Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	19 October 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.

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Since August 2021, 13 reports have been closed or superseded, with 16 new reports received by the UHB. These are listed in Appendix 2.

As of 28th September 2021, there are 95 reports currently open. 49 of these reports have recommendations that have exceeded their original completion date, which has increased from the 45 reports previously reported in August 2021.

There is a decrease in recommendations where the original implementation date has passed from 102 to 86. The number of recommendations that have gone beyond six months of their original completion date has also reduced from 51 to 44 as reported in August 2021. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC August 21	New reports since August 21	Closed reports since August 21	Open reports at ARAC October 21	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	6	0	2	4	2	2	1
CHC	2	1	0	3	2	2	2
CHC / HIW Contractors	2	0	0	2	2	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	3	0	1	2	2	3	3
HEIW	0	0	0	0	0	0	0
HSE	8	0	1	7	0	3	3
HIW (Acute & Community)	9	0	2	8	5	15	4
HIW (MH&LD)	5	1	0	5	3	7	6
HTA	0	1	0	1	0	0	0
IA	26	6	6	26	14	26	14
MWWFRS	16	5	0	21	4	9	1
Peer Reviews	3	0	0	3	3	4	4
PSOW - S16	0	0	0	0	0	0	0
PSOW - S21	7	2	1	8	8	5	0
Royal Colleges	2	0	0	2	2	6	3
Other	1	0	0	1	0	1	0
WLC	2	0	0	2	2	3	3
TOTAL	**92**	**16**	**13**	**95**	**49**	**86**	**44**

**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 244 recommendations on the audit tracker that need to be implemented, of which 86 are red (behind schedule). The increase to 244 recommendations from the 212 reported at the previous meeting is primarily due to the areas of improvement identified in the recent 5 Letters of Safety Matters received from the MWWFRS. Appendix 1 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 12 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 19 recommendations which do not have revised timescales (53 reported at previous meeting) - this is where the date has passed and not known (N/K) is reported. The assurance and risk team are working with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented. The 19 recommendations are as follows:

- 2 recommendations relate to the Health & Safety IA report. Clarification is being sought from the Lead Officer if these can now be closed.
- 2 recommendations relate to the Withybush General Hospital Wards 9 and 10 Lessons Learnt IA report. Evidence has been sent to IA by the service, awaiting response from IA if the recommendations can be closed or if further detail required.
- 4 recommendations relate to the IA Brexit Risks and Actions Advisory Review Final Report. Since the audit tracker numbers were collated for this paper, IA have now agreed to close this report.
- 1 recommendation from the IA Governance Arrangements during the COVID-19 Pandemic report regarding agile working arrangements. Facilities Management are leading the agile working initiative, with Workforce and OD as part of the Agile Working Group. An update on the programme of work being undertaken was reported to Board in September 2021.
- 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. Staff have commenced with online training in lieu of face to face training, therefore progress is being made toward completing this recommendation.
- 2 recommendations from the RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report is being considered as part of the review of the Strategic Log recommendations.
- 1 recommendation from the IA Field Hospital Decommissioning report. Clarification of the timescale was requested as part of the ARAC Table of Actions. The audit tracker will be updated accordingly following the meeting.
- 6 recommendations from the MWWFRS Letter of Fire Safety Matters, Greville Court. A revised action plan has been requested from the Directorate to clarify the timescales.

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at end of September 2021, including trends since the last report to ARAC in 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.

The arrows included in the table below are as follows:

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

Service	Open reports as at October 21	Overdue reports as at October 21	Total number of recs October 21	Total overdue (red) recs October 21	Recommendations overdue by more than 6 months	Comments
CEO Office (Welsh Language)	3 (↑)	2 (→)	8 (↑)	4 (↑)	3 (↑)	WLC investigation - 3 recommendations remain outstanding, delayed by COVID-19. New IA Welsh Language Standards report added to the tracker.
Community and Primary Care-Carmarthenshire	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Community and Primary Care-Ceredigion	1 (→)	1 (→)	0 (→)	0 (→)	0 (→)	AW report- 1 'External' recommendation.
Community and Primary Care-Pembrokeshire	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Digital and Performance	7 (↓)	3 (↓)	10 (↓)	9 (↓)	5 (↓)	Whilst there has been a significant improvement since the last meeting, there are 5 recommendations open that exceed the original implementation date by over 6 months, where the original completion dates have been extended several times. 2 overdue recommendations (1 over 6 months overdue) will be closed at IGSC by the end of December 2021.
Central Ops	2 (↑)	1 (→)	5 (↑)	4 (→)	4 (→)	Peer Review Out of Hours report – 4 recommendations with revised timescales to December 2021, previously delayed by COVID-19 and the service continues to have significant operational pressures. New IA Field Hospital Decommissioning report added to the tracker.
Estates	24 (↑)	5 (↑)	102 (↑)	11 (↑)	3 (↑)	Implementation of MWWFRS Enforcement Notices and Letters of Fire Safety Matters is progressing through phased works at GGH and WGH, overseen by the HSC. 11 recommendations from the 5 overdue reports - awaiting survey outcomes, contractor work and extended delivery dates on specialist equipment/materials. MWWFRS have been advised. 5 new Letters of Fire Safety Matters have been received since previous report.
Finance	3 (↑)	1 (↑)	11 (↑)	0 (→)	0 (→)	2 IA reports (Single Tender Actions, and Use of Consultancy) added to the tracker.
Governance	2 (→)	1 (↑)	2 (↓)	0 (→)	0 (→)	IA advisory review supported by Finance and Workforce & OD directorates.
Medical	1 (↑)	0 (→)	1 (↑)	0 (→)	0 (→)	1 new IA Human Tissue Act (HTA) Report - 1 Amber recommendation relating to assurance to be completed by December 2021.

Service	Open reports as at October 21	Overdue reports as at October 21	Total number of recs October 21	Total overdue (red) recs October	Recommendations overdue by more than 6	Comments
MH&LD	12 (↑)	8 (↑)	18 (↑)	12 (↑)	7 (→)	1 HIW Quality Check contains overdue recommendations. COVID-19 has impacted implementing recommendations raised in the HIW thematic review, however progress has been made against Delivery Unit reports with two recommendations closed. There are 7 recommendations open that exceed the original implementation date by over 6 months. Since the audit tracker numbers were collated for this paper, however discussions have been held with the Directorate and a number of these are expected to be closed by the next report. 2 new reports – 1 from CHC and 1 from HIW.
NQPE	9 (↓)	1 (↓)	19 (↓)	6 (↓)	4 (↓)	3 HSE recommendations slipped to December 2021, dependent on the recovery of face-to-face PAMOVA training post-COVID. Clarification being sought on whether 3 recommendations from 2 existing IA reports can be closed.
Pathology	1 (↑)	0 (→)	13 (↑)	0 (→)	0 (→)	New report from HTA has been added to the tracker, with recommendations expected to be completed by December 2021.
Primary Care, Community and Long Term Care	2 (→)	2 (→)	1 (↓)	0 (↓)	0 (→)	1 HIW UHB managed practice - outstanding recommendations close to completion.
Public Health	1 (↓)	1 (→)	2 (↓)	2 (↓)	2 (↓)	1 IA report - Reduced from 3 to 2 recommendations, remaining timescales have slipped to December 2021(since the audit tracker numbers were collated for this paper, Internal Audit have now agreed to close this report).
Radiology	2 (→)	1 (→)	9 (↓)	8 (↓)	1 (→)	HIW IRMER (PPH) - 7 recommendations overdue, with implementation affected by the departure of the Head of Service. The outstanding recommendations are expected to be completed once new Head of Service in post. IA report - 1 recommendation revised date December 2021.
Scheduled Care	3 (→)	3 (→)	3 (→)	3 (→)	2 (↑)	PSOW report- 1 recommendation overdue. CHC report- 2 recommendations delayed by over 6 months, due to COVID-19.
Strategic Development & Operational Planning	4 (→)	3 (→)	9 (↓)	7 (→)	4 (↓)	3 IA reports- total 6 recommendations overdue. AW report- 1 recommendation slipped to December 2021. Overall 7 recommendations have exceeded their original implementation date, of which 4 have exceeded 6 months. Evidence has been submitted for 1 recommendation to IA for confirmation to close, 3 recommendations are delayed due to the delays in the relevant Capital projects. 2 recommendations are anticipated to be closed following an internal capital governance review being reported to ARAC.
USC BGH	1 (→)	1 (→)	4 (→)	3 (→)	3 (↑)	RCP follow up – recommendations to be evaluated as part of Strategic Log review.

Service	Open reports as at October 21	Overdue reports as at October 21	Total number of recs October 21	Total overdue (red) recs October	Recommendations overdue by more than 6	Comments
USC GGH	2 (🡻)	2 (🡻)	3 (🡻)	3 (🡻)	3 (🡻)	DU report - 2 recommendations overdue. HIW report - 1 recommendation slipped to November 2021.
USC WGH	2 (➔)	2 (🡹)	1 (➔)	1 (🡹)	0 (➔)	1 PSOW report - awaiting closure form PSOW. HIW report – 1 recommendation behind schedule, slipped to December 2021.
Women & Children	10 (🡹)	9 (🡻)	22 (🡻)	13 (🡹)	3 (🡻)	1 IA report- 4 recommendations overdue. 1 New IA report (Women and Child Health Directorate Governance review – Phase 2). 1 Royal College report - 3 recommendations overdue. 4 HIW reports - total of 6 recommendations overdue
Workforce & OD	2 (➔)	1 (➔)	1 (➔)	0 (➔)	0 (➔)	AW report - 1 amber recommendation.
Unscheduled Care	1 (➔)	1 (➔)	0 (➔)	0 (➔)	0 (➔)	CHC report - 1 'External' recommendation.
Total	**95**	**49**	**244**	**86**	**44**	

Potential areas of concern include services listed below. The assurance and risk team are discussing these concerns with the services/directorate.

Potential areas of concern

Digital and Performance – Whilst there has been a significant improvement since the last meeting, there are 5 recommendations open that exceed the original implementation date by over 6 months, where the original completion dates have been extended several times.
2 overdue recommendations (1 over 6 months overdue) will be closed at IGSC by the end of December 2021.

Central Operations - 4 recommendations (over 6 months overdue) with revised timescales to December 2021, previously delayed by COVID-19 and the service continues to have significant operational pressures.

Mental Health and Learning Disabilities - There are 7 recommendations open that exceed the original implementation date by over 6 months. Since the audit tracker numbers were collated for this paper, discussions have been held with the Directorate and 4 of the recommendations have been indicated as closed, with 1 recommendation changed to 'External'. Final approval of recommendations to be formally closed by the relevant Director.

Radiology – Progress has been made since the August 2021 report to ARAC; however, implementation of the remaining outstanding recommendations has been impacted by not having a Head of Service in place during a period of significant operational pressures.

Women and Children – 13 recommendations have exceeded their original implementation date, of which 3 have exceeded 6 months. 2 of these recommendations are delayed due to face to face training required and the Respiratory Syncytial Virus (RSV) pressures on the service. Implementation of 7 recommendations has been delayed due to delays in the implementation of the Women and Children's project (Phase 2) at GGH. Since the audit tracker numbers were collated for this paper, 4 red recommendations (not over 6 months) have been closed.

Argymhelliad / Recommendation

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital 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 HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority

	IA – Internal Audit IGSC – Information Governance Sub Committee IRMER – Ionising Radiation (Medical Exposure) Regulations Management & Technology Sub Committee MH&LD – Mental Health & Learning Disabilities MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience NWIS – NHS Wales Informatics Service PAMOVA – Prevention, Assessment & Management Of Violence & Aggression PPE – Post Project Evaluation PPH – Prince Philip Hospital PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SIFT – Service Increment for Teaching SSU – Specialist Services Unit UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Board Secretary

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

	legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: **Reputational:**	As above.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	No direct impacts from this report

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Oct-19	~~Oct-20~~ ~~Apr-21~~ Oct-21	External	21/10/2020 update-Work is on-going at an All-Wales level to produce an e-learning module for all Health Boards. This has been delayed due to Covid-19, but the group plans to launch the new e-learning model in April 2021.It is anticipated that face-to-face corporate induction sessions will recommence within the next month (November 2020). Revised date of April 2021 provided. 28/01/2021 update-Work is progressing at an All-Wales level, with Hywel Dda UHB input, to produce an e-learning module for all Health Boards in Wales. This has been delayed due to Covid-19, but the group is on track to launch the new e-learning model in April 2021 by the amended deadline. Recommendation is currently outside the gift of the UHB to implement. 26/05/2021- Reporting officer confirmed no update provided at this moment but the UHB has inputted into the process. Welsh Language standards meeting due in June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 18/08/2021- At a recent All Wales Welsh Language Officers meeting (July 2021), Betsi Cadwaladr informed the meeting that the expected date for completion is October 2021.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_001	N/A	R1. The Health Board must conduct a review to check that appointment letters sent from other departments comply with standard 5 and act upon the results of the review.	Full action plan held by Welsh Language team.	Apr-20 Mar-21	~~Oct-20~~ ~~Mar-21~~ Sep-21	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/2021 – Directorates have completed an assessment. Work has been done to ensure compliance. Due to current Covid pressure the information from the Operations directorate is incomplete. As a result of Covid and a cyber-attack on the WL Commissioner's office an extension has been granted on collating the remaining information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 13/08/2021- Revised timescale of Sept 2021 provided. The WL Commissioner has not pursued this investigation, however we have recently communicated with them asking for clarity on the next steps. The WL Commissioner still hasn't confirmed whether they wish to receive our partial report or offer us a further extension to provide a full report. The Health Board has pro-actively approached the WL Commissioner more than once regarding this investigation and provided them with their original correspondence as they had lost all documents due to the cyber attack. A recent internal Audit within the Health Board has highlighted the need that any outstanding assessments from directorates be escalated and discussed at Exec Team.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_002	N/A	R2. The Health Board must conduct a review to check that forms provided to the public by other departments comply with standard 36 and act upon the results of the review.	Full action plan held by Welsh Language team.	Apr-20 Mar-21	~~Oct-20~~ ~~Mar-21~~ Sep-21	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/21 – Directorates have completed an assessment. Work has been done to ensure compliance. Due to current Covid pressure the information from the Operations directorate is incomplete. As a result of Covid and a cyber-attack on the WL Commissioner's office an extension has been granted on collating the remaining information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 13/08/2021- Revised timescale of Sept 2021 provided. The WL Commissioner has not pursued this investigation, however we have recently communicated with them asking for clarity on the next steps. The WL Commissioner still hasn't confirmed whether they wish to receive our partial report or offer us a further extension to provide a full report. The Health Board has pro-actively approached the WL Commissioner more than once regarding this investigation and provided them with their original correspondence as they had lost all documents due to the cyber attack. A recent internal Audit within the Health Board has highlighted the need that any outstanding assessments from directorates be escalated and discussed at Exec Team.
CSG584	Aug-19	Welsh Language Commissioner	Investigation under section 71 of the Welsh Language (Wales) Measure 2011 of a possible failure to comply with Welsh language standards	Open	N/A	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	CEO	CSG584_003	N/A	R3. Hywel Dda University Health Board must provide sufficient written evidence to satisfy the Welsh Language Commissioner that it has carried out enforcement actions 1-2.	Full action plan held by Welsh Language team.	Apr-20 Mar-21	~~Oct-20~~ ~~Mar-21~~ Sep-21	Red	16/11/2020- WL Commissioner's Officer has agreed to an extension to 19/03/2021, and has requested to receive a progress update by mid December 2020. Assistant Director of Communications is currently coordinating the progress update with service managers. 04/12/2020- recommendation changed back from red to amber due to extension from WL Commissioner's Officer. 27/01/21 – An annual review meeting was held between the Health Board and the WL Commissioner's office on 26/01/21. It was agreed that we would provide the evidence already collated by the 19/03/2021 date and a new date will be set for the remaining Operations directorate information. 26/05/2021- Ops Directorate did not provide information within revised timescale, reporting officer has spoken to lead investigator at WL Commissioner regarding delay, other Health Boards are in similar situation. Waiting for clarity from WL Commissioner office which has been dealing with a cyber attack issue. The UHB will send WL Commissioner office what information it has by end of June 2021. 19/07/2021- update request sent to reporting officer with a deadline of 29/07/2021. 13/08/2021- Revised timescale of Sept 2021 provided. The WL Commissioner has not pursued this investigation, however we have recently communicated with them asking for clarity on the next steps. The WL Commissioner still hasn't confirmed whether they wish to receive our partial report or offer us a further extension to provide a full report. The Health Board has pro-actively approached the WL Commissioner more than once regarding this investigation and provided them with their original correspondence as they had lost all documents due to the cyber attack. A recent internal Audit within the Health Board has highlighted the need that any outstanding assessments from directorates be escalated and discussed at Exec Team.
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. 19/08/2021- The Draft District Nursing (DN) Welsh Levels of Care Acuity and Dependency tool (WLoC tool) underwent phase 1 of testing in July 2021. Evaluation and analysis of this pilot is currently underway with a report due to be shared with the All Wales Nurse Staffing Programme in December. The next phase of testing/rollout is likely to commence in January 2022.
WAO_infoBack Up	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_infoBack Up_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 further delays on the completion of this work due to performance issues with the BT circuits, which has impacted on the delivery date. Please note that the impact of the BT issues could not have been anticipated, and is beyond the control of the Health Board. The delays are due to a blocked cable duct, under a road outside of Prince Philip Hospital, which requires the road to be dug up and the duct cleared, which requires the council and BT to arrange a suitable time to undertaken the work. The latest date that the Digital Team have been given is September 2021 for this work to be completed. This work is expected to be completed by the end of September / October 2021. 28/09/2021 - The Digital Team are still waiting for the Prince Philip Hospital Wide Area Network (WAN) upgrade to be completed. Whilst BT have now upgraded the circuit, firewall issues are preventing 'go-live'. We are working with our firewall maintainer to address this.
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.	Sep-19	~~Sept-20~~ ~~Jan-21~~ ~~Mar-21~~ ~~Apr-21~~ ~~Jun-21~~ ~~Aug-21~~ Oct-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 paper is ready to be submitted to the August Information Governance Sub-Committee (IGSC). To be closed once report received at IGSC. 28/09/2021 - An updated Policy will be presented to the October meeting of IGSC

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB_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 noncompliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence that this recommendation, to seek advice on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to is in train.	May-19	~~May-21~~ ~~Aug-21~~ ~~Oct-21~~ Nov-21	Red	18/03/2021- There is currently still lone working on evenings and weekends. There has been a recent push by the Assistant Director of Digital Services to implement the new switchboard system across the 3 counties by May 2021, which will enable switchboards to switch to different sites. The new system will resolve this recommendation and negate the need for an OCP to be undertaken with staff. 11/05/2021-Digital Business Manager update- the new solution is not yet in place due to delays in some of the technical elements. We are meeting as a senior team to assess what is required and move at pace to get this completed. Working to get new system working alongside the current solution in the next couple of weeks. 4 sites now all under the same management. Revised date of August 2021 provided for both systems to be in place and testing to take place. 30/06/2021- Equipment being installed for testing in August 2021, hopeful the switchboard crossover will then be implemented and the recommendations closed. 28/07/2021 - The Digital Team have encountered a number of issues, outside of their control, which has affected the implementation of the new Switchboard solution. Therefore there has been a delay in the ability for lone workers (nights and weekends) to be able to have a compulsory break from the switchboard. The work is due to be completed by September/October 2021, in line with the wider network improvements within the Health Board. This will allow staff to switch over between sites to allow them to have a break. The system will installed on sites shortly to allow for training and testing and for the staff to become familiar with the new system before the full switch over. Work is also being carried out with the switchboard supervisors to look at streamlining processes and making information available across sites. 27/09/2021 - The completion of this recommendation is linked to the improvements on the network which has been delayed due to BT. The Health Board has been held up by the remedial work required to unblock a duct under the main road outside PPH, which required the council to dig up the road. This work has now been completed and we anticipate finalisation of the network upgrade by mid-October. Once the work outlined above has been completed, the Team will be able to release the required bandwidth for the Switchboard infrastructure to go live.
HDUHB-2021-22-01	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.	Jul-21	~~Jul-21~~ ~~Sep-21~~ Nov-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 is established. However the Health Analytics Team are seeking confirmation and legal advice 27/09/2021 - Investigation regarding IP rights was sought by the Health Analytics Team and the literature examined identified ambiguity in whether IP rights sit with the employer or employee. It is suggested that legal advice may be necessary, since the tool was majority funded by Hywel Dda with support from further education. The Education and Compliance Advisor has been asked for a view, but to date, we are still awaiting formal guidance.
HDUHB-2021-22-01	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 asset register and an	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).	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 27/09/2021 - The DPIA is in draft.
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 will choose how we navigate through these levels according to our need, priority and investment, which may mean that our progress will not be linear, however, with the right direction and strategic funding we will reach level 6 by the end of the five years. By the end of 2022, we anticipate to be at level 2, and in 2024 level 4, with Level 6 being attend the following year.	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 Management Systems Society (HIMSS) maturity matrix. We will then look to commission a third-party supplier to undertake an audit which will form the gap analysis and improvement plan 27/09/2021 - The scope for the work has been agreed, with a quote received from a supplier to provide an onsite workshop, arranged for 11th November 2021. Following the completion of this work a report will be provided to the Health Board which will detail a GAP analysis and a development roadmap to improve the digital maturity of the Health Board.
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 the adoption.	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 support nationally. Currently looking into several mandatory training options. 28/07/2021 - Currently exploring the purchase of sufficient licenses to be able to roll out the training to all staff within the Health Board and encouraging staff to complete the course. Relevant forms have been completed and submitted to Learning & Development to make the training mandatory within Hywel Dda. The training would be done through ESR and a record kept on the system of those who had completed the course successfully. 27/09/2021 - No further updates have been taken forward with this recommendation as we are awaiting a decision from Digital Health and Care Wales (DHCW), who are looking to provide additional support to the Health Boards. Continue exploring the licence agreement with DHCW
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.	Dec-20 Feb-21	~~Dec-20~~ ~~Feb-21~~ ~~Mar-21~~ ~~May-21~~ ~~Aug-21~~ ~~Sep-21~~ Nov-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 27/09/2021 - Work is progressing well with the new Service Desk system and the Incident Management Procedure is under development. This will be completed end of October.
HDUHB-2021-09	May-21	Internal Audit - HDUHB	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	Jun-21	~~Jun-21~~ Sep-21	External	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. 27/09/2021 - as above. Further requests for an update have been submitted to the directors of DHCW.
HDUHB-2021-09	May-21	Internal Audit - HDUHB	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.	Aug-21	~~Aug-21~~ Dec-21	Red	28/07/2021 - Ongoing and on track to complete by the end of August 2021 27/09/2021 - Following the appointment of a WIS Application Support Specialist, processes have been formalised, documented and circulated to key lead users and departments. DQ reports on completeness & accuracy are now being circulated to area leads (MVCs & Primary Care) on a regular basis. Users have the ability within WIS to 'cash up' clinics at the end of each day to ensure there are no 'un-outcomed' patients at the end of every day. Due to the limited reporting functionality within WIS the HB are reliant on the data views being made available to us via DHCW – this has limited effectiveness to identify patterns in the errors like a specific user or time of day etc, therefore limiting the effectiveness of any feedback that can be provided by the DQ team. An 'Information Quality Assurance Report' will be taken to IGSC to seek assurance of the processes currently in place. Recommend to close post IGSC meeting in December 2021.
Delivered under contract P474	Oct-17	Stratia Consulting	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB	Open	N/A	Digital and Performance	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	Stratia_015	Medium	A.12.4:NWIS are purchasing the LogRhythm SIEM solution. Once the purchase and staff training has been completed its deployment to the various Health Boards should be expedited.	Reliant on NWIS national procurement of LogRhythm solution. No progress to date as revenue funding from Welsh Government has not been released to the Health Board. ADI has written to the Director of Informatics Planning for NHS Wales for an update on checklists. In the meantime NWIS will be providing on-boarding activities to ensure any readiness work is understood (2 HDD staff members attending LogRhythm training 25-26th March, 2020).	N/K	~~Jun-21~~ ~~Oct-21~~ Nov-21	Red	05/03/2021- Update from Digital Business Manager - We successfully appointed to the Cyber Security role on the 19th February and employment checks have started. Their first set of tasks once induction has been completed will be to implement the available SIEM solution. We would expect SIEM to be implemented by the end of June 2021.Due to update received recommendation no longer noted as 'external rec', i.e. outside the gift of the UHB to implement. 13/05/2021- Digital Business Manager confirmed rather than waiting on national work the UHB have gone with a new system (Splunk) which is currently being implemented and led by the cyber security specialist. An update on the progress of this work will be provided to IGSC in June 2021. The completion date will be reviewed following the paper to IGSC. 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 - This work is being carried out by the Cyber Security Senior Specialist together with a new provider (Splunk) and initial workshops have taken place. Work is anticipated to begin to install our Splunk SIEM solution in the next four weeks, to allow an update paper is to be brought to the October 2021 IGSC meeting. 27/09/2021 - Splunk implementation commenced on 13th September 2021 and our systems are currently being onboarded. Splunk integration with the national SIEM is also underway.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber- on schedule, Green-complete)	Progress update/Reason overdue
SSU-HDU-2021-02	May-21	Internal Audit - SSU	Withybush General Hospital Wards 9 & 10 Lessons Learnt	Open	N/A - Advisory Review	Estates	Strategic Development and Operational Planning	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.	Sep-21	Sep-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. 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. 21/07/2021- Chaser email sent 16/07/2021. Internal Audit also trying to make contact with Project Director. 08/09/2021- Capital Planning update - Work is currently ongoing on the PPE evaluations with a report being prepared for September 2021 CEIM&T.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	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.	Mar-22	Mar-22	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. 21/07/2021- Internal Audit agreed to review recommendation and response from Discretionary Capital Projects Manager to establish if this can be closed. 27/08/2021- email sent to Discretionary Capital Projects Manager following response from Internal Audit requesting evidence to close. 16/09/2021- Discretionary Capital Projects Manager provided timescale of March 2022, as they will be unable to provide further scheme evidence at this stage of the year as the majority of planned 21/22 DCP schemes are either at tender stage or just commenced on site.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	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.	Mar-22	Mar-22	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. 21/07/2021- Internal Audit agreed to review recommendation and response from Discretionary Capital Projects Manager to establish if this can be closed. 27/08/2021- email sent to Discretionary Capital Projects Manager following response from Internal Audit requesting evidence to close. 16/09/2021- Discretionary Capital Projects Manager provided timescale of March 2022, as they will be unable to provide further scheme evidence at this stage of the year as the majority of planned 21/22 DCP schemes are either at tender stage or just commenced on site.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	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.	Mar-22	Mar-22	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. 21/07/2021- Internal Audit agreed to review recommendation and response from Discretionary Capital Projects Manager to establish if this can be closed. 16/09/2021- Discretionary Capital Projects Manager provided timescale of March 2022, as they will be unable to provide further scheme evidence at this stage of the year as the majority of planned 21/22 DCP schemes are either at tender stage or just commenced on site.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	Withybush General Hospital Wards 9 & 10 Lessons Learnt	Open	N/A - Advisory Review	Estates	Strategic Development and Operational Planning	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.	Sep-21	Sep-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. 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. 21/07/2021- Chaser email sent 16/07/2021. Internal Audit also trying to make contact with Project Director. 08/09/2021- Capital Planning update - Work is currently ongoing on the PPE evaluations with a report being prepared for September 2021 CEIM&T.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	Withybush General Hospital Wards 9 & 10 Lessons Learnt	Open	N/A - Advisory Review	Estates	Strategic Development and Operational Planning	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.	Sep-21	Sep-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. 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. 21/07/2021- Chaser email sent 16/07/2021. Internal Audit also trying to make contact with Project Director. 08/09/2021- Capital Planning update - Work is currently ongoing on the PPE evaluations with a report being prepared for September 2021 CEIM&T.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	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.	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. 21/07/2021- Internal Audit agreed to review recommendation and response from Discretionary Capital Projects Manager to establish if this can be closed. 27/08/2021- email sent to Discretionary Capital Projects Manager following response from Internal Audit requesting evidence to close. 16/09/2021- evidence submitted to Internal Audit, awaiting response if recommendation can now be closed or if further evidence required.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	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_010	N/A	R10. Supervising Officers should be provided with further guidance/direction on the completion/timeliness of cost reporting to avoid the issues identified at this project.	The issues identified above are fully accepted by management and will be considered further at the post project evaluation undertaken on the project.	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 is complete and attached evidence, to be confirmed with Internal Audit if happy to close. 27/08/2021- email sent to Discretionary Capital Projects Manager following response from Internal Audit requesting evidence to close. 16/09/2021- evidence submitted to Internal Audit, awaiting response if recommendation can now be closed or if further evidence required.
SSU-HDU-2021-02	May-21	Internal Audit - SSU	Withybush General Hospital Wards 9 & 10 Lessons Learnt	Open	N/A - Advisory Review	Estates	Strategic Development and Operational Planning	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.	Sep-21	Sep-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. 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. 21/07/2021- Chaser email sent 16/07/2021. Internal Audit also trying to make contact with Project Director. 08/09/2021- Capital Planning update - Work is currently ongoing on the PPE evaluations with a report being prepared for September 2021 CEIM&T.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-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 • C4C audit methods and practices should be actioned by all Domestic Supervisors to ensure C4C are consistently thorough across all sites. • Audits should be planned ahead and noted on schedules and rotas to ensure audits are completed and do not get overlooked if a member of staff is away or on secondment. • If a member of staff is absent during the 48 hours following an audit, an alternative Domestic Supervisor should be deployed to check that the action plan arising from the cleaning audit has been completed in the functional area. • PMS should be asked to remap the rooms on the software and make amendments to the system so it accurately reflects the functional areas being audited. This will mean that the C4C system will be more user friendly and audits will be less time consuming to undertake.	inspecting C4C 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 C4C upgrade along with the revised National Cleaning Standards for Wales 2009, planned for April 2018, all domestic supervisors will be retrained which will present an opportunity to address any non-consistency in audits and reduce any subjectivity. It is also planned to implement rotation audits across sites and comparison made to further assure consistency by the Soft FM Compliance Manager. Careful planning will ensure Nursing and Estates staff are advised in advance of the audit times and dates to ensure they are able to attend. Supervisory cover will be allocated in the period following the audit, to ensure all relevant action plans are developed and implemented. PMS have proposed as part of the implementation programme of the new version of MICAD Software, for them to verify and amend the layouts and room functions, this is planned for April 2018. All layouts are to be updated and this action is facilitated by NWSSP.	Jun-18	Mar-22 Sep-22	Red	As required the audit check list is amended to the current use on the Estate. Any additional elements are added so that the area is scored as if it was already on the system. The information on the existing system has been amended to reflect the functional use of areas to make more user friendly/less time consuming. Some areas have now moved priority ratings from Very High to High Risk and vice versa as the use of areas has now changed. The full remap of areas would be part of the updated system which is still pending. 04/12/2020- Still awaiting updated system, recommendation outside gift of UHB to implement. 04/02/2021- Internal Audit currently undertaking follow up. 04/03/2021-Director of Estates, Facilities and Capital Management confirmed that in the last couple of weeks that new software SYNBIOTIX to replace current C4C system has been agreed. Implementation is planned to take place Q3/4 of 2021/22. 10/05/2021- There are concerns with a possible delay in IT implementing the new software, Assistant Head of Operational Facilities Management to check with IT for update. This recommendation was previously noted as an external recommendation and has since reverted back to Red (behind schedule) as it is now within the gift of the Health Board to implement. 10/06/2021-Regular dialogue taking place with Head of Digital Operations and Assistant Director of Digital Services. 27/08/2021- Full rollout on soft FM for 2 acute sites will hopefully be achievable by March 2022, but all 4 sites is likely to take longer (including all the clinical staff being up to speed on accessing the help desk function to access portering services etc.). A"Synbiotix Project Group" is to be established, and involvement of key catering / soft FM personnel as the UHB build the delivery of this project. Revised timescale of September 2022 included on the tracker, if progress is quicker than estimated the completion date will be brought forward. 15/09/2021- this recommendation has been dependent on implementing hardware, etc which has been outside the gift of the Estates team.
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	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. 31/08/2021- email from Internal Audit confirmed the recommendation should sit with Assistant Director of Strategic Planning as it relates to the PBCs for the new and repurposed buildings. 08/09/2021- Head of Capital Planning in discussion with internal audit on ownership of 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_002	Medium	R2. The PBCs and as they progress to Outline and Full business case stages will need to determine the in-house Estates staff requirements, and how these will be satisfied given current pressures.	Agreed. The Health Board will need to determine how the necessary Estate in-house staff resources is established in order to successfully deliver the AHMWW and Business Continuity/Major Infrastructure PBCs.	Feb-21	Feb-21	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 agreed. Recommendation changed to 'External' on the audit tracker. Director of Estates, Facilities and Capital Management responded on 24/03/2021 that it might be worth looking at this item in two parts . The PBC´S referred to are for the AHMWW which is with Assistant Director Of Strategy & Planning and the other is the Major Infrastructure Business Continuity work which is with Director of Estates, Facilities and Capital Management . The two processes are likely to have different timelines in terms of Endorsement by WG so the need for Estates type staff and the timing of these staff will differ also. 06/05/2021- Estates are giving their commitment that this will be achieved but evidence will not be available until the PBC progresses, which is dependent on WG decision. 10/06/2021- UHB attending WG Infrastructure Investment Board on 24/06/2021 to present the case and answer any questions. 01/07/2021- UHB attended WG Infrastructure Investment Board on 24/06/2021- positive meeting, awaiting outcome with a letter to be sent to CEO advising of outcome. Audit Manager to check with Internal Audit team for further clarification of this recommendation.
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 BJCs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC.	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. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). 15/09/2021- This recommendation is for future action and can only be demonstrated once the BJCs or OBCs are produced.
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 BJCs (Business Justification Cases) / OBCs (Outline Business Cases) which will follow the PBC.	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. 22/07/2021- Internal Audit confirmed- 'These recommendations relate to the Infrastructure PBC where a big chunk of money to address backlog maintenance in the existing estate (rather than the major new build PBC in Whitland that the Assistant Director of Strategic Planning is working on). These recommendations can only be demonstrated once the BJCs or OBCs are produced. 15/09/2021- This recommendation is for future action and can only be demonstrated once the BJCs or OBCs are produced.
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.	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. 15/09/2021-Head of Facilities Information & Capital Management to check with Head of Property Performance if this recommendation is on track.
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).	Dec-20	Dec-20 Oct-21	Red	13/01/2021- Assistant Head of Operational Facilities Management believes the timescale of December 2020 noted in the report is incorrect and will be clarifying this with the Internal Audit team. 04/03/2021- timescale should be October 2021, CAFM doesn't go live until April 2021, only then recommendation can be progressed. Assistant Head of Operational Facilities Management having another conversation with Internal Audit and feedback to Assurance & Risk Officer. 18/03/2021-Assistant Head of Operational Facilities Management confirmed Internal Audit will not revise date on report, therefore this recommendation remains red. December 2020 timescale was included in the report in error, the correct timescale for this recommendation is October 2021. 06/05/2021- on track for October 2021 at present. There could be a potential delay if the rollout of CAFM is delated, which is currently with Digital Services to progress. 10/06/2021- Once rollout of CAFM by Digital Services is fully implemented this timescale will be reviewed as the service will then be in a position to implement this recommendation which is currently dependent on Digital Services. 05/08/2021- Roll out in September 2021 for the main system. 17/08/2021- Internal Audit requested evidence (emails/meeting notes) to assist in closing the recommendation. 23/08/2021- evidence submitted to Internal Audit, awaiting response if this recommendation can now be closed.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KS/SJM/00113573-KS/890/05 (supersedes EN/262/08)	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fore Safety) Order 2005: Article 30 Premises: St Caradogs, Bro Cerwyn, Fishguard Road, 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 provided 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 Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 15/09/2021- update reported to Health & Safety Committee in July 2021, MWWFRS will provide extension date closer to April 2022 (current completion date).
BFS/KS/SJM/00114719-/KS/890/02	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	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 Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Sep-20 Jan-21	~~Jan-21~~ ~~Feb-21~~ ~~Jun-21~~ ~~Aug-21~~ Oct-21	Amber	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 fulfil 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. 05/08/2021- revised date has been agreed with MWWFRS, letter to be drafted to MWWFRS shortly. 15/09/2021- Asbestos has led to work being extended to October 2021. MWWFRS have been informed and they have confirmed via email they are happy to extend the date to 11/10/2021. Recommendation turned back to amber as a result.
BFS/KS/SJM/00114719-/KS/890/02	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/02	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~~ Oct-21	Amber	Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. Once new dates are officially agreed with the MWWFRS this recommendation will be changed back to amber. 21/07/2020 - correspondence received from MWWFRS that original completion date has been extended to 30/01/2021 for this advanced works. 17/12/2020- This work has been completed. 21/05/2021 - correspondence received from MWWFRS stating that they were not content that recommendation had been fully actioned and therefore re-issued KS890/02, with a 28 day period to fulfil requirements. Report therefore re-opened and recommendation turned from green back to red. 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. 05/08/2021- revised date has been agreed with MWWFRS, letter to be drafted to MWWFRS shortly. 15/09/2021- Asbestos has led to work being extended to October 2021. MWWFRS have been informed and they have confirmed via email they are happy to extend the date to 11/10/2021. Recommendation turned back to amber as a result.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Aug-21 Dec-21 Apr-22	Dec-21 Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2022 as agreed in the programme for Phase 1 Works (presented to them on the 02 October 2020). 04/03/2021-on track as per agreed programme of work. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 15/09/2021- update reported to Health & Safety Committee in July 2021, MWWFRS will provide extension date closer to April 2022 (current completion date).
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_002	High	R2. Compartmentation – All Vertical Breaches and / or Penetrations To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Withybush Hospital are addressed. Fire resisting structures are to continue to slab/ upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Aug-21 Dec-21 Apr-22	Dec-21 Apr-22	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2022 as agreed in the programme for Phase 1 Works (presented to them on the 02 October 2020). 04/03/2021-on track as per agreed programme of work. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 15/09/2021- update reported to Health & Safety Committee in July 2021, MWWFRS will provide extension date closer to April 2022 (current completion date).
BFS/KS/SJM/00114719-KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Apr-22 Apr-25	Dec-24 Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. Commencement of work to take place in May 2022. This will be a large piece of work involving entering individual wards and decanting of services as required. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 04/03/2021-on track as per agreed programme of work. 06/05/2021-still on track, UHB meeting with WG 07/05/2021 to establish when to start the work on ward areas.
BFS/KS/SJM/00107739-01	Aug-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Glangwili General Hospital, Dolgwili Road, Carmarthen SA31 2AF 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~~ ~~Aug-21~~ Sept-21	Red	17/12/2020- On track. Contractors have been engaged. 12/01/2021- Revised letter from MWWFRS confirms this item is to be completed in line with the agreed advanced, first and second phase works. Stage 1 / Advanced works relate to Vertical Escape routes by end August 2021. 29/01/2021- action plan provided by Assistant Head of Operational Facilities Management shows recommendation to be completed by Feb-21. 04/03/2021- Contractors will be completed work next week. 24/03/2021- Assistant Head of Operational Facilities Management confirmed this recommendation is still outstanding, revised timescale April 2021. 06/05/2021- There are a some additional blocks remaining, which will be completed when contractors have been appointed at the end of May 2021 - Completion June 2021. Recommendation remains amber as still within timescale set by MWWFRS of August 2021. 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. 05/08/2021- order placed with Contractor, will be completed by MWWFRS timescale of August 2021. 15/09/2021- One hole left in the ceiling which contractors will complete by end of September 2021.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KBJ/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/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: -: The door leaf or leaves. -: The frame in which the door is hung. -: Hardware essential to the functioning of the door set, 3 x hinges. -: Intumescent seals and smoke sealing devices/Self closure. -: Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	Mar-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 15/09/2021- update reported to Health & Safety Committee in July 2021, MWWFRS will provide extension date closer to April 2022 (current completion date).
BFS/KBJ/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/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	Mar-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 15/09/2021- update reported to Health & Safety Committee in July 2021, MWWFRS will provide extension date closer to April 2022 (current completion date).
BFS/KS/SJM/00175424/00175421/001754280017542526/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/001754280017542526/00175425_001	High	R1. Compartment • A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 17/12/2020- Compartmentation survey has been completed. 12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/08/2021- Business case has been approved and work is now taking place on the site.
BFS/KS/SJM/00175424/00175421/001754280017542526/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/001754280017542526/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	All works to be completed by December 2021 (delayed from August 2021 due to COVID-19). Survey will be completed by July 2020 which will establish the extent of the work to be undertaken. This work is part of the stage 2 WGH Fire Enforcement Programme and will take to December 2021 to be fully completed. Letter dated 24/08/2020 from MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. This work to be completed as part of Phase 1. 12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/08/2021- Business case has been approved and work is now taking place on the site.
BFS/KS/SJM/00175424/00175421/001754280017542526/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/001754280017542526/00175425_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be the preferred safer option, it was explained to me that this was due to the residents being able to smoke within the premises before the smoking ban to reduce the false alarm calls. • It was noted that there was a detector being covered at time of inspection within the kitchen of the Pembroke county block (First floor flat F block). You must ensure that this practice is not repeated, information must be given to the occupants explaining the severity of this action. • Due to the Server within the Means of escape an additional detector within the area of the device is required (due to the lintel between the detector and the server) noted within the Pembroke county and St Thomas block (but this should include all blocks if server is on escape route in the same way). The change should be carried out and commissioned by	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 MWWFRS granted extension to coincide with the timescale the stage 2 works (phase 1) revised to Dec 2021 agreed within the outcome of the meeting on the 06 June 2020 and again agreed as in meeting on the 20 August 2020. 12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 06/05/2021- Letter from MWWFRS dated 19/03/2021 - 'Further to the conversation on the possibility of the Phase 1 works at Withybush General Hospital running over the completion date due to the complexity and capital value of this project, as we have over 12 months to the current expiry date, we would not want to review this enforcement notice until early in to 2022'. Recommendation to remain amber until contact is made to MWWFRS in March 2022 as they have requested, to update them on the progress of the works, at which point MWWFRS will discuss the extension of the notice at that date. 05/08/2021- Business case has been approved and work is now taking place on the site.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
KS/890/07	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/07	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 us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Oct-20 Feb-21 Aug-21 Sep-21	Aug-21 Sep-21	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/07 to be completed by 31/08/2021 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for Aug-21 completion. 04/03/2021- still on track for August 2021, figure has been submitted to WG for advanced work for GGH, expect quick turnaround response in next couple of weeks. 06/05/2021 & 10/06/2021- on track. 05/08/2021- email received from MWWFRS confirming revised deadline of end of September 2021 due to returning fire doors to manufacturer. 15/09/2021- on track to complete by end of September 2021, as reported to the Health & Safety Committee July 2021.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Oct-20 Feb-21 Jul-22	Jul-22	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for July 2022 completion. 04/03/2021- on track. 06/05/2021- Currently on track, subject to detailed assessment as part of the BC work. 10/06/2021- BJC for Phase 1 is going to WG in July 2021. The UHB will write to MWWFRS following this meeting if an extension is required. 05/08/2021- BJC going through SDOCC Committee in August 2021, once approved this will be submitted to WG. 15/09/2021- Chair's approval following SDOCC in August 2021, currently with WG for approval.
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_02	High	R2.Compartmentation – All Vertical Breaches and / or Penetrations. To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the intermediate floors between levels within Glangwili Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 2nd Oct 2020). Fire resisting structures are to continue to slab/ upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Oct-20 Feb-21 Jul-22	Jul-22	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- on track for July 2022 completion. 04/03/2021- on track. 06/05/2021- Currently on track, subject to detailed assessment as part of the BC work. 10/06/2021- BJC for Phase 1 is going to WG in July 2021. The UHB will write to MWWFRS following this meeting if an extension is required. 05/08/2021- BJC going through SDOCC Committee in August 2021, once approved this will be submitted to WG. 15/09/2021- Chair's approval following SDOCC in August 2021, currently with WG for approval.
KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/09_01	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Oct-20 Feb-21 Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 17/12/2020- Director of Estates, Facilities and Capital Management confirmed 'All Vertical Escape Routes' included in the notice (schedule section) in error. 04/03/2021-On track. 06/05/2021 & 10/06/2021- work has not commenced yet but within timescale for the programme of work by August 2024.
General/00111720	May-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters - Tregaron Community Hospital, Dewi Road, Tregaron, SY25 6JP	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 3 mm	Full action plan held by Estates.	Aug-21	~~Aug-21~~ ~~Sept-21~~ ~~Oct-21~~ Nov-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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- Head of Operations confirmed this will be fully implemented by mid October 2021- door due to be received September 2021 and installation late September to early October 2021. 23/09/2021- Revised action plan states further 3 week delay in manufacturing. Commence on site 25/10/2021 to complete by 08/11/2021.
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_001	High	Article 8 Item 1 - Fire doors: 2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired or replaced so that the doors close completely into their rebates.	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 MWWFRS 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- Head of Operations confirmed this will be fully implemented by mid October 2021- door due to be received September 2021 and installation late September to early October 2021. 23/09/2021- Revised action plan states recommendation to be completed by 31/10/2021.
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_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	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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 MWWFRS that restricting access to upper floors will remove any need to fire resisting construction. Formal agreement required from MWWFRS before recommendation can be closed. 15/09/2021- MWWFRS will revisit the site on 05/10/2021 to reassess the site and establish if any recommendations can be closed.
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_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 MWWFRS 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. 23/09/2021- Revised action plan states recommendation to be completed by 31/10/2021 (to be checked with procurement).
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_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 MWWFRS 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. 23/09/2021- Revised action plan states recommendation to be completed by 31/10/2021
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_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 MWWFRS 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. 23/09/2021- Revised action plan states recommendation to be completed by mid October 2021.
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_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 Oct-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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. 23/09/2021- Revised action plan states delay in manufacturing, to be completed end of October 2021.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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_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 Oct-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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. 23/09/2021- Revised action plan states delay in manufacturing, to be completed end of October 2021.
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_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 Nov-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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. 23/09/2021- Revised action plan states delay- work now commencing 18/10/2021, to be completed by 26/112021.
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_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 Sept-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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. 23/09/2021- Revised action plan states to be completed by end September 2021.
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	Sep-21 Oct-21	Red	10/06/2021- 2 action plan meetings are taking place and a response to MWWFRS 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. 23/09/2021- Revised action plan states to be completed by end October 2021.
BFS/KS/SJM/00107739-02	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 MWWFRS 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/00107739-02	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 MWWFRS 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.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_002	High	2.2. 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-minutes standard of fire resistance.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General00295247	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Aeron block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General00295247_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.	Oct-21	Oct-21	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan shared by Head of Operations provides target date of October 2021.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.3. Fire doors should only be kept open by magnetic devices that releases when the fire alarm operate.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_002	High	2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113169	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ty Dyfi block of flats, Bronglais General Hospital, Caradoc Road, Aberystwyth. SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00113169_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.	Oct-21	Oct-21	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan shared by Head of Operations provides target date of October 2021.
Admin - General/00113168	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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113168	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	1.2. Self-closing devices on all fire resisting doors are to be checked and if required adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113168	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	1.3. Fire doors should only be kept open by magnetic devices which release when the fire alarm operates.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 1808/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113168	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	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113168	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_002	High	2.1. The staircases should be maintained with suitable materials to provide a fire resisting standard of at least 30 minutes. For example, the post box which opens on to the protected staircase.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00113 168	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/00113 168_002	High	2.2. 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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 168	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/00113 168_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.	Oct-21	Oct-21	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan shared by Head of Operations provides target date of October 2021.
Admin - General/00113 166	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/00113 166_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 that 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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_001	High	1.2. Self-closing devices on all fire resisting doors are to be checked and if required adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_001	High	1.4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_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.	Mar-22	Mar-22	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan from Head of Operations confirms survey work will be completed by end of September 2021. Costs and timescales to be confirmed post survey. 23/09/2021- Works programmed to be completed end March 2022.
Admin - General/00113 166	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/00113 166_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.	Oct-21	Oct-21	Amber	01/07/2021- Letter from MWWFRS state 'You should complete the work outlined in the schedule as soon as possible, balancing the need for safety against the demands on your business or undertaking'. Estates now reviewing and formulating action plan for completion of the work required. Action plan to be shared with Assurance and Risk Officer once finalised. 18/08/2021- Action plan shared by Head of Operations provides target date of October 2021.
HDUHB-2021-10	May-21	Internal Audit - HDUHB	Brexit Risks and Actions Advisory Review Final Report	Open	Advisory	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	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	Advisory	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	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	Advisory	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	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	Advisory	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	Amber	No information provided within the advisory report as to recommendation owner nor timescale for completion
2443A2021-22	Jun-21	Audit Wales	Audit of Accounts Report	Open	N/A	Workforce & OD	Finance	Annmarie 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.	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Open	Advisory	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:	N/K	Dec-21	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC. 10/08/2021 - update received as follows: This will require further discussion/consideration as there is no straightforward solution that could easily be implemented. The Workforce team attempted to log all staff temporary movements during Covid (deployments) although Directorates tended to deploy in real time and sometimes on a shift by shift basis. The Workforce team were therefore unaware of numerous movements which had already been effected by local Line Managers. Managers did not utilise ESR to log changes due to the regularity and volume of staff movements which would have made it a cumbersome exercise. We will undertake to establish how other HB's handles this issue. 14/09/21 update received the Operational Workforce team will now establish how many staff remain on deployment from their substantive roles, the reason and the location of temporary role. Discussions will then take place with substantive ad interim Line Managers in order to determine likely duration. It is proposed that staff change forms will be completed for all current and future deployments of over 8 weeks duration in order to help track movements and to enable substantive Line Managers to backfill. Discussions need to take place with Directorate service teams and Trade Unions and therefore it is estimated that this process will be complete by end of Dec 21.
HDUHB2021-11	Sep-20	Internal Audit - HDUHB	Governance Arrangement during the Covid-19 Pandemic	Open	Advisory	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:	N/K	N/K	Amber	25/05/2021- Audit tracker will be updated once update has been reported to ARAC. 10/08/2021 - update received as follows: The Agile working agenda is not being led from W&OD. Facilities are about to tender re some project management in order to build an infrastructure within the Health Board. The Home Working Policy does come under the remit of Workforce although will be reviewed as part of the HB wide initiative referred to above. 14/09/21 update received Facilities management are leading this initiative. Key design assumptions for the project will shortly be discussed with Execs and then submitted to Board at end of Sept. The T&F group met 13/09.21 – Workforce are part of this group and will ensure that any policy change is addressed as part of the actions.
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.	GP's and Primary care staff will be provided with a Service Specification for referral to CAMHS LPMHSS	Nov-19	~~Dec-20~~ Jun-21	Red	Training for GP's will be delivered via MS Teams advise this change to 6 months to enable above. 19/02/2021. No progress since last update. 22/03/2021 Primary Mental Health Lead appointed and work plan will be to progress training sessions with GP s provide the written criteria in English and welsh and close this action by June 2021 . 18/5/2021 Action Complete The Primary Mental Health Lead has commenced engagement with GP Leads across the HB footprint discussing and planning the training required. GP letters complete and available in English and Welsh and will be sent out to all GPs along with the SCAMHS Service Specification on 1/6/2021. to be confirmed end of June. 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
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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 S-CAMHS to AMHS	Dec-19	~~Dec-20~~ ~~Mar-21~~ Sept -21	Red	The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England and the Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services. 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed Transition Lead moving back into post April 2021 and work plan will be prioritised and the Transition Policy will be reviewed and updated and signed off at written control group – on track for Sept . 18/5/2021 On Track Transition Lead has resumed post and has a workplan established to meet actions identified in HIW action Plan. 22/6/2021 Role of transition lead -on track.
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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.	Dec-19	~~Dec-20~~ ~~March-21~~ Sept -21	Red	Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated.~~The~~ The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed Transition Lead moving back into post April 2021 and work plan will be prioritised . Transition Policy will be reviewed and updated and signed off at written control group – on track for Sept . 18/5/2021 On track The revised Policy will be sent to the written control group once complete. 22/6/2021 Transition Policy being updated in line with National Guidance
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning	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	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 - T4CYP Good Transition Guidance for CAMHS - Young Persons Passport - NICE Guidelines Transition - Emotional needs of young people and families –systemic approach	Dec-19	~~Dec 20~~ ~~March 21~~ Sept -21	Red	Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated.~~The~~ The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services . 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed Transition Lead moving back into post April 2021 and work plan will be reviewed and updated and signed off at written control group – on track for Sept and Transition Lead will arrange 2 x workshops for above to engage adult staff. 18/05/21 Transition Lead has established local transition groups with identified staff from the Adult Mental Health teams to focus on developing the workshops and disseminate good practice in respect of Transition. 22/6/2021 On track, monthly meetings are held with locally identified transition reps in 3 counties and updated Transition Policy being developed for formal sign off in July 2021
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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	Aug-19	~~Dec 20~~ ~~March 21~~ Sept -21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically. Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services 19/02/2021. No progress since last update. 22/03/2021 Head of Service has confirmed that Head SCAMHS will set up a Transition steering group May 21. 18/05/2021 On Track, Head of Service has established a multi disciplinary /agency Transition Steering Group and the first meeting will be 25/6/2021. 22/6/2021 Role of the Transition Lead is to monitor pathways and systems and report back to the Transition Steering group
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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 - Quality assurance on adherence to policy/ processes HDUHB will undertake an audit of transition on an annual basis to review its compliance with Transition Policy via the Quality Assurance Team (Appendix 5)	Aug-19	~~Dec 20~~ ~~March 21~~ Sept -21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically . Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated. The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services . 19/02/2021. No progress since last update. 22/03/2021 Head of Service confirmed that the Head SCAMHS will set up a Transition steering group May 21. 18/5/2021 On Track, Head of Service has established a multi disciplinary agency Transition Steering Group and the first meeting will be 25/6/2021 to include management actions. 22/6/2021 Role of the Transition Lead is to monitor pathways and systems and report back to the Transition Steering group.
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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.	Sep-19	~~Dec 20~~ ~~June 21~~ Sept- 21	Red	16/12/2020 HOS confirmed COVID 19 impacting on availability of Transition Lead to complete actions due to having to work clinically Realistically this will not be achieved by March 2021 due to C19 impact and advise a revised target of September 2021 as we don't know how long c19 restrictions will impact or when staff will be vaccinated . The Primary MH Lead has left her post and we have advertised and recruited a new b7 who starts Feb 2021 but will need an induction as coming from England. The Transition Lead has to work clinically now due to c19 as staff levels are low and we've had to prioritise essential services. 19/02/2021. No progress since last update. 22/03/2021 ~~T~~transition Lead moving back into post April 2021 and work plan will be priority 18/5/2021 On Track, Updated Transition Policy will have Young Persons Passport documents embedded. Training will be provided on use of document across SCAMHS and AMHS. Audit of process will include views and experiences of young people. 22/6/2021Transition Policy will be shared with young peoples /service user forum Future Minds in S-CAMHS for comments prior to submission to written control group for ratification.
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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.	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).

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_HAHSMNYO2019	Mar-19	HIW MHLD	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_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.	Sep-19	~~Mar 21~~ Sept 21	Red	Delayed due to Covid 19 recruitment priority. Relies on a new Transitional Lead post. No update August 2020. 02/10/2020 Requested update - Change completion date to Sept 2021 due to training pack needing to be developed by the transition worker and training set up on MST. 16/12/2020 Time frame realistic and dependant on all above actions being implemented. 19/02/2021. No progress since last update. 22/03/2021 Head of Service confirmed Training sessions will be organised. 18/5/2021 On track .Training Plan being developed for rolling programme over next 12 months. 22/6/2021 Steering Group consists of scamhs and Adult Mental health representatives to improve communication and understanding of the different needs of young people who need to transition Welsh Government is reviewing all Transition processes across Wales with a view to implementing a digital transition passport . HOS scamhs and Transition Lead will be involved in this work stream.
HIW_JTRCMHT	Feb-19	HIW MHLD	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 Administration System (WPAS) anticipated this year, followed by migration to Welsh Community Care Information System (WCCIS) across health and social care services.	Dec-22	N/K	External	4/12/2020 update requested, response received: WPAS migration has been completed however some issues between the interfaces of the systems are being ironed out. 19/02/2021 This recommendation is partially completed by the HB. The HB has agreed with the Delivery Unit to deliver a presentation on any outstanding actions. Outlining the thematic actions that are considered unachievable. (Outside of gift of the HB).
20136	Apr-21	HIW MHLD	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 unavailable to address these concerns then the service will escalate accordingly.	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. 31/05/2021 Recommendation revert back to Amber as not completed until Nov 2021. 4/06/2021 Recommendation is now Red. 07/09/2021 - confirmation from ward manager received that no bathroom refits/work had started in August. Recommendation to remain red.
20136	Apr-21	HIW MHLD	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 Synbiotix system (already in place in other Health Boards) that will allow real time data, reaction and improvements in efficiency in cleaning standards. This system is being phased in throughout the 2021/22 financial year.	Mar-22	Mar-22	Amber	19/05/2021 New system delayed, although the C4C work identified is being progressed and capital funding has been approved work is likely to be completed November 21.
20136	Apr-21	HIW MHLD	Quality Check: Morlais Ward, GGH	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.	NK	NK	Amber	19/05/2021 Awaiting WG relaxation of current of social distancing rules to be approved prior to face to face training being recommenced. 07/09/2021 - Fire training has recently commenced via Microsoft Teams and members of staff are booking on and attending
19009	Sep-19	HIW MHLD	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 DOL's and MHA will be developed and draft will be sent to HB legal department for review prior to ratification	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.
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.	Aug-21	Aug-21	Red	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.	Aug-21	Aug-21	Red	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.	Aug-21	Aug-21	Red	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.
LPJ/HD/04102019/06	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 Experience	JHET/HD/0410 2019/06_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 Sep-21	Apr-21 Sept-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 22/06/2020- Update provided to Health & Safety Assurance Committee. Recs are behind schedule with varying timescales until April 2021. 07/09/2020- HSE has granted extension to 29/01/2021. 25/01/2021- Action Plans submitted to HSE, feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber. 15/07/2021- Health & Safety Manager confirmed still on track for September 2021 date.
LPJ/HD/04102019/06	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 Experience	JHET/HD/0410 2019/06_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. 25/01/2021- Action Plans submitted to HSE, showing this recommendation not being fully implemented until post Covid. Feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber. 15/07/2021- Health & Safety Manager confirmed still on track for September 2021 date.
LPJ/HD/04102019/06	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 Experience	JHET/HD/0410 2019/06_005	High	R5. Implement a programme for making available the relevant information, instruction and training to those required to investigate and record incidents. OR Implement any other equally effective measures to remedy the said contravention.	Various actions noted under this measure.	May-20 Jul-20 Jan-21 Sep-21	Dec-20 Sep-21	Amber	The HSE wrote a notice of extension agreeing that the timescale of 01/05/2020 for this improvement notice is extended to 31/07/2020. 07/09/2020- HSE has granted extension to 29/01/2021. This recommendation is on track to be implemented by this date. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE showing this recommendation as complete. Feedback from HSE January 2021 visit awaited. 19/03/2021- HSE letter confirming extension to 24/09/2021 for this notice. Red recommendations turned back to amber. 15/07/2021- Health & Safety Manager confirmed still on track for September 2021 date.
LPJ/HD/04102019/08	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 Experience	JHET/HD/0410 2019/08_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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
LPJ/HD/04102019/08	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 Experience	JHET/HD/041020190 19/08_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.
JHET/HD/0410 2019/02	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/0410 2019/02_003	High	R3. Identify sources of information on manual handling incidents and near misses, and use these to reach a reliable estimate of occurrence and severity. This could include: a. Incidents recorded on Datix and how these are coded; b. Referrals to Occupational Health related to musculoskeletal disorders; c. Sickness absence records related to musculoskeletal disorders; d. Information from employee groups who do not have access to Datix; e. Information from employee representatives; f. Information from those providing training under the All	See management response for recommendation1 - not clear how the actions are split across the 5 recommendations	May-20 Jul-20 Jan-21 Jun-21 Sep-21	Dec-20 May-21 Jun-21 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. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.
JHET/HD/0410 2019/02	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/0410 2019/02_001	High	R1. Establish a management system to monitor and review the implementation of your Manual Handling Policy number 273. This should include but is not limited to: a. Setting standards by which to assess the performance of those with responsibilities. b. Developing systems for proactive monitoring by managers and senior managers appropriate to their roles to identify whether suitable risk controls are in place. c. Developing systems for the auditing of risk control measures by competent person(s) outside the line management chain.	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 Sep-21	Oct-20 Dec-20 May-21 Jun-21 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 granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.
JHET/HD/0410 2019/02	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/0410 2019/02_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 Sep-21	Oct-20 Dec-20 May-21 Jun-21 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 granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-The M&H Team are in the process of developing an SBAR to request funding for a new 0.6FTE Band 4 to assist the team in fulfilling their duties. Revised timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.
JHET/HD/0410 2019/02	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/0410 2019/02_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 Sep-21	Oct-20 Dec-20 May-21 Jun-21 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 granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.
JHET/HD/0410 2019/02	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/0410 2019/02_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 Sep-21	Oct-20 Dec-20 May-21 Jun-21 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 granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper-All of the actions identified in the notice schedule are in the process of being addressed by the Moving and Handling Team (M&H Team) through their Action Plan for 2020-2021. Timescale December 2020. 25/01/2021- Action Plans submitted to HSE showing recommendations will be fully implemented by May 2021, feedback from HSE January 2021 visit awaited. 19/03/2021- Formal HSE letter confirms extension to 25/06/2021 for this improvement notice. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.
LPJ/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/0410 2019/07_002	High	R2. Where such manual handling operations cannot be avoided you should in consultation with the Health Board's health & safety competent persons, and with their employee representatives, assess the risks and identify additional controls for all manual handling activities in theatres: You should take into consideration the following: a) Identifying all of those activities which pose a risk to employees' health and are not included in the All Wales Manual Handling Passport including: static support of patients' limbs, moving and handling patients into the prone position, repositioning patients during surgery. b) Developing systems to carry out suitable and sufficient risk assessments c) Identifying changes in processes to avoid manual handling or additional controls to reduce the risk to employees' health. d) Providing suitable and sufficient information, instruction and training to those who will be carrying out the patient handling e) Providing suitable and sufficient information, instruction and training to those who will be carrying out inanimate load risk assessments including wheeled operations. f) Developing a system to communicate the findings of the assessments and controls identified to eliminate or	Various actions noted under this measure.	May-20 Jul-20 Jan-21 Jun-21 Sep-21	Jul-20 Oct-20 Dec-20 May-21 Jun-21 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. Delayed to October 2020. Some of the delays are due to the impact of COVID-19 and the required re-directing of resource to manage the evolving Health Board response to the situation. Others, such as the contractor compliance work, are based on a phased approach to compliance. 07/09/2020- HSE has granted extension to 29/01/2021. 02/11/2020- update from H&S Assurance Committee paper shows timescale of December 2020. 25/01/2021- Action Plans submitted to HSE, showing one action outstanding to May 2021. Feedback from HSE January 2021 visit awaited. 17/03/2021- H&S Manager confirmed HSE requested additional information that has been submitted, therefore they are hoping this improvement notice will be formally signed off by HSE shortly. 19/03/2021- Health & Safety Manager confirmed HSE confirmed they consider this recommendation to be outstanding, recommendation amended from green to red. HSE granting extension to June 2021. Formal letter from HSE should be received next week. 11/05/2021-Health & Safety Manager confirmed this rec is on track to be completed by June 2021. 15/07/2021- Health & Safety Manager confirmed HSE has recently visited PPH & BGH, including checking up on this work. Awaiting formal response from HSE, however it is anticipated from informal feedback that an extension to September 2021 will be granted. 03/08/2021- Letter dated 23/07/2021 from HSE confirming further extension to 24/09/2021. Recommendation changed from red back to amber as a result of the formal extension.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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 are happy for all MBs to be closed. Formal letter from HSE should be received next week. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021. 12/07/2021- Health & Safety Manager confirmed December 2021 timescale remains. This is dependent on the recovery of face-to-face PAMOVA training post-Covid which will continue to improve.
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 are happy for all MBs to be closed. Formal letter from HSE should be received next week. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021. 12/07/2021- Health & Safety Manager confirmed December 2021 timescale remains. This is dependent on the recovery of face-to-face PAMOVA training post-Covid which will continue to improve.
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 are happy for all MBs to be closed. Formal letter from HSE should be received next week. MB to stay red until formal confirmation received. 30/03/2021-Director of Nursing, Quality and Patient Experience confirmed MB to stay open until outstanding work completed, recommendation remains red. 11/05/2021-Health & Safety Manager confirmed this action is dependent on the recovery of face-to-face violence and aggression training post-COVID19 for which a plan has been developed with revised timescale of December 2021. 12/07/2021- Health & Safety Manager confirmed December 2021 timescale remains. This is dependent on the recovery of face-to-face PAMOVA training post-Covid which will continue to improve.
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 advise the Heads of Department if performance / compliance does not reach the standards required. The role will involve proactively working with the Health & Safety Team to establish and maintain a culture of safe, environmentally friendly practices across the organisation. Working with the Directorate senior management team, they will be responsible for implement the Health & Safety Policy and systems, and keeping up-to-date with the relevant legislation. In the meantime, the H&S Team are undertaking H&S departmental audits that commenced March 2020. Planned annual programme in place.	Aug-20	Oct-20 Sep-21	Red	The dept. H&S Co-ordinator/Champion role has not been implemented to date due to the work undertaken for the H&S team with the HB response and management of COVID-19 pandemic. The H&S Training programme that has been established will be utilised to provide training to these staff. The Pilot course is being held on the 16th & 23rd October 2020. 23/10/2020- requested update from reporting officer that recs 2, 3 and 4 have now been implemented. Awaiting response. 26/01/2021- Internal Audit are planning scope of next Health & Safety IA report with H&S team, to be reported to ARAC in April 2021 (if it does not make February 2021 agenda). 25/03/2021- draft report to ARAC shows this recommendation as partially completed. Establishment of Departmental Health and Safety Champions/Co-ordinators has not been completed due to our departmental contribution to COVID-19 commitments. However, H&S Induction Training for Managers has progressed with approximately 150 staff completing the course since October 2020. Departmental Audits commenced in March 2020 with a planned annual programme in place. This recommendation will be completed as part of improvements to departmental management and ownership of health and safety by September 2021. 06/07/2021- Update requested from reporting officer by 16/07/2021, no response as of 29/07/2021. 27/09/2021- Lead officer confirmed recommendation remains outstanding due to other demands. This 'H&S Champions / Co-ordinators' model has not been progressed. In its place we have provided training to departmental managers in the form of the H&S induction. This model is to be reviewed by the H&S team.
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.	Jul-21	N/K	Red	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. 27/09/2021- lead officer confirmed this has not been submitted yet but he will double check.
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.	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. 27/09/2021- lead officer confirmed KPI's written and included in the HSE Action Plan submitted to the HSE Sept 21
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.	Jul-21	N/K	Red	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. 27/09/2021- lead officer confirmed escalation reports will be submitted to the HSC where appropriate from Directorate meetings. Risk and assurance officer clarifying if Chairs of each directorate meeting have been reminded.
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_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.	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. 27/09/2021- lead officer confirmed total training figures have been collated but not Directorate specific. Data can be extracted directly from ESR. Risk and assurance officer clarifying if training figures are reported to directorate/service quality and safety meetings
How are healthcare services meeting the needs of young people? Thematic Review 2019	Mar-19	HIW MHLD	How are healthcare services meeting the needs of young people? Thematic Review 2019	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.	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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.	Dec-19	Dec-21	Red	09/02/2021- update from new SDM- We have improved boarder free working amongst the clinicians and this has reduced the need to have an enhanced clinical leadership on shift in the short to medium term. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021- Meetings have begun with the clinicians from across Hywel Dda. These meetings cover multiple topics including OOH working practices such as border free working. These meetings will continue over the next 2-3 months. Further updates will be available following the meetings and evaluation of points raised and actions. The Shift Supervisors are being encouraged to manage the shifts more robustly to enable a more efficient service and access to care by patients contacting the service. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged.
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.	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. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged.
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.	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. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged.
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 26/02/20 to discuss staff behaviour. This was reviewed at Exec Team at the last OOH performance review in December 2019.	Jan-20	~~Mar-20~~ ~~Oct-20~~ Dec-21	Red	Partially complete- Meeting took place with Assistant Director of Organisation Development on 26/02/20 to discuss staff behaviour. Actions resulting from this meeting, including an additional UHB Values session with staff has been delayed due to COVID-19. Approximate revised date of December 2021 but could be delayed further depending on COVID. 09/02/2021- recommendation still delayed due to Covid, however in the meantime any significant issues are reported to the Director of Operations. 25/03/2021- Deputy Director of Operations advised he is currently not in a position to provide assurance the December 2021 deadline will be met. Deputy Director of Operations confirmed he will arrange to have an in depth conversation with the new SDM to establish if these dates are still realistic in light of Covid. 28/05/2021-The Clinical Lead and Service Delivery Manager are planning to meet all the OOH workforce to discuss issues and seek a team approach to identify good practice and areas requiring improvement. Regular contact with the Deputy Medical director and Associate Medical Director and their inclusion in meetings is allowing a timely response to discussion points and access to further support and advice. The SDM has begun discussion to design and implement a staff survey which will be made available to the entire OOH workforce. The results will enable a meaningful evaluation of the OOH workforce, allowing consideration of the needs and opinions in service improvement. 16/08/2021- The work to address the four recommendations continues with no conclusions and so at this point the progress updates remain unchanged.
21002	Jun-21	HIW Contractors	Tenby Surgery (UHB Managed Practice)	Open	N/A	Primary Care, Pharmacy (community), LTC & LVWS	Estates	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.	Flooring: actions will be as follows; 1. Inspection by team – 16/06/2021 (completed) 2. Tender to be developed by 02/07/2021 3. Tender to be awarded by 09/07/2021 4. Replacement flooring to be fitted by 10/09/2021 Photographs of completed works to be submitted as evidence by 10/09/2021	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." 27/08/2021- Update from Quality Manager Primary Care- The contractor is starting the flooring on 08/09/21. This is where another room will be completed. By this point that will mean two rooms have had IP&C compliant flooring installed. The contractor is then not available to install the rest of the area's until 27th September – 1st October. They have been booked for these dates. 06/09/2021 - call with Business Manager of General Medical & Provider Services, and Head of GMS, confirming delay to completion date. RW to e-mail estates to confirm expected completion date of 01/10/2021 prior to updating HIW on progress. 17/09/2021- Head of Operations (Facilities) confirmed the flooring supplier will be return to complete all remaining areas latest 01/10/2021 subject to vinyl supplies arriving next week from the EU. Head of Operations will provide clarity next week.
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.	Nov-20	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. 07/09/2021 The policy Co-ordination Officer advised the existing version of the BCPolicy was formally extended until 31/12/2021.
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 to aid escalation and de-escalation during periods of high demand or pressure in the system. This work was taken over by events at the end of January / beginning of February 2020.	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 EP Officer emailed Policy Co-ordination Officer to advise this policy should be approved at PPPAC. 07/09/2021 The policy Co-ordination Officer advised the existing version of the BCPolicy was formally extended until 31/12/2021. The EP Officer will review and update and the policy will be presented to the H&S committee for approval.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB 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. Please note any staff member that works less than full time hours does not receive overtime payments until they reach normal working hours.	Apr-19	Aug-20 Dec-21	Red	Further meetings have been held with leads from the programme management office in an effort to maintain momentum Another is scheduled to happen in August . In addition discussions in July have been held with Workforce and Organisational Development regarding the bespoke leadership training for the radiology site leads. Any changes to current staging rotas have taken into consideration new ways of working There however has been no opportunity to present developments to date or the revised staffing models to the executive team due to the response to Covid-19 . 24/08/2020- revised date of December 2021 date as this relies on a new system, substantial more staff and a whole radiology transformation. Update to be provided to ARAC in February 2021. 04/02/2021- Head of IA to check the detail of the recommendation to see if the original recommendation has been addressed. 26/02/2021- Update to ARAC Feb2021 meeting reports recommendation 8 as outstanding. This recommendation is connected to the historic arrangements for the radiography out of hours provision. 25/03/2021- Reporting officer provided a revised date of December 2021 for the new rota system to be embedded and sustainable on-call arrangements in place. A further update has been requested to ARAC for its August 2021 meeting.
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	Jun-21	~~Jun-21~~ Sep-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. 23/09/2021 - A notice board has been ordered and is due to arrive by the end of September. This will display patient and staff feedback. We are also working with the Head of Culture and Workforce experience team to align staff experiences with patient experiences.
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	May-21	~~May-21~~ Nov-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. 23/09/2021 - RPG did not take place due to managerial changes. This will now take place in Nov. A Radiology health board wide programme will be implemented - this will be pulled together by new RSM when in post.
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	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. 23/09/2021 - Reviewing method of doing so - this will be agreed at the next Medical Exposure Group scheduled for Nov 21.
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.	May-21	~~May-21~~ Nov-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. 23/09/2021 - Management changes have delayed - This will be completed when new RSM begins role , expected Nov 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).	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. 23/09/2021 - To be reviewed and agreed at RPG Nov 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	Jul-21	~~Jul-21~~ Nov-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. 23/09/2021 - To be reviewed and agreed at RPG Nov 2021
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince	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	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021	May-21	~~May-21~~ Nov-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	May-21	~~May-21~~ Nov-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. 23/09/2021 - To be reviewed and agreed at RPG Nov 2021
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.	Jul-21	~~Jul-21~~ 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. 07/07/2021- email sent to Assistant Director (NQPE) for updates on PSOW recommendations by 28/07/2021. 28/07/2021- June meeting did not go ahead as planned and this is now scheduled for September 2021. Assistant Director (NQPE) advised service that she needs to be informed asap if there are any concerns about this date as PSOW will need to be informed. 07/09/2021- Assistant Director (NQPE) confirmed the reflection exercise it to take place on 17/09/2021, the matter is on the agenda and the team has already received a copy of the presentation which will be forwarded to the Assistant Director after the date, so she can complete the evidence with the ombudsman.
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.	Mar-21	Mar-21 Sep-21	Red	By the middle of quarter 2 (August 2020) will have better idea of the waiting lists due to COVID and will review this recommendation at this time to establish if March 2021 deadline is still feasible. 26/11/2020- Update from SDM- No change since last update. We are continuing with the community schemes in relation to glaucoma and cataracts, and a consultant is reviewing these patients to ensure that anyone with an urgent condition is offered a hospital appointment. We are exploring digital opportunities with our community optometrist practices for AMD referrals. We will have a better idea of timescales for implementation by January 2021. 25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 22/09/2021- Update requested on 03/09/2021 with deadline of 17/09/2021, no response received.
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.	Mar-21	Mar-21 Sep-21	Red	See update in recommendation 1- due to current COVID situation only those with greatest risk of sight loss now been given priority on the pathway. Recommendation to be reviewed in August 2020 to establish if March 2021 deadline is still feasible. 26/11/2020- Update from SDM- Continue to work with community optometrist practices to explore the opportunities for multi disc team working in community settings, for example the digital work mentioned above is a current project we are scoping. 26/03/2021- Updates have been requested from the reporting officer however due to operational pressures and annual leave no update has been received as of 26/03/2021. 25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021.
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	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. 25/08/2020 update- still awaiting national roll out as part of national work stream. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 22/09/2021- Update requested on 03/09/2021 with deadline of 17/09/2021, no response received.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU_HDA_1920_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 Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_001	Medium	R1. Cardigan Integrated Care Centre (original R1): Clarification should be provided to differentiate between the Project Group quorum, members and attendees.	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 project i.e. - Inclusion of quoracy arrangements in approved Project Group terms of reference; - Development of full activity based resource plans for all stages of the project which should be subject to regular review; - The regular review and update of the Project Governance Framework throughout a project's duration; and - Preparation of management control plans at the outset of projects.	May-19	~~Jul-21~~ ~~Oct-21~~ Nov-21	Red	23/02/2021 - as per this new follow up report (follow up of SSU_HDA_1920_01.2), recommendation outstanding as follows: Management advised that due to the impact of Covid on the availability of service leads this has not yet been undertaken. It is anticipated the PPE will be undertaken during the summer. This recommendation was previously considered as actioned per updates received from the service (SSU_HDA_1920_01.2_001). Recommendation has been re-opened as part of this more recent follow up review, and noted that the recommendation owner is now Head of Capital Planning and not Project Director as per previous report. 04/03/2021- on track for July 2021 date. 14/04/21, 09/06/21 & 09/07/2021- Planning Project Manager update- Post project Evaluation for Cardigan ICC has been delayed due to COVID-19. It has been agreed with WG that the Cardigan PPE/Gateway 5 Review will now be undertaken in October 2021. 11/08/2021- Initial meeting with WG has been held, outcome WG will now contact Assurance Hub to arrange the Gateway 5 review, now likely to be in Nov 21. Internal PPE will be concluded in advance of the Gateway 5 review. 08/09/2021- Work on the internal PPE has commenced.
SSU_HDA_1920_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 Wheeler-Jones / Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU_HDA_1920_01.1_002	Medium	R4: Bronglais Front of House: The planned post project evaluation (PPE) exercise for the Bronglais Front of House development will consider the issues raised in the prior Bronglais audit reports as follows: - An evaluation of the adequacy of design solution for the development; - Confirmation (or otherwise) that the original business case assumptions remain valid, or implications will be assessed; and - performance against the targets of the business case will be assessed.	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 Evacuation lift]. The Project Director will lead the completion of the PPE by March 2021.	Sep-19	~~Mar-21~~ ~~Sept-21~~ Jan-22	Red	23/02/2021 - as per this new follow up report follow up of SSU_HDA_1920_01.2), recommendation outstanding as follows: The Project Director will lead the completion of the PPE by March 2021. The recommendation was previously considered to be outstanding from the previous follow up report. 04/03/2021- more realistic date of September 2021 provided, this work has been delayed due to other work prioritised due to Covid-19. 14/04/21, 09/06/21 & 09/07/2021- Planning Project Manager update- Post project Evaluation for BGH Front of House has been delayed due to COVID-19. It has been agreed with WG that the FOH will be an internal PPE and a date needs to be agreed with the County Team. 11/08/2021 and 08/09/2021 update- The conclusion of this review will be reported to CEIM&T in January 2022.
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 (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_006	High	R6: In accordance with the NEC contract, the external advisers should provide a detailed assessment report of the delays to date (to include contributing factors, programme and cost implications, acceptance / rejection etc.)	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.) (Update to Management Response June 2021- PM will produce a detailed retrospective assessment once the work on Section 1 and 2 of the scheme is complete. Completion date for Section 2 has been delayed.)	Jul-20	~~Aug-21~~ Oct-21	Red	Complete-PM is undertaking this on a monthly basis and incorporating into monthly report on an ongoing basis. CEIM&T report in July 2020 provides retrospective position 05/05/2021 - follow up report issued in 2020/21 on Women and Children Development (SSU HDU 2021 03) provided the following update: "Partially Addressed - A full review of delays awarded was reported to PPPAC in August 2020 and the Project Group now receives incremental updates on the delays to date. To fully action the above, a formal report should be prepared by the advisers to include: •delays claimed; • delays awarded (including detailed events, rationale and relevant contractual clause); • rejected claims for delays (including rationale and relevant clauses); and • delays not yet covered by claims. It has been agreed that this will now be produced at the end of the current phase to cover all delays accepted/ rejected to date. Revised Responsibility and Timescale is Project Director / Immediate. Assurance and risk officer to clarify with Planning colleagues when this recommendation will be completed. 28/05/2021- Head of Capital Planning confirmed PM will produce a detailed retrospective assessment once the work on Section 1 and 2 of the scheme is complete. Completion date for Section 2 has been delayed. No revised timescale received. 09/06/2021 & 09/07/2021- Meeting with Internal Audit, the report will be prepared at the end of Section 2., which is currently scheduled for the end of July 2021. 22/07/2021- Internal Auditor confirmed recommendations 6 & 8 are linked to one another and are unlikely to be concluded until the end of August 2021 and the end of the current stage of the project. 11/08/2021 & 08/09/2021 update- Section 2 completion has been delayed to September 2021.
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 (Planning)	Director of Strategic Development and Operational Planning	SSU-HDU-1920-02_008	Medium	R8: Reporting to the Project Group should be extended to include: * mitigating factors e.g. Compensation Events; * early access to phases * extended programmes for individual phases; * economies generated from overseeing phases; * the impact of delays from prior phases and forward impact on remaining phases; * remaining potential for phase over-lap; and * delay damages arising.	The Project Manager will produce more detailed reports to the Project Group in future, to include the points listed in the audit report	Jun-20	~~Jul-20~~ ~~Jun-21~~ 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 above), key project time impacts including issues relating to the major Compensation Events were seen to be routinely reported to the Project Group as they arose. As such, incremental delay was well reported. However, an analysis of unagreed delay, between time pending review, and other delay was not identified. Management have advised that a summary of time spent on each phase compared to budget will be added to reporting." Revised responsibility and timescale is Project Director / Immediate. Assurance and risk officer to clarify with Planning colleagues when this recommendation will be completed. 28/05/2021- Head of Capital Planning confirmed this is will be captured in monthly PM report from June 2021. 09/06/2021- Report provided to Audit, awaiting confirmation that this can be closed. 09/06/2021 to 11/08/2021- Report provided to Audit, awaiting confirmation that this can be closed. 22/07/2021- Internal Auditor confirmed recommendations 6 & 8 are linked to one another and are unlikely to be concluded until the end of August 2021 and the end of the current stage of the project. 11/08/2021 & 08/09/2021 update- Report provided to Internal Audit, awaiting confirmation that this can be closed.
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 (Planning)	Director of Strategic Development and Operational Planning	SSU Capital Governance_005	N/A - Advisory Review	R5. There is an opportunity to standardise and define expected UHB governance arrangements within procedures, including for example, standardised terms of reference for Project Boards/ Groups etc.	Agreed. Existing procedural arrangements will be reviewed and defined as appropriate.	May-21	~~Jul-21~~ Oct-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. 09/07/21 to 11/08/21 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. 08/09/2021 - ToRs were agreed at Aug-21 ARAC. Report expected in Oct-21.
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 (Planning)	Director of Strategic Development and Operational Planning	SSU Capital Governance_008	N/A - Advisory Review	R8. The UHB's established capital governance and control arrangements will be reviewed and enhanced, together with its existing procedural documentation, to comprehensively document the control framework.	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.	May-21	~~Jul-21~~ Oct-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 recommendations contained in this advisory report. 09/07/21 to 11/08/21 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. 08/09/2021 - ToRs were agreed at Aug-21 ARAC. Report expected in Oct-21.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
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	Educational Packs for GPs are ready to go and a launch at Welsh Government level is imminent – but no date has been received as yet. As soon as the pack is received the Community Learning Disabilities Team will participate in the delivery of the training to primary Care Teams. 11/09/2020- Unfortunately this remains on hold as Public Health Wales have not circulated the Packs as yet. 18/11/2020- Reporting officer confirmed there has been no further update on when the Education Packs are likely to be circulated to the GPs by the central LD team in WG. 26/03/2021- Awaiting confirmation of new reporting officer. 25/05/2021- Assurance and risk officer has contacted Assistant Director of Nursing for confirmation if she is the correct person to contact for updates going forward, awaiting response. 19/07/2021- update provided by Professional Lead LD nursing on behalf of Assistant Director of Nursing, (Nursing Practice)- The 'delivering healthcare to people with a learning disability' has been launched by Welsh Government and Improvement Cymru. An E-Learning version is currently in development. Due to the pandemic a full launch has not been possible. However HDUHB now employ 3 Primary Liaison nurses and 3 Health Check Champions (individuals with a learning disability) who are working to improve the quality, quantity and outcome of the annual health check. They plan to launch the training as part of their ongoing work. The Health Check Champions have developed 2 posters which were circulated to all GP practices and Hospital out -patient and emergency departments during learning disability awareness week at the beginning of June, and will be circulated to day care services when they re-open.(see attached) The learning disability service is currently undergoing service review as part of this work a physical health pathway will be developed which will clarify processes for people with a learning disability their families/carers and all those who support their physical health.
RCP 2019	Sep-19	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 (5 Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	Mar-21 Mar-23	Red	This is part of a wider site plan and progress was being made across key areas but now, is necessarily on hold, due to Covid. Acute stroke is the only one where day rate tariff is now in place. 25/01/2021- Responsible officer confirmed this is a part of the BGH Clinical Strategy work which will be completed by March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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.	Mar-21	Mar-21 Mar-23	Red	As above, as part of wider site plan. Working collaboratively with SC in regard to reinstatement of scheduled activity (Covid plan) which is working well. Also exploring options for local site management representation for SC. 25/01/2021- Responsible officer confirmed this is a part of the BGH Clinical Strategy work which will be completed by March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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 work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	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 it isn't effectively represented in this action plan. Telemedicine has been enhanced and progress escalated due to Covid. Many clinical services are using technology extensively to reduce risk and enable patients to access care, where appropriate via virtual means. Attend Anywhere and other software are being trialled by the Scheduled Care Directorate, who manage OPD. They have produced an SBAR which gives dates etc. for implementation. BGH team (HD is Mid Wales lead for telemedicine) are providing an update to the November 2020 Mid Wales Board re telemedicine. Due to Covid we have established a fruitful primary care operations group for Ceredigion (meets bi weekly) BGH are progressing a dedicated telemedicine suite for the site (Spring 2021 approx.) which will enable tertiary interface and patient consultations, including for in patients. 25/01/2021- Responsible officer confirmed good progress being made with telemed but this will be a work in progress linked to the strategy for some time. Though some elements can be considered completed. Recommendation to remain amber for the time being, to be further reviewed in March 2021. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm if this recommendation is implemented, and if not and the recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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.	Dec-20	Dec-20 N/K	Red	On hold due to Covid. 25/01/2021- Responsible officer confirmed this remains on hold due to Covid. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm if this recommendation is implemented, and if not and the recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. If this is not part of Clinical Strategy then a revised timescale will be required. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth |University. Both developments will include clinical skills facilities.	Sep-22	Sep-22	Amber	12/10/2020- PGC Development on the BGH site in progress. Completion to be confirmed but 2021/22. Programme of improvement to under and post graduate site accommodation is in hand – completion by June 2020. School of Health Sciences with incorporated School of Nursing is in the accreditation process at present with a plan for completion and first intake September 2022. 25/01/2021- Responsible officer confirmed in progress for September 2022 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	Sep-22	Amber	12/10/2020 – PGC development. Works completion due 2021/22. 25/01/2021- Responsible officer confirmed in progress for September 2022 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	Dec-21	Amber	Part of above 25/01/2021- Responsible officer confirmed in progress for December 2021 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RCP 2019	Sep-19	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_005	N/A	5.4 Develop the postgraduate education centre, including clinical skills and simulation equipment	Working with Aberystwyth University to establish a Faculty of Health Sciences with School of Nursing locally (awaiting accreditation from RCN_	Mar-23	Mar-23	Amber	On track. 25/01/2021- Responsible officer confirmed in progress for March 2023 timescale. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
RCP 2019	Sep-19	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_005	N/A	5.5 Develop the postgraduate education centre, including clinical skills and simulation equipment	Establish how the SIFT funds are accounted for within the HB	Jul-20	May-21	Red	In hand. Monies allocated to improve accommodation on site. 29/10/2020- requested revised timescale and progress update from Director of Secondary Care. 25/01/2021- Responsible officer confirmed accommodation improvement on track, additional 20k now allocated and work should be completed by May 2021. Original completion date of July 2020 was stated in error. SIFT monies now identified – recent meeting with Assistant Director (Medical Directorate) who has a plan for sites in hand subject to agreement with the DoF. 25/03/2021- This recommendation is currently being progressed by the Assistant Director (Medical Directorate) and the Director of Finance. 08/07/2021- SBAR paper to be written to CEIMTSC to advise of the impact to the DCP.
RCP 2019	Sep-19	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_006	N/A	6.3 Ensure training posts are attractive with time for research, teaching and quality improvement	Potential for a Rural Medicine module (rotation) in the future to be based at Aberystwyth University in line with evolving Royal College thinking.	Mar-23	Mar-23	Amber	Long term plan. 25/01/2021- Responsible officer confirmed this could potentially take longer than March 2023 as it sits with the Deanery and is out of her hands. Recommendation will remain amber for now and to be reviewed closer to the original timescale date of March 2023. 24/03/2021- Assurance and risk officer contacted reporting officer to confirm that if this recommendation is captured within the BGH Clinical Strategy then is she happy for it to be closed. Reporting officer out of office until 29/03/2021. 11/05/2021-Assurance and risk officer emailed reporting officer re. recommendations moving to Strategic Log, awaiting response from reporting officer. 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.
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	DelUnitCardio002	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~~ Nov-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. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 10/08/2021 – new outcome form utilised from 09/08/21. Compliance audit to be undertaken w/c 06/09/21 which will report findings and remedial actions by end of September 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	DelUnitCardio003	N/A	R3b: In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): b. clinical agreement that all referrals sent to tertiary service clearly include the clinically determined PSD and current adjusted PSD, including a standardised referral form which is consistent across HDUHB.	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~~ Sep-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. 11/06/2021 update -Audit currently being undertaken across all 4 HDUHB referring sites. Findings and recommendations will be collated and reported by the end of June 2021. Cardiology SDM and SSM will focus on any needed remedial actions from July 2021 and re-audit compliance in October 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 10/08/2021 – Compliance audit currently in progress and will report findings and remedial actions in September 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	DelUnitCardio003	N/A	R3f.In advance of any national guidance or clinical agreement, establish regionally (between HDUHB and ABMUHB): f. a move towards the electronic referral of patients between Cardiology and Cardiac Surgery, based on the above work.	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 tertiary care element and processes of all pathways – it is anticipated that this work will provide an updated perspective of the needed digital/electronic component of future cardiology pathways. This project runs to the end of March '22 at which point it will report its findings and recommendations relevant to this action. 10/08/2021 – Cardiology Pathway Transformation Project in progress and will report it's recommendation re development of an electronic referral system by March 2022.
18264	Jun-19	HIW	HIW Cadog Ward & Ceri Ward, Glangwili Hospital, 5-6/3/19	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Olwen Morgan	Director of Operations	Cadog_014	N/A	R14:The health board must ensure that oxygen is accurately prescribed and a record of administration maintained on the All Wales Drugs Chart.	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~~ Nov-21	Red	Senior Nurse currently working alongside Senior Nurse for Medicines Management to devise training package. Will form part of wider HB approach to addressing training needs for all practitioners in relation to oxygen administration. Suspended due to Covid-19 pandemic. To rearrange for October 2020. 22/01/2021- Hospital HON confirmed she will check with clinical Directors that this was discussed with medical staff and will check training status. 19/02/2021- Hospital HON confirmed she will discuss with Dr. Ward to undertake audit of O2 prescribing. 26/03/2021- update from Consultant Respiratory -'the project should be complete within the next 2 months. Hopefully sooner. It may take a bit longer to organise an educational session, so a rough timescale of 2-3 months'. Revised timescale of June 2021. 29/07/2021- update requested on 16/07/2021 by deadline of 28/07/2021, no update received. 11/08/2021- The doctors who were doing the oxygen QIP have completed the first cycle, they are handing over to the current team to complete. Hopefully within 2-3 months.
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	Aug-20	Aug-20 April-22	External	16/09/2020 Update received: SH advised A report on this is to be submit to the mental capacity and consent group next week for approval. It's been delayed as some of the key consultees in mental health haven't been available and the consent group hasn't met since February due to Covid response issues. If approved by the group next week it will still need to go for approval by the equivalent Mental Health scrutiny group, I'm not sure when they next meet. Further progress to be issued next week. 6/11/2020 update received from DOLS Co-ordinator. We have a DoLS policy that is within its review date. LPS will be completely new legislation and the DoLS policy will become obsolete on its introduction as it completely replaces DoLS. The work on the interface could be added to the current DoLS policy as an appendix detailing procedures to be followed, it can then be added to a future LPS policy as very similar issues will remain under the new legislation. Unable to provide a new date new LPS not expected before April 22. 11/03/2021 Recommendation currently outside the gift of the Health Board until new legislation is in place. 27/08/2021 Deprivation of Liberty Safeguards Coordinator advised, the changes to the DoLS policy regarding the MHA/MCA interface were approved and have been implemented. The LPS implementation date is still April 2022, but it is widely expected to be postponed again until at least October 2022. The implementation of LPS, including development of a policy, is being led by Madeleine Peters, Head of Mental Capacity and Consent. One option being considered is to incorporate policy relating to LPS into an amended Mental Capacity Act policy, as this will also need to be updated. No final decision made on that at present however.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
19097	Jul-20	HIW	Wards 7 & 11, WGH 04-05 Feb 20	Open	N/A	Unscheduled Care (WGH)	Estates	Janice Cole-Williams	Director of Operations	19097IA_004	High	R4. The Health Board is required to provide HIW with details of the action it will take to ensure that: Fire doors are fitted to the entrance of ward 7 in line with the requirements of the Enforcement notice issued by the Mid and West Wales Fire and Rescue Service to ensure the Health Board adequately protects patients, staff and the general public in the event of fire. We were informed that the doors to the entrance of ward 7 were not fire doors. An Enforcement Notice was issued by the Mid and West Wales Fire and Rescue Service requiring action to fit fire doors by the 30th November 2019. We were informed the doors were due to be replaced in September 2020 at the earliest as part of phase 2 of improvement work.	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 supportive of the approach being taken by the Health Board. This work will include doors at the entrance to Ward 7 and any other Fire Doors necessary within the escape routes in this Hospital. The MWWFRS have recommended that the remaining works within Wards and Departments will be undertaken as a second stage to the above.	Aug-21	Aug-21 Dec-21	Red	25/02/2021 One immediate recommendation remains at Withybush General Hospital (WGH) Ward 7, relating to fire safety doors at the entrance to ward. This has not gone beyond the timescale for completion (August 2021) which is in line with the fire safety work programme being undertaken by Estates. 30/07/2021 Capital Development manager advised Ward 7 entrance doors, would hope be completed by December 2021 as the second floor is the first part of the overall Phase 1 programme which should complete mid 2022.
19258	Jul-20	HIW	PACU and Cilgerran Wards, Glangwili General Hospital	Open	N/A	Women and Children's Services	Estates	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	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. 19/03/2021 Issued email requesting update interim Manager recently taken over. 07/04/2021 escalated via DSN awaiting update. 26/05/2021 The issue of storage is delayed due to other areas already underway need to be completed before work can be start and it is an access and emergency route to the plant rooms. Likely to be 9-10 months-Jan 2022. 15/09/2021 Requested update. SDM advised. Temporary demountable solution is being sourced as a part of RSV preparations (Supported by Gold group) as a capital bid, by 30/11/21- current time frame. SDM and capital projects continue to plan for more permanent solution
19258	Jul-20	HIW	PACU and Cilgerran Wards, Glangwili 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	Aug-21	Aug-21 Dec-21	Red	18/09/2020 Request for update issued: Response: All fire training is completed via ELearning on ESR. 20/11/2020 issued for update: Service response: Due to Covid restrictions and social distancing the fire officer has agreed that fire safety training level 2 is to be completed via ELearning on ESR. 03/02/2021 DSN to check and establish any gaps in the training within the areas. 07/04/2021 escalated via DSN awaiting update. 27/05/2021 Face to face training reliant on relaxation of WG guidelines. 08/09/2021 Requested update on the number of outstanding staff in PACU and Cilgerran awaiting response. 23/09/2021 The acute paeds teams are at 82.61% for the fire e learning on ESR but this is lower than it should be as some of the face to face training done last month by Richard Jupp has not been imputed into the ESR records. Staff who attended to check their ESR records and contact Fire Trainer to get this updated. Face to face dates for fire training have been shared with the teams, difficulties with timings of online sessions 11-13 runs through lunchdifficult to release clinical staff, other options being explored.
19259	Jul-20	HIW	Puffin Unit / PACU, Withybush 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	Nov-20	Nov-20 Jan-21 Apr-21 Jun-21 Aug-21 Dec-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 and approved on the 14/07/2021. Awaiting the final implementation plan for training to be rolled out. 07/09/2021 Awaiting clarification if the recommendation is completed or if further time is needed. G 15/09/2021 Some work still to be completed for the Sepsis posters and information dissemination, this has been delayed due to AI and other training. Paediatric Professional & Practice Development Nurse to pick up this work. 23/09/2021 "The plan to start rolling out training as of next Wednesday across paediatrics' in GGH initially and then to BGH and WGH including the A&E and paediatric departments. This has been delayed by the need to prioritise the RSV training for the surge in acutely ill respiratory children which is still ongoing.
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	Dec-23	Dec-23	Amber	02/12/2020 Service Response: Recruitment remains a challenge. On-going campaigns are being added to social media. Senior Nurses will be attending RCN virtual job fair in January 2021. 04/02/21 Senior nurse and unit manager attended RCN virtual job fair- no applications for vacancies yet. Recruitment continues to be a challenge but 1 QIS appointed and 1 paediatric nurse. Successful recruitment of 2 newly qualified nurses via adult streamlining, due to start in March 2021. 2 nurses have completed part 1 of neonatal training. 19/03/2021 issued for update no response. 13/05/2021 Minimal change in staffing situation and recruitment continues to be a challenge. We have appointed into the Practice educator post (B6)- start date of end of May. Aware of a few nurses who qualify in September who would like to work in SCBU- hoping to recruit via streamlining. 2 nurses have enrolled in Intensive Care module this year. No NLS courses have been available due to COVID however there are starting again in May 2021. 12/07/2021 Requested update awaiting a response. 04/08/21 Senior nurse advised, streamlining process completed and successful with 3 applicants to start from September 2021. Band 6 recruitment continues to be a challenge. Band 5 establishment almost complete - plan to develop own staff to progress to QIS. QIS in post currently 61%. NLS planned for November in GGH.
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.	Mar-16	N/K	External	The new 24/7 system is to be developed and implemented at an All Wales Level. 5/10/2020 Response received. There is currently no progress on this recommendation as it is being taken forward at an All Wales level by the All Wales Network. 04/12/2020 No progress awaiting All Wales response. 27/01/2021 No progress requires an All Wales solution. 07/04/2021 SDM to establish who the links are. 12/07/2021 No progress awaiting an All Wales Network response.
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Open	Limited	Women and Children's Services	Strategic Development and Operational Planning	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	May-21	May-21 Oct -21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 NWSSP-SES have been given the information and are working with PM and TCA on reviewing the claims received from Tilbury Douglas. 10/07/2021Requested new date from Head of Capital Planning Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 Follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 09/09/21 UHB's understanding of the position to be reported and sent to Shared Services
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Open	Limited	Women and Children's Services	Strategic Development and Operational Planning	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	May-21	May-21 Nov -22	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 10/07/2021Requested new date from Head of Capital Planning Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 09/09/2021 this review and action will be ongoing until the end of the scheme
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Open	Limited	Women and Children's Services	Strategic Development and Operational Planning	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	May-21	May-21 Nov 21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021 Currently outstanding. 10/07/2021Requested new date from Head of Capital Planning Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 09/09/2021 Project Manager is currently chasing the outstanding documentation

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service/ Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSU-HDU-2021-03	Apr-21	Internal Audit - SSU	Glangwili Hospital Women & Children's Development	Open	Limited	Women and Children's Services	Strategic Development and Operational Planning	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	May-21	May-21 Nov 21	Red	26/05/2021 Discussed with Head of Service emailed ER& KM Capital Planning for current position. 27/05/2021This 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. 10/07/2021Requested new date from Head of Capital Planning Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 09/09/2021 Project Manager is currently chasing the outstanding documentation
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	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 celebrated, the reliance on goodwill is unsustainable in the longer term. There must also be consideration of succession planning to ensure the progress made is maintained.	Explore the development of a Paediatric Specialist post for Diabetes- local program director middle grade	Jun-21	Jun-21 Dec-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 via job planning. 15/09/2021 SDM confirmed this recommendation is under constant review via job planning, discussions with SDM acute Paeds and Clinical Director ongoing.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	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)	Jul-21	Jul-21 Dec-21	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. SDM to chase Diabetes Lead PDSN for progress. 09/04/02021 SDM meeting arranged with PDSN WC 12/04/2021 25/05/2021 SDM working with Assistant Director of Patient Engagement possibly be completed by Dec 21. 12/07/2021 SDM has emailed for an update. 15/09/2021 Request to update position from Diabetes, update received. Currently a parent representative is attending Wales Network meetings. SDM working with the team to discuss option for MDT meetings
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	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 expeditated to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition programme suspended due to COVID 19. HB to support all Clinicians across all areas to participate in the Transition programme when re-started.	N/K	Dec-21	Amber	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 26/05/2021 initial discussions started ongoing. 12/07/2021 SDM confirmed this work is likely to be completed by Dec 2021. 15/09/2021 SDM confirmed this work is likely to be completed by Dec 2021.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	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 expeditated to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition is more successful by an employed youth worker. Paper to be developed to evidence best practice.	Aug-21	Aug-21 Mar-22	Red	Report verified with SDM 29/03/2021 issued report for update to SDM Community Children Services - re issued 08/04/2021. 09/04/2021 No update. 25/05/2021 No update 12/07/2021 No further progress at this time. 15/09/2021 No progress at this time.
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	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 NWIS	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. 15/09/2021 No progress at this time.
19127 (NDQP)-Peer Review Report	Jan-20	HIW	Glangwili Hospital (Maternity), 7-9 October 2019	Open	N/A	Women and Children's Services	Estates	Julie Jenkins	Director of Operations	19127_003 (NDQP)-Peer Review Report_014b	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	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 received-Signage completed, letters completed. On hold due to Covid 19 as staff relocated, full implementation to be reviewed possible Dec 2020. 18/09/2020 Request for update issued: Response received HoM Actions partially completed clinic letters completed. Further review of bilingual requirements to be completed. 20/11/2020 issued for update: Delayed due to Covid until new unit is completed and re-alignment of service signage for all maternity Services. 26/01/2021 Delays on Phase 2 work, due to the impact of Covid new date proposed August 2021. 02/03/2021 CB checked with Rob Elliott date confirmed Aug-21 correct. 26/05/2021 Signage maybe delayed due to delays in the Phase 2 end of Sept 2021. 12/07/2021 Delays on Phase 2 work, possibly completed by December 21. 17/09/2021 Delays on Phase 2 work, possibly completed by December 22.

Reports Closed on the Audit Tracker since ARAC August 2021

Report name	Lead Executive/Director
Audit Wales: Hospital Catering and Patient Nutrition Follow-Up Review	Director of Nursing, Quality and Patient Experience
Audit Wales: Clinical coding follow-up review	Director of Finance
Delivery Unit: All Wales Review of the Quality of Care and Treatment Planning in Adult Mental Health and Learning Disability Services, July 2017	Director of Operations
Health and Safety Executive: Material Breaches – The Management of Health and Safety at Work Regulations 1999, Regulation 3 (1) – Mental Health MB9	Director of Nursing, Quality and Patient Experience
Health Inspectorate Wales: Glangwili Hospital (Towy Ward), 25/11/2020	Director of Operations
Health Inspectorate Wales: Mass Vaccination Centres	Director of Public Health
Internal Audit: Mass Vaccination Programme	Director of Public Health
Internal Audit: Quality and Safety Governance	Director of Nursing, Quality and Patient Experience
Internal Audit: WCCIS Project (Ceredigion Locality)	Director of Finance
Internal Audit: Closure of Actions	Director of Nursing, Quality and Patient Experience
Internal Audit: Estates Assurance Follow Up	Director of Operations
Internal Audit: Management of Fire Enforcement Notices	Director of Operations
Public Service Ombudsman (Wales): 14585	Director of Operations

Reports Opened on the Audit Tracker since ARAC August 2021

Report name	Lead Executive/Director	Final report received at
Community Health Council: Mental Health Care In Our Pandemic	Director of Operations	Quality and Safety Experience Committee, September 2021
Health Inspectorate Wales: St Caradog Ward, Withybush Hospital	Director of Operations	Quality and Safety Experience Committee, September 2021
Human Tissue Authority: Glangwili General Hospital (12136) – Routine 27/07/2021	Director of Operations	Quality and Safety Experience Committee, September 2021
Internal Audit: Field Hospital Decommissioning (Advisory Report)	Director of Operations	Audit and Risk Assurance Committee, August 2021
Internal Audit: Human Tissue Act Compliance	Medical Director	Audit and Risk Assurance Committee, August 2021
Internal Audit: Single Tender Actions	Director of Finance	Audit and Risk Assurance Committee, August 2021
Internal Audit: Use of Consultancy	Director of Finance	Audit and Risk Assurance Committee, August 2021
Internal Audit: Welsh Language Standards	Chief Executive	Audit and Risk Assurance Committee, August 2021

Internal Audit: Women and Child Health Directorate Governance Review	Director of Operations	To be received at Audit and Risk Assurance Committee, October 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Fire Safety Group, August 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Fire Safety Group, August 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Fire Safety Group, August 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Director of Operations	Fire Safety Group, August 2021
Mid and West Wales Fire and Rescue Service: Letter of Fire Safety Matters - Greville Court, Albion Square, Pembroke Dock, SA72 6XF	Director of Operations	Fire Safety Group, August 2021
Public Service Ombudsman (Wales): 202000537 (Mental Health)	Director of Operations	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 14585	Director of Operations	Improving Experience Sub-Committee