021: Discretionary Capital Projects Manager confirmed this would apply to future projects as this was a lessons learnt exercise - final audit report was issued on 26th May 2021. Design team have been fully briefed and action would be deemed complete. This action would apply to all projects approved for 2021/22 Financial Year. |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_009 | N/A | R9. Project Highlight reports should be submitted to all CEIM&T meetings | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Discretionary Capital Projects Manager | Jul-21 | Jul-21 | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 10/06/2021: email sent to Discretionary Capital Projects Manager requesting timescales for Estates recommendations, and confirmation of Project Director to establish contact for timescales and updates. 11/06/2021: Discretionary Capital Projects Manager confirmed the Capital team, finance and planning copied into to all |
| SSU-HDU-2021-02 | May-21 | Internal Audit - HDUHB | Withybush General Hospital Wards 9 & 10 Lessons Learnt | Open | N/A - Advisory Review | Estates | Estates | Rob Elliott / Lee Davies / Jo Wilson | Director of Operations | SSU-HDU-2021-02_011 | N/A | R11. The post-project evaluation exercise for this scheme should be completed as a priority (led by the Project Director), incorporating a detailed review of the issues adversely impacting on the successful delivery of this project, including time, cost and quality issues alongside benefits realisation and end user satisfaction. | The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project. | Project Director | N/K | N/K | Amber | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 11/06/2021: Discretionary Capital Projects Manager confirmed this recommendation sits with the Project Director. Assurance and Risk Officer to establish contact for timescales and updates. 30/06/2021: Assurance and Risk Officer emailed Project Director for timescales and current position of recommendation. |
| HDUHB-1718-34 | Feb-18 | Internal Audit - HDUHB | National Standards for Cleaning in NHS Wales | Open | Reasonable | Estates | Estates | Rob Elliott | Director of Operations | HDUHB-1718-34_001 | High | R4 + CAC audit methods and practices should be actioned by all Domestic Supervisors to ensure CAC 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 opportunity to address any non-consistency in audits and reduce any | Inspecting CAC Audits across the Health Board in order to ensure that consistency is appropriately applied. Due to the imminent release of the new MICAD System and CAC upgrade along with the revised National Cleaning Standards for Wales 2009, planned for April 2018, all domestic supervisors will be retained which will present an opportunity to address any non-consistency in audits and reduce any | | Jun-18 | Mar-22 | Red | 09/06/2021: Noted in the body of the report that: A number of the reporting issues identified from this review have been addressed through the enhanced reporting mechanisms implemented by the estates team since April 2020, resulting in improved monitoring, reporting and project governance arrangements. 10/06/2021: email sent to Discretionary Capital Projects Manager requesting timescales for Estates recommendations, and confirmation of Project Director to establish contact for timescales and updates. 11/06/2021: Discretionary Capital Projects Manager confirmed the Capital team, finance and planning copied into to all 04/12/2020: Still awaiting updated system, recommendation outside gift of UHB to implement. |
| HDUHB-2021-10 | May-21 | Internal Audit - HDUHB | Brexit Risks and Actions Advisory Review Final Report | Open | N/A - Advisory Review | Finance | Public Health | 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 | Open | N/A - Advisory Review | Finance | Public Health | 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 | Open | N/A - Advisory Review | Finance | Public Health | 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 | Open | N/A - Advisory Review | Finance | Public Health | 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 |
| HDUHB2021-11 | Sep-20 | Internal Audit - HDUHB | Governance Arrangement during the Covid-19 Pandemic | Open | Advisory | Governance | Governance | N/A | Board Secretary | HDUHB2021-11_001 | High | PRIORITY REC 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. | Management response not included in the report, following update provided in TOA from December 2020 Audit Committee: The Board and Committee Standard Operating Procedure will include an appendix detailing the governance response to an emergency situation such as a pandemic or winter pressures which will include areas such as an assessment of committee meetings and frequencies that need to continue, and ensures the focus is on | Board Secretary | N/K | Aug-21 | Amber | 25/05/2021 - Audit tracker will be updated once update has been reported to ARAC. The Board and Committee Standard Operating Procedure will include an appendix detailing the governance response to an emergency situation such as a pandemic or winter pressures which will include areas such as an assessment of committee meetings and frequencies that need to continue, and ensures the focus is on patient quality and safety. 26/07/2021 - update received from Alison Gittins: The SOP is currently out for consultation, and is due for approval at the forthcoming SODOC meeting on 26th August. |
| HDUHB2021-11 | Sep-20 | Internal Audit - HDUHB | Governance Arrangement during the Covid-19 Pandemic | Open | N/A - Advisory Review | Governance | Finance | 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. | Not included in report, following update provided in TOA from December 2020 Audit Committee: | Director of Finance | 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 | Open | N/A - Advisory Review | Governance | Workforce & OD | N/A | Board Secretary | HDUHB2021-11_009 | N/A | Assess learning from the recruitment process to establish if that can enhance the efficiency of the routine process for the future. | Not included in report, following update provided in TOA from December 2020 Audit Committee: | Director of Workforce and OD | 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 | Open | N/A - Advisory Review | Governance | Workforce & OD | N/A | Board Secretary | HDUHB2021-11_010 | N/A | Ensure there is a fully updated record of staff movement / redeployments. | Not included in report, following update provided in TOA from December 2020 Audit Committee: | Director of Workforce and OD | 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 | Open | N/A - Advisory Review | Governance | Finance | N/A | Board Secretary | HDUHB2021-11_011 | N/A | Updating policy to include the expenditure of grant funds and the receipt and handling of donated assets (highlighted in separate Internal Audit Report). | Not included in report, following update provided in TOA from December 2020 Audit Committee: | Director of Finance | 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 | Open | N/A - Advisory Review | Governance | Workforce & OD | 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. | Not included in report, following update provided in TOA from December 2020 Audit Committee: | Director of Workforce and OD | N/K | N/K | Amber | 25/05/2021 - Audit tracker will be updated once update has been reported to ARAC. |
| HDUHB-1920-04 | Jun-20 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | The Health & Safety Team will develop a model of introducing 'H&S Champions / Co-ordinators' into several departments during 2020/21. H&S Co-ordinator model currently being developed with the aim to submit the proposal to the H&SA Committee August 2020. The champions will co-ordinate and implement local H&S arrangements and | 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). |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | The amendments will be made to the Health and Safety Policy and submitted to the Health and Safety Assurance Committee for approval following the necessary consultation. | 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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 | A standardised agenda for directorate level quality assurance meetings has been provided to all directorates with Health and Safety as a core heading. Use of the standardised template agenda will be reinforced by the Director of | 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | A formal audit programme shall be devised and presented to the Health and 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | The development of KPIs forms part of the current work towards satisfying the requirements of the HSE. | 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | A standardised agenda which includes Health and Safety has been issued to all services as part of the revision of quality governance and assurance arrangements. The Health of Health, Safety & Security will work with the chair | 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and 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. | The Health of Health, Safety & Security will remind the Chair of each directorate level quality governance meeting to provide exception reports for consideration at HSAC meetings as appropriate. | 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. 06/07/2021 - Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on schedule) | Progress update/Reason overdue |
|--------------------|----------------|------------------------|---|------------------|------------------|-------------------------|-----------------------------|---|---|--------------------------|----------------|---|--|--|--------------------------|-----------------------------|--|---|
| HDUHB-2021-01 | Apr-21 | Internal Audit - HDUHB | Health & Safety | Open | Reasonable | Nursing | Nursing (Health and Safety) | Stan 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. | Training figures will be collated at agreed timescales and reported to the directorate/service quality and safety meetings and the Health & Safety Assurance Committee. | 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 bi-monthly service email in early July 2021. 06/07/2021: Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-1920-10 | Jun-20 | Internal Audit - HDUHB | Business Continuity | Open | Reasonable | Public Health | 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. | The Policy will be amended to reflect that training for BCM and associated TNA and record keeping has been replaced with hands-on support, guidance and instruction by the Emergency Planning Team to individual(s) responsible for creating the BC Plan for each department. | Claire Conroy | Nov-20 | Jun-21 Dec-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. 21/05/2021 Requested update of outstanding recommendations, no response. Escalated to Director of PH with request for update by 11 June 2021. Awaiting response. 08/07/2021 BCP policy is being reviewed to include the addition required, discussions underway with the Policy Co-ordination Officer, will likely to be completed December 2021. |
| HDUHB-1920-10 | Jun-20 | Internal Audit - HDUHB | Business Continuity | Open | Reasonable | Public Health | 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 | A review of the Health Board's Business Continuity Planning Policy was postponed earlier this year due to the Coronavirus outbreak. As we are still in response mode to this crisis, we agree to review the policy as it stands as an interim measure. The reviewing of this Policy was intentionally paused in the New Year following learning taken from the extreme pressures and sustained periods of escalation of the urgent care system, particularly during December 2019. It was proposed that we would develop a Business Continuity Framework | Claire Conroy | Nov-20 | Jun-21 Dec-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. 21/05/2021 Requested update of outstanding recommendations, no response. Escalated to Director of PH with request for update by 11 June 2021. Awaiting response. |
| HDUHB-1920-10 | Jun-20 | Internal Audit - HDUHB | Business Continuity | Open | Reasonable | Public Health | 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. | All Departmental Business Continuity plans to be shared, managed and reviewed through departmental shared drives. This new process will be reflected in the Policy. In addition, model BCM plans will be placed on the intranet as examples of good practice for guidance purposes. | Claire Conroy | Nov-20 | Jun-21 Jul-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. 21/05/2021 Requested update of outstanding recommendations, no response. Escalated to Director of PH with request for update by 11 June 2021. Awaiting response. |
| HDUHB 1819-32 | Oct-19 | Internal Audit - HDUHB | Radiology Directorate | Open | Reasonable | Radiology | 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. | As per previous response, the on call arrangements are historic with the reasoning for this being the need to sustain out of hours services with the levels of staff available. However it is noted key staff are often away from the department on rest days and this is acknowledged as a significant issue with efficiency. Compensatory rest days count towards the basic hours with the current on call arrangements and as per previous response the system is to be reviewed with the task and finish group and staff consultation. | | 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 |
| HDUHB-2021-09 | May-21 | Internal Audit - SSU | Local Deployment of the Welsh Immunisation System (WIS) | Open | Reasonable | Digital and Performance | Digital and Performance | Assistant Director of Informatics | Director of Finance | HDUHB-2021-09_001 | Medium | Management should ensure the completion of a post-implementation review of local arrangements is undertaken | Agree – The Digital Team will work with Digital Health and Care Wales (DHCW) to develop a lessons learned document to be taken through the Health Board assurance and governance process | Assistant Director of Digital Services | Jun-21 | Jun-21 Sep-21 | Red | 28/07/2021 - DHCW have yet to finalise their review and lessons learned report and the Health Boards are anticipating a draft in September 2021 for comment. |
| HDUHB-2021-09 | May-21 | Internal Audit - SSU | Local Deployment of the Welsh Immunisation System (WIS) | Open | Reasonable | Digital and Performance | Digital and Performance | Assistant Director of Informatics | Director of Finance | HDUHB-2021-09_002 | Medium | Management should consider developing a governance framework with metrics to review WIS data within the Health Board and Primary Care for completeness, consistency, accuracy, validity and timeliness to enable confidence in data reliability. | Agree – The Welsh Immunisation System (WIS) will be incorporated into the Health Board data quality framework, and will form part of the data quality reporting to the Information Governance Sub-Committee (IGSC) | Assistant Director of Digital Services | Dec-21 | Dec-21 | Amber | 28/07/2021 - Ongoing |
| HDUHB-2021-09 | May-21 | Internal Audit - SSU | Local Deployment of the Welsh Immunisation System (WIS) | Open | Reasonable | Digital and Performance | Digital and Performance | Assistant Director of Informatics | Director of Finance | HDUHB-2021-09_006 | Low | Management should ensure all remaining records are amended in a timely manner as an accurate reflection of the patient consultation. | Agree – The Data Quality Team under the auspices of the Head of Information Services are addressing the remaining records. | Assistant Director of Digital Services | Aug-21 | Aug-21 | Amber | 28/07/2021 - Ongoing and on track to complete by the end of August 2021 |
| SSU_HDU_1920_01.02 | Feb-21 | Internal Audit - SSU | Estates Assurance Follow Up | Open | Substantial | Estates | Estates | Rob Elliott / Simon Chiff / 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). | Partially implemented Management advised that there has been no progress reported from Finance to identify where the SIFT funding for accommodation is placed on a recurring basis on the Bronglais, Prince Philip and Glangwill sites. Subsequently, no progress has been made on moving the SIFT monies centrally to Medical Education. | 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. 08/07/2021- SBAR paper to be written to CEIMTSC to advise of the impact to the DCP. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red- behind schedule, Amber- on schedule, Green- on track) | Progress update/Reason overdue |
|------------------------|----------------|----------------------|---|------------------|------------------|--|--|---|--|----------------------------|-----------------------|--|--|---|--------------------------|-------------------------|--|--|
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | Strategic Development and Operational Planning | 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. | Agreed | Assistant Director of Strategic Planning | 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. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. 02/07/2021- Recommendation owner changed to Assistant Director of Strategic Planning following discussion with Internal Audit. |
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | Estates | Rob Elliott | Director of Operations | SSU-HDU-2021-08_002 | Medium | R2. The PBCs and as they progress to Outline and Full business case stages will need to determine the in-house Estates staff requirements, and how these will be satisfied given current pressures. | Agreed. The Health Board will need to determine how the necessary Estate in-house staff resources is established in order to successfully deliver the AHMWW and Business Continuity/Major Infrastructure PBCs. | Assistant Director of Strategic Planning / Director of Estates, Facilities & Capital Management | Feb-21 | Feb-21 | External | 13/01/2021- Director of Estates, Facilities and Capital Management confirmed timescale of February 2021. 04/03/2021- Director of Estates, Facilities and Capital Management confirmed once WG endorse the UHB will then determine the Estate staff requirements. PBC isn't through scrutiny process yet. This recommendation is linked to the approval of the PBCs which hasn't yet taken place. Assurance & Risk Officer to discuss with Internal Audit. 24/03/2021- Internal Audit confirmed this recommendation is currently outside the gift of the UHB to implement until the PBC is signed. Recommendation changed to "External" on the audit tracker. Director of Estates, Facilities and Capital Management confirmed. |
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | Estates | Rob Elliott | Director of Operations | SSU-HDU-2021-08_003 | Medium | R3. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Urgent but un-related works arising subsequently in the same time frame. | Agreed. It is recognised that such works will arise and will additionally need funding in the same time horizon as the discretely funded works of each business case. This will be taken into account at detailed design stages of BICs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC. | 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. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. |
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | Estates | Rob Elliott | Director of Operations | SSU-HDU-2021-08_004 | Low | R4. Call-off business cases (from the "Business Continuity/Major Infrastructure - Programme Business Case") will be co-ordinated with and discretely provide for Co-located issues (known, or discovered following invasive works). | Agreed. It is recognised that such works will arise and will additionally need funding in the same time horizon as the discretely funded works of each business case. This will be taken into account at detailed design stages of BICs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC. | 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. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation. |
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | 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. | Agreed. We will review an appropriate range of reporting, including appropriate analysis of 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 & 10/06/2021- on track for October 2021 at present. |
| SSU-HDU-2021-08 | Dec-20 | Internal Audit - SSU | Backlog Maintenance | Open | Reasonable | Estates | 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. | Agreed. This will be re-reviewed in light of the review of reporting requirements (as recommended above). | Head of Property Performance in liaison with the Assistant Head of Operational Performance | Dec-20 | Dec-20 | 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. |
| HDUHB-2021-28 | Jan-21 | Internal Audit - SSU | Quality and Safety Governance | Open | Reasonable | Nursing | 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. | Accepted. A template terms of reference has been developed for adoption by the Directorate. To share the template terms of reference with all directorates and give clear instruction on the expectations for adoption | 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. 06/07/2021- Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-28 | Jan-21 | Internal Audit - SSU | Quality and Safety Governance | Open | Reasonable | Nursing | 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. | Accepted. A template agenda has been developed for use by the Directorate. To share the template agendas with all directorates and give clear instruction on the expectations for adoption | 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. 06/07/2021- Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| HDUHB-2021-28 | Jan-21 | Internal Audit - SSU | Quality and Safety Governance | Open | Reasonable | Nursing | 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. | This good practice by the Scheduled Care Directorate is noted. Risk is included within the template agenda (see management forums for recommendation 2). To share the good practice through a variety of forums across the Health Board, including Acute Bronze meeting and Senior Nurse Management Team. | 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. 06/07/2021- Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. |
| SSU_HDA_192_0_01.1 | Feb-21 | Internal Audit - SSU | Capital Assurance - Follow Up | Open | Reasonable | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams / Rob Elliott / Anthony Tracey / Julian | Director of Strategic Development and Operational Planning | SSU_HDA_192_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. | Superseded: Noting that the Cardigan project is now complete and handed over, a Post Project Evaluation (PPE) should be undertaken to identify lessons learnt (including an assessment of Internal Audit recommendations and their application at future projects). Specifically issues identified at the Cardigan | Head of Capital Planning | May-19 | Jul-21 | Red | 23/02/2021 - as per this new follow up report (follow up of SSU_HDA_192_01_1), 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_192_0_01.1 | Feb-21 | Internal Audit - SSU | Capital Assurance - Follow Up | Open | Reasonable | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams / Rob Elliott / Anthony Tracey / Julian | Director of Strategic Development and Operational Planning | SSU_HDA_192_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: R5: 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.) | Outstanding At the time of issuing this report, the completion of the Front of House scheme was scheduled for June 2020. This is the end of the defects period for the final phase (Theatre Execution IP1). The Project Director will lead the completion of the PPE. The Project Manager will produce a detailed retrospective assessment of the delays to date in accordance with the requirements of the NEC contract (to include cause, time/cost impact and determination of acceptance / rejection of delay etc.) | Project Director | Sep-19 | Mar-21 | Red | 23/02/2021 - as per this new follow up report follow up of SSU_HDA_192_01_1), 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. The project is now on a monthly basis and incorporating into monthly report on an ongoing basis. CEIN&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 |
| SSU-HDU-1920-02 | Jun-20 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development Phase 2 | Open | Reasonable | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams | Director of Strategic Development and Operational Planning | SSU-HDU-1920-02_006 | High | R8: Reporting to the Project Group should be extended to include: * mitigating factors e.g. Compensation Events; * early access to phases * extended programme for individual phases | The Project Manager will produce more detailed reports to the Project Group in future, to include the points listed in the audit report | Project Director | Jul-20 | Aug-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 shown) key project time issues including scope relation to the major Compensation Events were seen to |
| SSU-HDU-1920-02 | Jun-20 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development Phase 2 | Open | Reasonable | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams | Director of Strategic Development and Operational Planning | SSU-HDU-1920-02_008 | 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 | Agreed. A reconciliation of identified / remaining project risks, affirming both the programme and available contingency, has been completed. The outcome was reported to the Project Group on Tuesday 12th May 2020. The risk register will be updated regularly (at least every two months) and at key project stages | Project Director | Jul-20 | Jul-20 | 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 project will be reviewed on a monthly basis and at the project close, on the day of the contract" |
| SSU Capital Governance | Dec-20 | Internal Audit - SSU | Capital Governance Arrangements | Open | Advisory | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams | 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. | Agreed. Existing procedural arrangements will be reviewed and defined as appropriate. | Paul Williams (Planning) | 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 & 09/06/2021- Planning Project Manager update- Review and update on procedures it still being undertaken. Revised completion date July 2021. 09/07/2021- An internal capital governance review being undertaken that will report to the audit committee in Oct-21. Scope of this review will be presented to Aug-21 ARAC. 21/07/2021- Scope will be reviewed once presented to ARAC in August 2021 to establish if the new report will supersede the recommendations contained in this advisory report. |
| SSU Capital Governance | Dec-20 | Internal Audit - SSU | Capital Governance Arrangements | Open | Advisory | Strategic Development and Operational Planning | Strategic Development and Operational Planning | Paul Williams | 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. | Agreed. A procedural review will be undertaken in light of the Audit Wales report. We will also seek to identify and apply best practice arrangements being applied elsewhere. | Paul Williams (Planning) | 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 & 09/06/2021- Planning Project Manager update- Review and update on procedures it still being undertaken. Revised completion date July 2021. 09/07/2021- An internal capital governance review being undertaken that will report to the audit committee in Oct-21. Scope of this review will be presented to Aug-21 ARAC. 21/07/2021- Scope will be reviewed once presented to ARAC in August 2021 to establish if the new report will supersede the |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on schedule) | Progress update/Reason overdue |
|---|----------------|--|--|------------------|------------------|-------------------------------|-------------------------------|--------------------------------|------------------------|----------------------------|----------------|---|-----------------------------------|--|--------------------------------------|--------------------------------------|--|--|
| SSU-HDU-2021-03 | Apr-21 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development | Open | Limited | Women and Children's Services | 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. | Agreed | Lisa Humphrey To request of NWSSP-SES | Jul-21 | Jul-21 | Amber | 16/05/2021 no update. 09/06/2021 in progress. |
| SSU-HDU-2021-03 | Apr-21 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development | Open | Limited | Women and Children's Services | 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. | Agreed | 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 Tibury Douglas. 10/07/2021 Requested new date from Head of Capital Planning |
| SSU-HDU-2021-03 | Apr-21 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development | Open | Limited | Women and Children's Services | 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. | Agreed | 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 10/07/2021 Requested new date from Head of Capital Planning |
| SSU-HDU-2021-03 | Apr-21 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development | Open | Limited | Women and Children's Services | 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 | Agreed | 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 10/07/2021 Requested new date from Head of Capital Planning |
| SSU-HDU-2021-03 | Apr-21 | Internal Audit - SSU | Glangwili Hospital Women & Children's Development | Open | Limited | Women and Children's Services | Women and Children's Services | Lisa Humphrey/Project Director | Director of Operations | SSU-HDU-2021-03_012 | Medium | In exceptional circumstances, extensions of normal contractual time frames for agreeing Compensation Events should be approved by the Project Group, and formally agreed between the parties. | Agreed | 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 now part of the monthly PM report to Project Team and Project Group. Awaiting final confirmation as this was closed last time. HOCP to confirm with Auditors. 14/06/2021 Head of Capital Planning has confirmed that the auditors have requested more info on this one. therefore reopened. until confirmed closed. 10/07/2021 Requested new date from Head of Capital Planning |
| BFS/KS/SJM/0113573-KS/890/05 (Supersedes EN/262/08) | Feb-20 | Mid and West Wales Fire and Rescue Service | Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, Haverfordwest, SA61 2PG KS/890/05 | Open | N/A | Estates | 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 | Full action plan held by Estates. | | 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. 28/01/2021 - Director of Estates, Facilities and Capital Management confirmed the enforcement notice should have been revised by MWWFRS to a timescale of April 2022 to align with the dates verbally agreed with MWWFRS and in the revised Letter of Fire Safety Matters received in January 2021. This recommendation is to remain red until the Enforcement Notice has been revised by the MWWFRS. 03/02/2021 - MWWFRS confirmed that this enforcement notice now runs in line with the agreed completion dates of: Stage 1 Jan 2021 & Stage 2 April 2022. Recommendation turned back to amber. 06/05/2021 - Letter from MWWFRS dated 19/03/2021 - "Further to the conversation on the possibility of the Phase 1 works at |
| BFS/KS/SJM/0114719-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: Worthybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02 | Open | N/A | Estates | 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 Worthybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided. | Full action plan held by Estates. | | Sep-20 Jan-21 | Jan-21 Feb-21 Jun-21 Aug-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 had been fully actioned and therefore re-issued KS890/02, with a 28 day period to fulfill requirements. Report therefore re-opened and recommendation turned from green back to red. 10/06/2021 - CEO letter dated 27/05/2021 to MWWFRS confirming due to procurement and delivery timescales this won't be fully implemented until 20/08/2021. |
| BFS/KS/SJM/0114719-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: Worthybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02 | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Sep-20 Jan-21 | Jan-21 Feb-21 Jun-21 Aug-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 fulfill requirements. Report therefore re-opened and recommendation turned from green back to red. 10/06/2021 - CEO letter dated 27/05/2021 to MWWFRS confirming due to procurement and delivery timescales this won't be fully implemented until 20/08/2021. Awaiting formal response from MWWFRS. |
| BFS/KS/SJM/0114719-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: Worthybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00114719_03_001 | High | R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Worthybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided. | Full action plan held by Estates. | | Aug-21 Dec-21 Apr-22 | Dec-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 Worthybush 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. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red- behind schedule, Amber- on schedule, Green- completed) | Progress update/Reason overdue |
|--|----------------|--|--|------------------|------------------|--------------|--------------------|---------------------|------------------------|---|----------------|--|-----------------------------------|----------------------|----------------------------|--------------------------------------|---|--|
| BFS/KS/SJM/0114719-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: Wyllybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00114719_03_002 | High | R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Wyllybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided. | Full action plan held by Estates. | | Aug-21 Dec-21 Apr-22 | Dec-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 MWFRS 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 MWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Wyllybush 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 MWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWFRS will discuss the extension of the notice at that date. |
| BFS/KS/SJM/0114719-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: Wyllybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/04 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00114719_004 | High | R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Wyllybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided. | Full action plan held by Estates. | | Apr-22 Apr-25 | Dec-24 Apr-25 | Amber | This work is part of the phase 2 WGH Fire Enforcement Programme. 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 MWFRS this notice is extended to 30 April 2022 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/0107739 | 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, Dolgellau Road, Carmarthen SA31 2AF BFS/KS/SJM/00107739 | Open | N/A | Estates | 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) | Full action plan held by Estates. | | Feb-21 Aug-21 | Feb-21 Apr-21 Jun-21 Jul-21 | Amber | 17/12/2020 - On track. Contractors have been engaged. 12/01/2021 - Revised letter from MWFRS 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 MWFRS of August 2021. 09/06/2021 - Assistant Head of Operational Facilities Management update- New tender submitted for HB wide compartmentation works - This is being arranged in July 2021. |
| BFS/KS/SJM/0107739 | 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, Dolgellau Road, Carmarthen SA31 2AF BFS/KS/SJM/00107739 | Open | N/A | Estates | 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 Redfm 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 | Full action plan held by Estates. | | Feb-21 Aug-21 | Feb-21 Mar-21 Jul-21 | Amber | 17/12/2020 - Being delivered, on track for Feb-21. 12/01/2021 - Revised letter from MWFRS 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 MWFRS of August 2021. 09/06/2021 - Assistant Head of Operational Facilities Management update-on track to be completed by the end of July 2021. |
| BFS/KB/SJM/00113573 | 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) BFS/KB/SJM/00113573 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KB/SJM/00113573_001 | High | R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: -- The door leaf or leaves. -- The frame in which the door is hung. -- Hardware essential to the functioning of the door set, 3 x hinges. -- Intumescent seals and smoke sealing devices/Self closure. -- Self-closers to be fitted to all doors and not compromise strips and seals of fire doors. | Full action plan held by Estates. | | Mar-20 Dec-21 Apr-22 | 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 MWFRS 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 MWFRS 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. 06/05/2021 - Letter from MWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Wyllybush 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 MWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWFRS will discuss the extension of the notice at that date. |
| BFS/KB/SJM/00113573 | 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) BFS/KB/SJM/00113573 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KB/SJM/00113573_002 | High | R2. St Nons. Reinstatement the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system. | Full action plan held by Estates. | | Mar-20 Dec-21 Apr-22 | 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 MWFRS 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. |
| BFS/KS/SJM/0175424/00175421/00175428/00175426/00175425 | Jan-20 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Wyllybush General Hospital, Kensington, St Thomas, etc. | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425_001 | High | R1. Compartment - A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. - All Loft hatches are to be fire resisting to a minimum of 30 minutes. - Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other | Full action plan held by Estates. | | 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 MWFRS 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. |
| BFS/KS/SJM/0175424/00175421/00175428/00175426/00175425 | Jan-20 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Wyllybush General Hospital, Kensington, St Thomas, etc. | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425_002 | High | R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: - Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Bombrook) | Full action plan held by Estates. | | 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 MWFRS 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. |
| BFS/KS/SJM/0175424/00175421/00175428/00175426/00175425 | Jan-20 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Wyllybush General Hospital, Kensington, St Thomas, etc. | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425_003 | High | R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape It was noted that there was heat detection in the bedrooms and entrance | Full action plan held by Estates. | | 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 MWFRS 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. |
| 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: Wyllybush General Hospital | Open | N/A | Estates | 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 them on the 02 October 2020). | Full action plan held by Estates. | | Oct-20 Feb-21 Aug-21 | Aug-21 | Amber | 13/11/2020 - Letter dated 05/11/2020 from MWFRS 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. Survey has been submitted to MWFRS for approval of work for GCH enforcement notice. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on schedule) | Progress update/Reason overdue |
|------------------|----------------|--|--|------------------|------------------|--------------|--------------------|---------------------|------------------------|--------------------------|----------------|--|-----------------------------------|----------------------|----------------------------|-----------------------------|--|---|
| KS/890/08 | Nov-20 | Mid and West Wales Fire and Rescue Service | Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | KS/890/08_01 | High | R1 Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Clangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to them on the 02 Oct 2020). | Full action plan held by Estates. | | Oct-20 Feb-21 Jul-22 | Jul-22 | Amber | 13/11/2020- Letter dated 05/11/2020 from MWFRS 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. 17/07/2021- On track for July 2022 completion. |
| KS/890/08 | Nov-20 | Mid and West Wales Fire and Rescue Service | Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | KS/890/08_02 | High | R2 Compartmentation – All Vertical Breaches and / or Penetrations. To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Clangwili Hospital are addressed as agreed in the programme for Phase 1 Works (presented to them on the 02 Oct 2020). | Full action plan held by Estates. | | Oct-20 Feb-21 Jul-22 | Jul-22 | Amber | 13/11/2020- Letter dated 05/11/2020 from MWFRS 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. 17/07/2021- On track for July 2022 completion. |
| KS/890/09 | Nov-20 | Mid and West Wales Fire and Rescue Service | Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | KS/890/09_01 | High | Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartments within Clangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to them on the 02 Oct 2020). | Full action plan held by Estates. | | Oct-20 Feb-21 Aug-24 | Aug-24 | Amber | 13/11/2020- Letter dated 05/11/2020 from MWFRS 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 31/07/2022 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. 17/07/2021- On track for July 2022 completion. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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 2mm. | Full action plan held by Estates. | | Aug-21 | Aug-21 Sept-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation with Sept-21 timescale. 27/07/2021- Target date for completion of this work (subject to survey outcome) mid October 21. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | General/00111720_001 | High | Article 8 Item 2 - Structural Separation: 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Sept-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation with Sept-21 timescale. 27/07/2021- Target date for completion of this work (subject to survey outcome) mid October 21. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 | Amber | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation as complete, Assurance and Risk Officer to clarify if this is correct. 27/07/2021- Agreement reached with MWFRS that restricting access to upper floors will remove any need to fire resisting construction. Formal agreement required from MWFRS before recommendation can be closed. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation with October 2021 timescale. 27/07/2021- Target date for completion of this work (subject to survey outcome) mid October 21. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Timescale not clear from action plan, Assurance and Risk Officer to clarify with Estates team. 27/07/2021- Target date for completion of this work (subject to survey outcome) mid October 2021. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Timescale not clear from action plan, Assurance and Risk Officer to clarify with Estates team. 27/07/2021- Target date for completion of this work mid October 2021. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Sep-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation to be completed by July 2021. 27/07/2021- Target date for completion of this work mid September 2021. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Sep-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Timescale not clear from action plan, Assurance and Risk Officer to clarify with Estates team. 27/07/2021- Action plan shows completed for end of September 2021. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 Oct-21 | Red | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation to be completed by August 2021. 27/07/2021- Action plan shows completion date slipped to October 2021 due to extended delivery dates on specialist equipment. |
| General/0011720 | May-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 | Amber | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Action plan shows recommendation to be completed by July 2021. 27/07/2021- On target to be completed by end of July 2021. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on-schedule) | Progress update/Reason overdue |
|--------------------------|----------------|--|---|------------------|------------------|--------------|--------------------|---------------------|------------------------|------------------------------|----------------|---|-----------------------------------|----------------------|--------------------------|-------------------------|--|---|
| 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 | Open | N/A | Estates | 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. | Full action plan held by Estates. | | Aug-21 | Aug-21 | Amber | 10/06/2021- 2 action plan meetings are taking place and a response to MWFRS will be confirmed in the next couple of weeks. Audit tracker to be updated once response sent and action plan agreed. 01/07/2021- CEO response letter sent 24/06/2021 including action plan for completion of works. Some timescales are longer than the 3 month deadline due to timescales for procurement and delivery of fire doors. Timescale not clear from action plan, Assurance and Risk Officer to clarify with Estates team. 27/07/2021- Exercise to be held to prove timings, this may result in timescale slipping. Update to be requested from service in August 2021. |
| BFS/KS/SJM/0107739 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00107739_001 | High | 1.1 The areas visited in this inspection should be included into the current Compartmentation survey (areas listed at end of schedule) | Full action plan held by Estates. | | Aug-24 | Aug-24 | Amber | 01/07/2021- Letter dated 08/06/2021 from MWFRS states 'To be completed in line with the agreed advanced, first and second phase works as mentioned within the document: Fire Precaution Upgrade Works Glangwili General Hospital, presented to us on the 6th Jan 2021'. Timescale of August 2024 added to tracker as this aligns with Phase 2 works completion date. |
| BFS/KS/SJM/0107739 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00107739_001 | High | 1.2 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. | Full action plan held by Estates. | | Aug-24 | Aug-24 | Amber | 01/07/2021- Letter dated 08/06/2021 from MWFRS states 'To be completed in line with the agreed advanced, first and second phase works as mentioned within the document: Fire Precaution Upgrade Works Glangwili General Hospital, presented to us on the 6th Jan 2021'. Timescale of August 2024 added to tracker as this aligns with Phase 2 works completion date. |
| BFS/KS/SJM/0107739 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00107739_002 | High | 2.3B Ensure that the means of escape is kept free from fire and smoke for a minimum period of 30 minutes by ensuring that: The undercroft by the pharmacy was fully accessible by the public. This area contains plant and other sensitive electrical systems, also items of combustibility which could encourage vandalism or arson to occur. This door should be locked at all material times. | Full action plan held by Estates. | | Jul-21 | Jul-21 | Amber | 01/07/2021- CEO letter response to MWFRS dated 24/06/2021 includes action plan to complete the work. Action plan shows recommendation to be completed by mid July. 27/07/2021- to be completed by end of July 2021. |
| BFS/KS/SJM/0107739 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00107739_003 | High | 3. 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 | Full action plan held by Estates. | | Jul-21 | Jul-21 | Amber | 01/07/2021- CEO letter response to MWFRS dated 24/06/2021 includes action plan to complete the work. Action plan shows recommendation to be completed by end of July. 27/07/2021- on track to be completed end of July 2021. |
| BFS/KS/SJM/0107739 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | BFS/KS/SJM/00107739_005 | High | 5. Ensure that everyone can evacuate quickly and safely by removing the bins from the access room to the plant room within the area of obstetrics department. | Full action plan held by Estates. | | Jul-21 | Jul-21 | Amber | 01/07/2021- CEO letter response to MWFRS dated 24/06/2021 includes action plan to complete the work. Action plan shows recommendation to be completed by end of July. 27/07/2021- on track to be completed end of July 2021. |
| Admin - General/00295247 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00295247_001 | High | 1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00295247 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00295247_001 | High | 1.2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
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| Admin - General/00295247 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00295247_001 | High | 1.4. All self-closing devices are to be regularly inspected and maintained. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
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| Admin - General/00295247 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin-General/00295247_005 | High | Ensure the Emergency Lighting system is properly tested and maintained in accordance with British Standard 5266 part one or the equivalent European standard. • Monthly • Annual Test by competent engineer | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113169 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Dyfl block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin-General/00113169_001 | High | 1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edges and frames are to be no more than 3 mm | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
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| Admin - General/0011 3168 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Hafren block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113168_001 | High | 1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
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| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_001 | High | 1.3. Fire doors should only be kept open by magnetic devices which release when the fire alarm operates. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_001 | High | 1.4. All self-closing devices are to be regularly inspected and maintained. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_001 | High | 1.5. Cupboard doors on the staircases should be kept locked shut. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_002 | High | 2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_002 | High | 2.2. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping, ducts, or cables, are to be sealed or bushed to at least 30-minute standard of fire resistance. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_003 | High | 3.1 The electrical fuse board within the cupboards should be boxed in by 30 minutes fire resistant OR All combustible materials should be removed from the cupboard. | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |
| Admin - General/00113166 | Jun-21 | Mid and West Wales Fire and Rescue Service | Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER | Open | N/A | Estates | Estates | Rob Elliott | Director of Operations | Admin - General/00113166_004 | High | 4.1 Ensure that the Emergency Lighting system is properly tested and maintained in accordance with British Standard 5266 part one or the equivalent European standard. • Monthly • Annual Test by competent engineer | Full action plan held by Estates. | | N/K | N/K | Amber | 01/07/2021- Letter from MWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red-behind schedule, Amber-on schedule, Green-on schedule) | Progress update/Reason overdue |
|---|----------------|----------------------------------|---|---------------------|------------------|---------------------------------------|---------------------------------------|--------------------------|------------------------|---------------------------|----------------|---|--|----------------------|--------------------------|-------------------------|--|---|
| Out of Hours Peer Review 21-22nd October 2019 | Nov-19 | Peer Review | Out of Hours Peer Review 21-22nd October 2019 | Open | N/A | Central Operations (Out of hours) | Central Operations (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. | Outstanding issue since the last peer review leading to inconsistencies and variance in practice and service. Yet to be completed. 1 to 1 meetings between clinical leads and UHB managers taking place to address the issues and the risks involved. Director of Operations is involved in discussions, which will require direction from the Medical Director. | David Richards | Dec-19 | Dec-21 | Red | 09/02/2021- update from new SDM. We have improved border 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 |
| Out of Hours Peer Review 21-22nd October 2019 | Nov-19 | Peer Review | Out of Hours Peer Review 21-22nd October 2019 | Open | N/A | Central Operations (Out of hours) | Central Operations (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. | This is being considered as part of the Executive Team project group. Timescale currently difficult to establish but is being fed into and will be considered as part of the redesign. | David Richards | Mar-20 | Dec-21 | 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 | Open | N/A | Central Operations (Out of hours) | Central Operations (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 | Initial meetings with Assistant Directors of Nursing have taken place. Senior Workforce Development Manager is assisting in mapping out workforce requirements. | David Richards | Dec-19 | Dec-21 | 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 | Open | N/A | Central Operations (Out of hours) | Central Operations (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 | Outstanding issues since the previous review and has not been addressed to the satisfaction of clinical/operational staff in hand- Meeting has been arranged with Assistant Director of Organisation Development on 26/02/2020 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019. | David Richards | Jan-20 | Mar-20 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. |
| Glangwili Neonatal Unit Peer Review Report | Aug-19 | Peer Review | Glangwili Neonatal Unit Peer Review Report | Open | N/A | Women and Children's Services | 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. | Completed training programme in place to support staff to achieve QIS. Due to the nature and length of available neonatal training programmes, the training of a further 6 WTE staff will not be completed until December 2023. Continue efforts to recruit QIS neonatal nurses | 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 |
| Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016 | Nov-16 | Peer Review | Children & Young People Diabetes MDT & Hospital measures for CYP services Peer review August 2016 | Open (external rec) | N/A | Women and Children's Services | Women and Children's Services | Margaret Devonald-Morris | Director of Operations | PeerReview-CYPDiabetes001 | N/A | R1. Absence of a 24 hour on-call advice system | Discuss development of a regional / All Wales 24/7 helpline with other UHBs as a more cost effective alternative to UHB specific arrangements. | Tracey Bucknell | Mar-16 | N/K | External | The new 24/7 system is to be developed and implemented at an All Wales Level. 15/10/2020 Response received. There is currently no progress on this recommendation as it is being taken forward at an All Wales level by the All Wales Network. 04/12/2020 No progress awaiting All Wales response. 27/01/2021 No progress requires an All Wales solution. 07/04/2021 SDM to establish who the links are. 12/07/2021 No progress awaiting an All Wales Network response. |
| 202000482 | Jan-21 | Public Service Ombudsman (Wales) | 16667 | Open | N/A | Mental Health & Learning Disabilities | 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. | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Aug-21 | Aug-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. 07/06/2021- timescale amended to the correct month of August 2021. 29/08/2021-Assistant Director (NQPE) confirmed this is on track for August submission date. |
| 202000482 | Jan-21 | Public Service Ombudsman (Wales) | 16667 | Open | N/A | Mental Health & Learning Disabilities | 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. | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Aug-21 | Aug-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. 07/06/2021- timescale amended to the correct month of August 2021. 29/08/2021-Assistant Director (NQPE) confirmed this is on track for August submission date. |
| 202000482 | Jan-21 | Public Service Ombudsman (Wales) | 16667 | Open | N/A | Mental Health & Learning Disabilities | 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. | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Aug-21 | Aug-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. 07/06/2021- timescale amended to the correct month of August 2021. 29/08/2021-Assistant Director (NQPE) confirmed this is on track for August submission date. |
| 201902007 | Mar-21 | Public Service Ombudsman (Wales) | 12941 | Open | N/A | Mental Health & Learning Disabilities | 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. | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Sep-21 | Sep-21 | Amber | 29/07/2021- Assistant Director (NQPE) confirmed on track to be completed by September 2021. |
| 201902007 | Mar-21 | Public Service Ombudsman (Wales) | 12941 | Open | N/A | Mental Health & Learning Disabilities | 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. | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Sep-21 | Sep-21 | Amber | 29/07/2021- Assistant Director (NQPE) confirmed on track to be completed by September 2021. |
| 201902007 | Mar-21 | Public Service Ombudsman (Wales) | 12941 | Open | N/A | Mental Health & Learning Disabilities | 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 | Action plans held with Ombudsman Liaison Manager. | Kay Isaacs | Sep-21 | Sep-21 | Amber | 29/07/2021- Assistant Director (NQPE) confirmed on track to be completed by September 2021. |

| Reference Number | Date of report | Report issued By | Report Title | Status of report | Assurance Rating | Lead Service | Supporting Service | Responsible Officer | Director | Recommendation Reference | Priority Level | Recommendation | Management Response | Recommendation Owner | Original Completion Date | Revised Completion Date | Status (Red- behind schedule, Amber- on schedule, Green- ahead of schedule) | Progress update/Reason overdue |
|---|----------------|---|---|------------------|------------------|-------------------------------|-------------------------------|---------------------|------------------------|--|----------------|---|---|---|--------------------------|-------------------------|---|---|
| 202003187 | Mar-21 | Public Service Ombudsman (Wales) | 202003187 | Open | N/A | Scheduled Care | 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. | Action plans held with Ombudsman Liaison Manager. | Lydia Davies | Jul-21 | Jul-24 Sep-21 | Red | 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. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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 | Recruit 1.0 WTE Paediatric Diabetes Specialist Nurse (PDSN). | 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. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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 | Recruit 0.4 WTE Dietician | 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. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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. | Explore the development of a Paediatric Specialist post for Diabetes- local program director middle grade | Local Programme Director, Tracey Bucknell | Jun-21 | Jun-21 | Red | 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. 12/07/2021 SDM confirmed this recommendation is under constant review in job planing. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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 dietician 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 dietician and drive forward the dietetic profile. | Recruit 0.4 WTE Dietician | 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. 12/07/2021 Recommendation being led and delivered by Dietetics Service. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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. | Diabetes Team Lead PDSN to be supported by Patient Engagement Team to develop patient engagement and co-production. Patient Engagement Team, (Assistant Director of Engagement) | 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. 09/04/2021 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. 12/07/2021 SDM has emailed for an update. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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. | Recruit 1.0 WTE Paediatric Diabetes Specialist Nurse (PDSN). | Tracey Bucknell & Diabetes Lead | 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 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. 12/07/2021 SDM confirmed interviews taking place week commencing 12/07/2021 |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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. | Recruit 0.4 WTE Dietician | 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. 12/07/2021 Recommendation being led and delivered by Dietetics Service. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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 expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes. | Transition programme suspended due to COVID 19. HB to support all Clinicians across all areas to participate in the Transition programme when re-started. | Paediatric & Adult Clinical | N/K | Dec-21 | Amber | Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 26/05/2021 initial discussions started ongoing. 12/07/2021 SDM confirmed this work is likely to be completed by Dec 2021. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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 expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes. | Transition is more successful by an employed youth worker. Paper to be developed to evidence best practice. | Tracey Bucknell | Aug-21 | Aug-21 | 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 12/07/2021 No further progress at this time. |
| National Diabetes Quality Programme (NDQP)-Peer Review Report | Apr-20 | Royal College of Paediatrics & Child Health (RCFCH) | National Diabetes Quality Programme (NDQP)- Peer Review | Open | N/A | Women and Children's Services | 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. | Explore development of 'e'-learning module with NWS | 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. 12/07/2021 No further progress at this time. |
| RCP 2019 | Sep-20 | Royal College of Physicians | RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report | Open | N/A | Unscheduled Care (BGH) | Unscheduled Care (BGH) | Hazel Davies | Director of Operations | RCP2019_001 | N/A | 1.1 Improve networking and collaboration with other sites and health boards | 1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke. | Hazel Davies | 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. |
| RCP 2019 | Sep-20 | Royal College of Physicians | RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report | Open | N/A | Unscheduled Care (BGH) | Unscheduled Care (BGH) | Hazel Davies | Director of Operations | RCP2019_001 | N/A | 1.2 Improve networking and collaboration with other sites and health boards | Additionally internal cross divisional planning is emergency - particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid. | Exec and Site Senior Team | Mar-21 | Mar-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. |
| RCP 2019 | Sep-20 | Royal College of Physicians | RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report | Open | N/A | Unscheduled Care (BGH) | Unscheduled Care (BGH) | Hazel Davies | Director of Operations | RCP2019_001 | N/A | 1.6 Improve networking and collaboration with other sites and health boards | Virtual systems such as "attend anywhere" - a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of | Hazel Davies | Apr-21 | N/K | 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 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 |
| RCP 2019 | Sep-20 | Royal College of Physicians | RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report | Open | N/A | Unscheduled Care (BGH) | 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 | BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility. | Graham Boswell, Educational Lead | Dec-20 | Dec-20 | 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. 15/07/2021 - request for outstanding recommendations from this report to be moved to Strategic Log to be requested at Exec team meeting on 28/07/2021. |

Reports Closed on the Audit Tracker since ARAC June 2021

| Report name | Lead Executive/Director |
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| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Switchboard MB2 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Prince Phillip Hospital Mortuary and Bereavement Services MB5 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Bronglais Hospital A&E/CDU MB6 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Community Mental Health Teams MB8 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - South Pembrokeshire Hospital MB10 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- Lifting Operations and Lifting Equipment Regulations 1998, Regulations 10 and 11 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Control of Substances Hazardous to Health Regulations 2002, Regulation 7. Prince Phillip Hospital MB13 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Control of Asbestos Regulations 2012, Regulation 10. MB12 | Director of Nursing, Quality and Patient Experience |
| Health and Safety Executive: Material breaches- The Management of Health and Safety at Work Regulations 1999, Regulation 3(1) - Estates MB1 | Director of Nursing, Quality and Patient Experience |
| Healthcare Inspectorate Wales: Quality Check: 10 Church Close, Begelly | Director of Operations |
| Healthcare Inspectorate Wales: Glangwili Hospital (Steffan Ward) 25/11/20 | Director of Operations |
| Community Health Council: Preseli Practice (Crymych Branch), January 2020 | Director of Primary, Community and Long Term Care |
| Internal Audit HDUHB2021-18: Patient Experience | Director of Nursing, Quality and Patient Experience |
| Internal Audit HDUHB1920-20: Cyber Security (Stratia Report) | Director of Finance |
| Internal Audit HDUHB2021-08: Partnership Governance (Integrated Care Fund) | Director of Primary, Community and Long Term Care |
| Internal Audit HDUHB1718-35: Theatres Directorate | Director of Operations |
| Internal Audit HDUHB2021-11: Governance Arrangement during the Covid-19 Pandemic | Board Secretary / Director of Finance |

Reports Opened on the Audit Tracker since ARAC June 2021

| Report name | Lead Executive/Director | Final report received at |
|---|----------------------------|---|
| Internal Audit HDUHB2021-09: Local Deployment of the Welsh Immunisation System (WIS) | Director of Finance | Audit and Risk Assurance Committee, June 2021 |
| Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - GLANGWILI GENERAL HOSPITAL, DOLGWILI ROAD, CARMARTHEN, SA31 2AF | Director of Operations | To be received at Health & Safety Assurance Committee Meeting, September 2021 |
| Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Director of Operations | To be received at Health & Safety Assurance Committee Meeting, September 2021 |
| Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Director of Operations | To be received at Health & Safety Assurance Committee Meeting, September 2021 |
| Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Premises: Ty Hafren block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER | Director of Operations | To be received at Health & Safety Assurance Committee Meeting, September 2021 |
| Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters Premises: Ty Teifi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER | Director of Operations | To be received at Health & Safety Assurance Committee Meeting, September 2021 |
| Audit Wales: Audit of Accounts Report | Director of Workforce & OD | To be received at Audit and Risk Assurance Committee, August 2021 |

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| Healthcare Inspectorate Wales: Tenby Surgery (UHB Managed Practice) | Director of Primary, Community and Long Term Care | To be received at Quality, Safety and Experience Assurance Committee, August 2021 |
| Healthcare Inspectorate Wales: Glangwili Hospital (Steffan Ward) 25/11/20 | Director of Operations | To be received at Quality, Safety and Experience Assurance Committee, August 2021 |
| Audit Wales: Structured Assessment 2021: Phase 1 Operational Planning Arrangements | Director of Operations | To be received at Audit and Risk Assurance Committee, August 2021 |