Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 February 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Beare, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Oversight of the timely implementation of recommendations has become even more important following the introduction of HIW's Service of Concern process for NHS organisations. This will allow HIW to identify and highlight any service which requires significant improvement. Its purpose is to increase transparency around HIW discharges its role, and ensuring that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. The document can be found via the following link: 20211115NHSSoCProcessdocumentFinal-EN_0.pdf (hiw.org.uk)

HIW have defined three threshold points to determine whether a service ought to be designated as one of concern as follows:

- Have Immediate Assurance (IA) and/or Improvement plan recommendations been actioned to an acceptable standard and agreed timescales?
- Have the same issues been raised during previous inspection/review activity and insufficient improvements been made?
- Have we received reliable information or gathered evidence to identify a matter requiring urgent action?

If the Health Board is not delivering within timescales, this could contribute to its services potentially being monitored under the Service of Concern process. The guidance has been shared with services, and implementation of recommendations against the timescales will be monitored as part of the ongoing discussions between the Assurance and Risk team and services.

Asesiad / Assessment

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

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

In recognition of operational pressures faced by services, no requests for updates were sent in December 2021 and requests sent in January 2022 have been directed to non-operational services. As of January 2022, due to the current reduced capacity within the Assurance and Risk team, the rolling programme to collate updates from services has been changed from bi-monthly to quarterly requests (with the exception of potential areas of concern where the bi-monthly requests remain). The frequency of requests for each service will continue to be reviewed.

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

As of 27th January 2022, there are 93 reports currently open. 49 of these reports have recommendations that have exceeded their original completion date, which has increased from the 39 reports previously reported in December 2021. Please note some services have not been requested to provide updates since the previous ARAC report, due to operational pressures. This detail can be found in the ‘Audit Tracker Summary Per Service / Directorate’ table later in the SBAR.

There is an increase in recommendations where the original implementation date has passed from 101 to 126. Detail on this increase can be found in the ‘Audit Tracker Summary Per Service / Directorate’ table. The number of recommendations that have gone beyond six months of their original completion date remains at 41 as reported in December 2021. The table overleaf provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

	Open reports at ARAC December 21	New reports since December 21	Closed reports since December 21	Open reports at ARAC February 22	Open reports which are overdue*	Red recommendations**	Red recommendations overdue by more than 6 months
AW	6	1	1	6	4	5	0
CHC	3	0	0	3	2	2	2
CHC / HIW Contractors	1	0	0	1	1	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
DU	2	0	1	1	1	2	2
HEIW	0	0	0	0	0	0	0
HSE	7	0	4	3	3	3	3
HIW	15	2	2	15	7	38	11
HTA	1	1	1	1	0	0	0
IA	26	7	6	27	18	29	11
Internal Review	1	0	0	1	0	3	0
MWWFRS	22	2	1	23	7	33	2
Peer Reviews	2	1	0	3	2	4	4
PSOW - S23 (Public interest)	0	1	0	1	0	0	0
PSOW - S21	2	1	1	2	0	0	0
Royal Colleges	2	0	0	2	2	4	3
Other (External Consultant)	1	0	0	1	1	0	0
WLC	2	0	0	2	1	3	3
TOTAL	**93**	**16**	**17**	**92**	**49**	**126**	**41**

**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 278 open recommendations (increase from 222 reported in December 2021) on the audit tracker. In addition to the new recommendations issued since the previous report, Appendix 1 also now includes the 21 recommendations highlighted as an 'external recommendation' (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. For completeness these recommendations are now included as part of the 'Total number of recs January 22' column in the 'Audit Tracker Summary Per Service / Directorate' table below.

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.

There are 32 recommendations in Appendix 1 that do not have revised timescales (where the date has passed and not known (N/K) is reported), which has increased from the 27 previously reported. The Assurance and Risk team are working with the relevant services to clarify the timescales, and/or whether any recommendations have been implemented. Due to operational pressures, and the reduced capacity within the Assurance and Risk team, progress updates have not been requested from some services since the last ARAC report in December 2021. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' section below.

The 32 recommendations are as follows:

- 3 recommendations from IA backlog maintenance report - the recommendations are future actions that cannot yet be evidenced as completed until the relevant business cases are produced. Assurance and Risk team to confirm timescale with lead officer.
- 2 recommendations from IA Discharge Processes report - This was reported to ARAC in December 2021 where it was asked for the management responses to be strengthened.
- 1 recommendation from a MWWFRS Enforcement Notice at GGH - It is currently unclear when Estates will be allowed access to these areas to complete the three outstanding fire doors due to the ongoing COVID-19 position. Discussions are underway with MWWFRS to ascertain whether it is possible to take a pragmatic approach to this and in effect sign off the Enforcement Notices associated with these works and include this work in the formal Phase 1 works.
- 1 recommendation from the IA Glangwili Hospital Women and Children's Development (SSU-HDU-2021-03) - This report had been previously closed, however following further clarification from the IA team this report has been re-opened.
- 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 to develop new models, where services and staff will have the ability to work in a more hybrid manner, was reported to Board in November 2021. Progress update will be requested in February 2022.
- 1 recommendation related to the IA Health and Safety IA report - Clarification is being sought from the Lead Officer if the recommendation can be closed.
- 3 recommendations from the Welsh Language Commissioner (WLC) investigation - review has been undertaken, however no response received from operational or nursing services due to operational pressures, only partial information collected. No response or further extension has been provided from the WLC. Progress update has not been requested since the last ARAC report due to timing of service request. Progress update will be requested in February 2022.
- 2 recommendations from new Peer Review - Congenital Heart Disease provider. 1 relates to the requirement for the UHB to receive a national template developed and agreed by Specialist Children's Surgical Centres, representatives of Congenital Heart Networks, and commissioners whereby timescales have not been set. Clarification to be sought to determine a completion date for the second recommendation relating to parents and carers obtaining details of local and national support groups.
- 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. Compliance is increasing for Fire training level 2 on Microsoft Teams and staff booked on to attend the sessions throughout the remainder of the year. Progress update has not been requested since the last ARAC report due to timing of service request. Progress update will be requested in February 2022.
- 3 recommendations from the RCP Cymru Wales visit to Ysbyty Bronglais: Follow up report – a meeting is scheduled with the new BGH General Manager to review and clarify progress of all outstanding recommendations.
- 6 recommendations from the AW Review of Quality Governance Arrangements – Hywel Dda University Health Board. Recommendations are progressing but original completion dates have passed, clarification is being sought from the Lead Officer if the recommendations can be closed, or revised timescales required.
- 1 recommendation from AW Structured Assessment 2021: Phase 1 Operational Planning Arrangements - Original completion date has passed, clarity of revised timescale to be requested from service.

- 5 recommendations from the AW Taking Care of the Carers - The Audit Tracker will be updated following the revised management response being submitted to ARAC February 2022.
- 2 recommendations from the MWWFRS Letter of Fire Safety Matters PPH - The letter was received in January 2022 and an action plan is currently being developed by Estates to resolve the issues raised.

Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 27th January 2022, including trends since the last report to ARAC in December 2022. A rolling programme to collate updates from services on a quarterly basis is in place in order to report progress to the Committee. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager.

The arrows included in the table below are as follows:

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

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

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

Service	Open reports as at January 22	Overdue reports as at January 22	Total number of recs January 22*	Total overdue (red) recs January 22	Recs overdue by more than 6 months	Comments
Acute Services	1 (➔)	0 (➔)	14 (🡅)	2 (🡅)	1 (🡅)	• Due to operational pressures, no update has been obtained since the December ARAC meeting. • HIW National Review on WAST - 19 recommendations (recs) raised- number of recs has increased as this number now includes the 6 external recs. 2 recs showing as overdue due to no update being obtained from the service.
CEO Office (Welsh Language)	3 (➔)	2 (➔)	8 (🡅)	4 (➔)	3 (➔)	• WLC investigation - 3 recs remain outstanding, delayed by operational pressures. • 2 IA reports - one report has 1 overdue rec, and the other report has an external report which has increased the total number of recs from 7 to 8. • Progress update has not been requested since the last ARAC report due to timing of service request. Audit and Risk Officer to schedule discussion of recs with new Director of Communications.
Community - Carmarthenshire (*N/A- No open reports at ARAC February 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Community - Ceredigion	2 (➔)	1 (➔)	16 (🡅)	12 (🡅)	0 (➔)	• Due to operational pressures, no service update has been sent to Ceredigion since the December ARAC meeting. • AW report - 1 'External' rec included, resulting in the number of recs increasing from 15 to 16. • 1 new HIW report – 12 recs now showing as overdue due to no update being obtained from the service. •
Community - Pembrokeshire (*N/A- No open reports at ARAC February 2022*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	N/A
Central Ops	2 (➔)	1 (➔)	5 (➔)	4 (➔)	4 (➔)	• 1 IA report. • Peer review - 4 recs (over 6 months overdue) previously delayed by Covid-19. Previous revised timescales to December 2021 will no longer be met. The outstanding recs from peer review report have been linked to risk 129 (Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients) on Datix and a further discussion will take place to ascertain if the recommendations are still appropriate/relevant, once operational pressures have eased.

Service	Open reports as at January 22	Overdue reports as at January 22	Total number of recs January 22*	Total overdue (red) recs January 22	Recs overdue by more than 6	Comments
Digital and Performance	8 (↑)	6 (↑)	10 (↑)	7 (↑)	1 (↓)	• 6 IA reports, including 1 new IA report on Deployment of WPAS into MH&LD. 5 IA reports can be closed following approval from the Director of Finance as all previously open recommendations were confirmed as fully implemented by the Digital Director. • In total the IA reports include 7 overdue recs. 1 red rec is 6 months overdue, due for closure in February 2022 regarding compliance with EWTD, with the delay as a result of works undertaken by a 3rd party supplier relating to switchboards which is now being resolved. • 1 AW report and 1 external consultant report - all recs completed and closure of the report to be requested from Director of Finance.
Estates	25 (↑)	9 (↑)	72 (↑)	35 (↓)	3 (↓)	• Number of outstanding recs has increased from 63 to 72, with the number of overdue recs decreased from 37 to 35. The majority of these recs are from the 23 MWWFRS Enforcement Notices (ENs) and Letters of Fire Safety Matters (LOFSMs). • MWWFRS continues to be kept fully up-to-date with any adjustments to the programme of phased works at GGH and WGH, and work undertaken at BGH. MWWFRS have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extensions required. 2 new Letters of Fire Safety Matters has been received, for WGH and PPH. • All MWWFRS recs overseen by HSC via the Fire Safety Update Report provided to every meeting by the Director of Estates, Facilities and Capital Management. •2 IA reports - 2 overdue recs. 1 rec expected be closed following Board in January 2022, and the other rec the Estates services are liaising with IT services for a revised date for implementation of hardware. •1 IA report closed.
Finance	2 (↑)	0 (↓)	3 (→)	0 (↓)	0 (→)	• New IA report on Financial Planning, Monitoring and Reporting report ongoing with an estimated completion date for recommendations of July 22. • IA report Use of Consultancy- all recs completed and closure of the report to be requested from Director of Finance. • IA Single Tender Action report closed since previous report.
Governance	1 (→)	0 (→)	2 (→)	1 (↑)	1 (→)	• IA advisory review remains open, with recs being supported by the Workforce & OD Directorate.
Medical	0 (↓)	0 (→)	0 (↓)	0 (→)	0 (→)	• IA Report on Human Tissue Act Compliance has been closed on the tracker since the previous meeting
MH&LD	7 (↓)	2 (↓)	21 (↑)	4 (↓)	1 (↓)	• Number of recs overdue by more than 6 months has reduced from 2 to 1. • A number of recommendations have been confirmed as completed since the previous ARAC, resulting in a HIW thematic report being closed, however the total number of recs outstanding for MHLD have increased due to the receipt of the HIW Ty Bryn immediate and improvement plan. • Total of 5 HIW reports. • 1 CHC report. • 1 IA report – 1 rec overdue.

Service	Open reports as at January 22	Overdue reports as at January 22	Total number of recs January 22*	Total overdue (red) recs January 22	Recs overdue by more than 6	Comments
NQPE	8 (🡻)	6 (🡹)	14 (🡹)	6 (🡹)	5 (🡹)	• 3 outstanding recs from 3 material breaches to be clarified with service if these can now be closed. • AW report - 6 overdue recs, clarification being sought from service if these are implemented. • 2 IA reports - 2 recs overdue, clarification being sought from service if these are implemented. • Assurance and Risk team continue to contact the service and an updated position will be included in this next Audit tracker report to ARAC. • 2 PSOW reports.
Pathology	1 (➔)	1 (🡹)	0 (🡻)	0 (➔)	0 (➔)	• Remaining recs raised within the HTA follow up report confirmed as completed, and awaiting formal approval of closure of the report from the Head of Service.
Primary Care, Community and Long Term Care	2 (🡹)	1 (➔)	6 (🡹)	0 (➔)	0 (➔)	• 1 HIW GP surgery (non-managed by the UHB) recs are being completed by the practice. The recs for this report are not included in the 'total number of recs' figures as it relates to an independent contractor. • New IA report. • Progress update has not been requested since the last ARAC report due to timing of service request.
Public Health	1 (➔)	1 (➔)	2 (➔)	2 (➔)	2 (➔)	• IA report - 2 outstanding recs however no service update request has been sent to Public Health since the December ARAC meeting.
Radiology	3 (➔)	2 (➔)	26 (🡻)	18 (🡹)	8 (🡹)	• Due to operational pressures, no update was obtained as at 27th January 2022 (date the tracker was run off for this report), however since this date a more positive position has been provided by the service which will be reflected in the next Audit Tracker paper to ARAC. • HIW IRMER (WGH) - 39 recs raised, of which 21 have now been completed. • HIW IRMER (PPH) - 7 red recs (overdue by more than six months). • IA report - 1 red recommendation which is overdue by more than six months, with a previous revised date December 2021, which has not been updated as no update requested from service.
Scheduled Care	1 (🡻)	1 (🡻)	3 (➔)	2 (🡻)	2 (➔)	• CHC report – 1 'External' rec and 2 recs delayed by over 6 months and due for completion in March 2022. • 1 IA report closed.
Strategic Development & Operational Planning	6 (🡹)	4 (🡹)	19 (🡹)	10 (🡹)	3 (➔)	• AW report - 1 overdue rec. • Internal review of Capital Governance - 3 recs overdue. • 4 IA reports (1 of which re-opened following clarification from Internal Audit) - total of 6 overdue recs. 3 overdue recs related to IMTP submission to WG in March 2022. Other 3 overdue recs have exceeded 6 months which are related to delays in Capital projects.
Therapies	1 (🡹)	0 (➔)	3 (🡹)	1 (🡹)	0 (➔)	• IA Therapies Directorate Review added to the tracker in December 21, with one overdue rec due for completion by the end of December 21. • No service update has been sent to confirm if the overdue recommendation has been implemented due to timing of service request.

Service	Open reports as at January 22	Overdue reports as at January 22	Total number of recs January 22*	Total overdue (red) recs January 22	Recs overdue by more than 6 months	Comments
USC BGH	1 (➔)	1 (➔)	4 (➔)	3 (➔)	3 (➔)	• RCP follow up – a meeting is being scheduled with the new BGH General Manager to review and clarify progress of all outstanding recommendations.
USC GGH	3 (➔)	2 (➔)	5 (🡻)	3 (➔)	3 (➔)	• Due to operational pressures, no service update has been sent to GGH since the December ARAC meeting. • DU report - 2 recs overdue relating to Cardiology, where revised dates of September and December 2021 have since passed. • 1 HIW report - 1 overdue rec due to no update being obtained from the service. • 1 PSOW report- updates obtained from the Ombudsman Case Manager
USC PPH	2 (🡹)	1 (🡹)	5 (🡹)	4 (🡹)	0 (➔)	• Due to operational pressures, no service update request has been sent to PPH since the December ARAC meeting. • New IA report on PPH Directorate Governance Review - 4 recs now overdue.
USC WGH	1 (➔)	1 (➔)	2 (🡹)	1 (➔)	0 (➔)	• HIW report, 1 rec remains related to the fire door. To confirm with service if this has been completed by the planned December 2021 date. 1 'External' rec. • Due to operational pressures, no service update has been sent to WGH since the December ARAC meeting.
Women & Children	6 (🡻)	4 (🡻)	27 (🡹)	3 (🡻)	1 (🡻)	• 1 Royal College report with 2 overdue recommendations. • 4 HIW reports - 6 overdue recommendations. • 2 Peer Reviews, with a review on Congenital Heart Disease added to the tracker in December 2021, containing 24 recommendations of which two are complete. • 1 IA and 1 HIW report closed since the previous reports.
Workforce & OD	4 (➔)	2 (🡹)	10 (🡹)	4 (🡹)	0 (➔)	• Due to operational pressures, no service update has been sent to Workforce & OD since the December ARAC meeting. • WLC report - 1 'External' rec now included which has increased the total number of recs from 9 to 10. • 1 IA report - 1 rec overdue due to no update being requested. • New AW report - 3 recs overdue due to no update being requested. Revised management response due to be reported to ARAC February 2022. • AW report - 1 rec completed, will be requesting approval from Director of Workforce & OD to close the report.
Unscheduled Care	1 (➔)	1 (➔)	1 (🡹)	0 (➔)	0 (➔)	• CHC report - 1 'External' rec, now included as part of the number of open recs.
Total	**92**	**49**	**278**	**126**	**40**	

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

Strategic Log

The Assurance and Risk team have been undertaking a review of recommendations on the Strategic Log with relevant Executive Directors and Lead Officers to establish the current position. Going forward, these recommendations will be included in the main audit tracker, with appropriate recommendations being reported as 'strategic' where the recommendations still require a long term/strategic solution (e.g. Capital prioritisation plan, Digital Strategy, Ward

refurbishment programme, etc.). The next Audit Tracker report to ARAC will include these recommendations.

Potential areas of concern

There has been no change in the potential areas of concern in respect of pace or non-implementation of recommendations since the previous report and these remain a focus of attention for the reasons outlined below:

Central Operations - 4 recommendations (over 6 months overdue) previously delayed by COVID-19. Previous revised timescales to December 2021 have not been met. Due to the operational pressures within the Health Board since the previous meeting, it has not been possible to discuss these with the service to ascertain whether these recommendations are still appropriate/relevant. The outstanding recommendations have been linked to corporate risk 129 (Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients) on Datix.

Radiology

8 recommendations are overdue by more than 6 months, which has increased by 2 since the previous paper. It is noted, however, that a new Head of Service commenced in post in November 2021, and is committed to addressing outstanding recommendations and reviewing associated risks on the Directorate risk register. Discussions on outstanding recommendations took place at the Radiology Governance meeting held in January 2022 (with attendance by the Assurance and Risk Team), where it was noted verbally that progress has been made to address the outstanding recommendations from recent HIW IRMER inspections. Due to operational pressures, no updates were requested from the service as at 27th January 2022 (date the Audit Tracker was run off for this report); however, since this date, a more positive position has been provided by the service which will be reflected in the next Audit Tracker paper to ARAC.

Mental Health & Learning Disabilities

While there has also been an improvement in the performance of MH&LD, and the closure of recommendations since the previous meeting, a Learning Disability Unit remains an area of focus due to the immediate improvement plan, containing 9 recommendations, and final report containing a further 5 recommendations. A three month progress update is due to be submitted to HIW on the recommendations raised from both the immediate and improvement plans in February 2022. At the time of writing, 4 recommendations have been fully implemented, and 3 are partially completed. None of the recommendations are noted as being overdue.

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 quarterly basis in order to report progress to the Committee.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching

	systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital 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
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~~ N/K	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. 20/10/2021- Work remains ongoing with this and no further updates currently. The review for this is January 2022.
2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	Work is underway to review the capacity and capability of the Planning Team. A proposal will be taken to the Executive Team to recurrently increase the capacity of the service planning team and further develop the 'business partnering' approach.	Sep-21	~~Sept-21~~ ~~Dec-21~~ N/K	Red	19/08/2021- Management response reported to ARAC August 2021. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- proposal for potential new posts were reported to Exec Team in August 2021.Director of Strategic Development & Operational Planning deciding the longer term arrangements for the team. 18/11/2021- Revised management response being reported to ARAC December 2021 meeting, tracker will be updated following the meeting. 26/01/2022- Head of Planning was unable to provide update. Assurance and Risk Officer to contact Director of Strategic Development and Operational Planning for clarification of timescale.
2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	With the increase in capacity, it is the intention that the members of the Planning team are exposed to a wider range of Planning activities to build their knowledge, understanding and capabilities in order to strengthen the overall Planning function (to include Operational Delivery Groups, ARCH etc)	Mar-22	Mar-22	Amber	19/08/2021- Management response reported to ARAC August 2021, timescale noted as 'Quarter 4 (subject to recruitment timescales)'. 08/09/2021- Head of Planning confirmed he will be the lead officer for this report and will provide progress updates going forward. 14/10/2021- proposal for potential new posts were reported to Exec Team in August 2021. Director of Strategic Development & Operational Planning deciding the longer term arrangements for the team. 18/11/2021- Revised management response being reported to ARAC December 2021 meeting, tracker will be updated following the meeting. 26/01/2022- Head of Planning was unable to provide update. Assurance and Risk Officer to contact Director of Strategic Development and Operational Planning for clarification if March timescale will be met.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_001b	High	R1.b The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Subcommittee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: b) issue guidance on record taking at meetings; and	Guidance document to be developed and issued with (R1a)	Nov-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- update to QSEC December 2021 - Minute taking guidance exists within the SOP. This is in the process of being shared with operational teams.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_001c	High	R1.c The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Subcommittee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily available when required. The Health Board should: c) ensure that local records are stored in a standard location to facilitate access.	Include within guidance document (R1b) a reminder of the importance of storing of meeting papers in accordance with corporate records management policy.	Nov-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- update to QSEC December 2021 - Central repository being considered similar to the discipline aligned to the Gold command and control approach.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_002	High	R2. There are inconsistent leadership arrangements at an operational level for assurance, risk, and safety across the Health Board. The Health Board should either strengthen current arrangements where staff resources for assurance, risk and safety are managed by directorates to improve consistency, or move to a model where those staff are managed centrally, ensuring that support available to the operational teams is consistent across the Health Board.	There are consistent leadership arrangements in place at operational level (acute, community and primary care) for assurance, risk and safety, however responding to the pandemic has impacted on the capacity of the leadership teams to be able to discharge all their accountabilities effectively. There has been a daily focus on managing risks across the system, however this has not always been reflected in the risks on the Datix Risk System. A review will be undertaken to enhance the capacity across operational and corporate teams to ensure a consistent approach to managing assurance, risk and safety. It is possible there will be a financial impact of the review and therefore this will need to be considered as part of the IMTP for 2022-23.	Dec-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- update to QSEC December 2021 - The Director of Operations is currently engaging with senior operational leads to identify suitable options to progress this. Time out scheduled for 30th November.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_003b1	High	R3b.1. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: (I) The joint review process will be used to reinforce the role of oversight by the local triumvirate teams. The expectation that there is communication and consultation between services where there are risks and issues that may affect impact more widely will be reiterated.	Dec-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- update to QSEC December 2021 -A schedule of joint review meetings is currently being planned for 2022 aligned to actions identified within the reviews already undertaken/highest risks.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_003b3	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- - update to QSEC December 2021 -DATIX implementation is being progressed within the Health Board. Some IT issues are impacting on pace of roll out however these are being discussed with the lead executive.
2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Nursing	Governance	Cathie Steele	Director of Nursing, Quality and Patient Experience	2583A2021-22_004	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-21	N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 14/02/2022- All Operational leadership teams (Triumvirates) have engaged in the joint risk reviews and this is already having a positive effect on recognition and management of risks.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_001a	Not stated	R1. Retaining a strong focus on staff wellbeing NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	There has been local investment and the Health Board has in place an expanded Staff Psychological Well Being Service with a comprehensive Staff Psychological Wellbeing Plan. The Health Board will ensure that this provision continues and that the range of service provision is regularly promoted	Mar-22	Mar-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_002a	Not stated	R2. Considering workforce issues in recovery plans NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	An action plan is being developed to take forward the recommendations of the discovery report, the staff survey and well-being matters survey. The common themes across these 3 pieces of work are: • Growing inspirational leaders • Creating spaces and ways of working that enable our people and services to thrive • Putting Wellbeing at the heart of Hywel Dda • Creating a safe and supportive place to work • Building on our Covid team spirit • Enabling learning and innovation The action plan will be presented at the People, Organisational Development and Culture Committee in December	Dec-21	~~Dec-21~~ N/K	Red	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_003a	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	User satisfaction feedback and clinical outcomes monitoring is in place for all 121 psychological support services and trend analysis is conducted monthly. User satisfaction and clinical outcomes are monitored on an ongoing basis with monthly reporting to the Wellbeing Dashboard.	N/K	N/K	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_004	Not stated	R4. Enhancing collaborative approaches to supporting staff wellbeing NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	The National Health and Wellbeing Network forum is attended regularly by the Head of Occupational Health, Head of Staff Psychological Wellbeing and Health Intervention Coordinator. Good practice on wellbeing resources and services is shared. Networking and Benchmarking is encouraged. The effectiveness of services is shared within the forum and cascaded as required.	N/K	N/K	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.

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AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_005	Not stated	R5. Providing continued assurance to boards and committees NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.	KPI's have been introduced on key Occupational Health functions including management referral activity and pre employment clearance times. There is a KPI in place of clearance within 5 working days for 85% of PPHQ's. These KPIs will provide assurance to the board and identify any issues which may impact on staff wellbeing e.g., clearance delays, delayed advice for managers. All recruitment activity is treated as high priority within the Occupational Health service to optimise capacity across the Health Board. Progress and impact are assessed across the Health Board and scrutinised by the People, Organisational and Culture Committee.	Apr-22	Apr-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_006a	Not stated	R6. Building on local and national staff engagement arrangements NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	Exit interviews are in place and "Thinking of leaving" interviews will be implemented in 2022.	Mar-22	Apr-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021. 26/01/2022- revised management response deferred to ARAC February 2022 meeting.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_001b	Not stated	R1. Retaining a strong focus on staff wellbeing NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	The Staff Wellbeing Information Line was launched on 19.11.21 and will be evaluated at the end of May 2022.	May-22	May-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_001c	Not stated	R1. Retaining a strong focus on staff wellbeing NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	A Health and Well Being Champions Network has also been established.	Dec-21	Dec-21	Red	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_001d	Not stated	R1. Retaining a strong focus on staff wellbeing NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	A COVID risk assessment is now part of the All-Wales Pre-employment Health questionnaire. The Occupational Health service aims to complete clearance for all pre employment questionnaires within 5 working days of receipt where possible. If an employee is identified as high-risk, further information is requested to facilitate the provision of Occupational Health advice to line managers prior to starting work to ensure that the necessary control measures are in place.	N/K	N/K	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_002b	Not stated	R2. Considering workforce issues in recovery plans NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	The Occupational Health Department will work closely with Wellbeing Service partners and HEIW to identify and share appropriate wellbeing services staff may access for wellbeing support. In addition, the Health Intervention Coordinator has been granted funding to develop over 100 peer support wellbeing champions from NHS Charities together budget. 55 have already been trained, with the intention of increasing this number to 100 by September 2022. The aim is to improve access to wellbeing support for all staff by promoting health and wellbeing within the workplace. Champions are ideally positioned to offer initial advice and signposting to appropriate support services. A process has also been put in place for champions to have direct access to funding to support local initiatives that promote staff wellbeing, and all champions are encouraged to share the needs of staff to inform the HB wellbeing agenda. The Health Board will ensure that our recovery plans are aligned to any workforce planning implications that may impact on wellbeing.	Sep-21	Sep-21	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_003b	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Evaluation plans are in place for the new Staff Wellbeing Information Line as well as the Staff Ecotherapy Programme. A Well-Being Dashboard is produced monthly.	May-22	May-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_003c	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	The Ecotherapy pilot will be evaluated on completion with a target date of April 2022 to inform future cohorts of the programme.	Apr-22	Apr-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_003d	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	The Occupational Health Service plans to deliver a monthly Occupational Health report. KPI's have also been introduced on key activities within the Occupational Health service.	N/K	N/K	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_003e	Not stated	R3. Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Evaluation of the wellbeing champions initiative is planned to establish a better understanding of the wellbeing champion role as it develops and the overall impact on staff wellbeing and areas for development.	Sep-22	Sep-22	Amber	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.
AW_TCOTC+A1671:V1671	Oct-21	Audit Wales	Taking Care of the Carers?	Open	N/A	Workforce & OD	Workforce & OD	TBC	Director of Workforce & OD	AW_TCOTC_006b	Not stated	R6. Building on local and national staff engagement arrangements NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	A 'Working in confidence' platform to support the staff voice will launch in December 2021. Under-represented groups will be contactable via the platform. All concerns, needs and views will be reported to the People, Organisational Development and Culture Committee on an ongoing basis.	Dec-21	Dec-21	Red	04/11/2021- Report added to tracker, management response to be reported to ARAC December 2021.

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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. 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. 22/11/2022- further progress update requested. No update provided as of 26/01/22, however Assistant Director of Nursing has suggested the Professional Lead LD nursing contact the Head of Patient Experience for any support required.
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~~ Mar-22	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 24/01/2022- update requested by the deadline of 07/02/2022.
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~~ Mar-22	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 24/01/2022- update requested by the deadline of 07/02/2022.
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. 08/10/21- further national delays to the roll out of EPR due to network concerns.
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_003	N/A	Whilst people may not be able to have face-to-face support or therapy, some people may feel that phone calls are helpful in the interim and these may need to be part of an active offer by the Health Board.	This will be addressed through the MH/LD 'keeping in touch group'.	Mar-22	Mar-22	Amber	Progress update provided to CHC as part of the management response in August 2021: 'Keeping in touch' Task and Finish Group has been established, next meeting 27th September 2021. 12/10/2021 - some of these actions are dependent in implementation of WPAS, therefore any services with a waiting list is being prioritised in Phase 2. WPAS can prompt MHLD to keep in touch. 13.01/2022 - The implementation of WPAS into IPTS is in preliminary discussions but not confirmed roll out date yet.
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_004	N/A	The Health Board needs to have clear ways of discussing discharge arrangements with people so that they do not feel decisions have been made without them having their views heard.	A discharge audit will be developed by the Quality Assurance Practice Development (QAPD) team in collaboration with operational services. Complete the audit and develop improvement plan based on the results.	Mar-22	Mar-22	Amber	Progress update provided to CHC as part of the management response in August 2021: A discharge audit has been designed for inpatient units and is on the HB annual audit plan. The inpatient audit tool has been developed based on the AIMS accreditation standards, the QAPD team will work with the CTP lead and nominated operational staff to adapt for use in community MH/LD services. Results of the audit will inform the development of a service wide improvement plan 12/10/2021 - audit proforma has been created and agreed, to confirm when audit will be undertaken in the CMHT. 07/12/2021 - Healthy Ward Checks currently underway, and to confirm progress of audits with Helen Thomas Bone.
MHCIOP	Aug-21	CHC	Mental Health Care In Our Pandemic	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health	Director of Operations	MHCIOP_005	N/A	Many people have expressed a need for easy and quick to access direct mental health support for all ages.	The MH/LD Directorate have been implementing a 111 Welsh Government pilot project. Trained Mental Health practitioners are embedded in the 111 service to guide and direct people to the appropriate service as required.	Mar-22	Mar-22	Amber	Progress update provided to CHC as part of the management response in August 2021: This single point of access will improve access to mental health services, this pilot will become a substantive 24hour, 7 day a week service, funded by WG. Substantive job descriptions are currently being developed to support the expansion of the service, which is currently being provided 7 days a week, Monday to Friday 6.30pm – 10.30pm, weekends 2pm until 10pm. It is expected that the 24/7 service will be implemented from December 2021 pending recruitment. There has been a rolling evaluation throughout the pilot. Ways of communicating the availability of the 111 service are currently being explored by the project team. The QR code for collating service user feedback is currently being developed and a question has been added asking about ease of access to service. 12/10/2021 - the service is currently being provided 7 days a week, (6:30am - 10:30pm Mon-Fri, and 2pm - 2am Sat-Sun), with job descriptions drafted in order to create a substantive team for this service. There is also an active project group including operational staff, supported by 111 in order to ensure easy and quick access to support. 07/12/2021 - Team Leader and Service Coordinator have been job matched, and recruitment currently underway - anticipating having the Bands 5 and 6 by mid December. Workshops undertaken with other service areas, and external workshops with Police, WAST etc. Currently on target with regards to completion date.
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.
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 & 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~~ Jun-22	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. 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. 23/11/2021-29 dates have been allocated specifically for A&Es/MIU for across the Health Board. Still limited to 8 participants per session and throughout 2021. A combination of training options have been used i.e., theoretical elements completed electronically via MS Teams or ESR and practical element in the classroom or all modules taught in a classroom. This has had to vary dependent on Covid 19 risk assessments for training which are reviewed every 3 months. In 2021 41 staff from A&E/MIU have been trained. This is an improvement and participants have informed the team that the training has been informative and helpful. However there remains limitations based on clinical pressures and staffing across all sites for release of staff to training. There will be continued improvement as we move towards mixing staff groups as it will mean that less staff need to be released at once in order for a course to be viable. The training team are still limited by resource and although have worked at creating good working relationships with A&E/MIU across the Health Board and being as flexible as possible with training, the lack of robust resourcing is felt. The in-reach work is limited by how far the team is stretched across the Health Board. If the team had the additional staff previously specified then an even more proactive focus could

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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 & 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~~ Jun-22	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. 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. 23/11/2021-29 dates have been allocated specifically for A&Es/MIU for across the Health Board. Still limited to 8 participants per session and throughout 2021. A combination of training options have been used i.e., theoretical elements completed electronically via MS Teams or ESR and practical element in the classroom or all modules taught in a classroom. This has had to vary dependent on Covid 19 risk assessments for training which are reviewed every 3 months. In 2021 41 staff from A&E/MIU have been trained. This is an improvement and participants have informed the team that the training has been informative and helpful. However there remains limitations based on clinical pressures and staffing across all sites for release of staff to training. There will be continued improvement as we move towards mixing staff groups as it will mean that less staff need to be released at once in order for a course to be viable. The training team are still limited by resource and although have worked at creating good working relationships with A&E/MIU across the Health Board and being as flexible as possible with training, the lack of robust resourcing is felt. The in-reach work is limited by how far the team is stretched across the Health Board. If the team had the additional staff previously specified then an even more proactive focus could
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 & 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~~ Jun-22	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. 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. 23/11/2021-29 dates have been allocated specifically for A&Es/MIU for across the Health Board. Still limited to 8 participants per session and throughout 2021. A combination of training options have been used i.e., theoretical elements completed electronically via MS Teams or ESR and practical element in the classroom or all modules taught in a classroom. This has had to vary dependent on Covid 19 risk assessments for training which are reviewed every 3 months. In 2021 41 staff from A&E/MIU have been trained. This is an improvement and participants have informed the team that the training has been informative and helpful. However there remains limitations based on clinical pressures and staffing across all sites for release of staff to training. There will be continued improvement as we move towards mixing staff groups as it will mean that less staff need to be released at once in order for a course to be viable. The training team are still limited by resource and although have worked at creating good working relationships with A&E/MIU across the Health Board and being as flexible as possible with training, the lack of robust resourcing is felt. The in-reach work is limited by how far the team is stretched across the Health Board. If the team had the additional staff previously specified then an even more proactive focus could
HIW_JTRCMHT	Feb-19	HIW	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). 12/10/2021 - CarePartner - integrated record system in place and being utilised. Have the facility to grant access to records to people should they need them. quality improvement is undertaken between operational services and QAPD. Ward Managers Forum (clinical) in place, and Community Management Forum being considered with relevant TORs to be updated to reflect this - forums where service improvements are being discussed. Standing agenda items such as PSOW reports, Level 1 incidents etc. Local Authority element of the recommendation remains outside of the gift of the HB. Phase 1 of WPAS has been completed, with CMHTs included in forthcoming Phase 2. 07/12/2021 - Local Authority attendance at twice daily meetings, and working collaboratively with the Health Board to ensure effective patient flow and managing patients in the community. The situation with regards CarePartner remains the same.
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.
19009	Sep-19	HIW	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. 12/10/2021 - review of the Mental Health Act, new legislation still being developed and will be looked at through the Mental Health Capacity Group. To send copy of the HIW report to Sarah Roberts for further review and discussion, and to possibly amend ownership and timescales for this recommendation as legislative changes will impact the whole Health Board and not specifically OAMHS. 07/12/2021 - Code of Practice consultation completed, however no new legislation in place. To set up meeting with Madeleine Peters to discuss the ownership of the recommendation.
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. 23/11/21 Confirmed at WGH QSE meeting this work will be completed by the end of Dec.
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 Jul-22	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 lunch difficult to release cinical staff, other options being explored. 30/11/2021 awaiting response. 15/12/2021 Head Workforce Education & Developement confirmed; Face to face training is still not taking place in PACU, Cilgerran or Puffin wards due to the ongoing Covid restrictions, however level 2 Fire training is now available via MS Teams which almost 50% of staff in these areas have now completed. The training is available weekly so the remaining staff will be targeted in the coming months to ensure full compliance. 17/01/2022 - E-learning fire safety currently stands at 86.49% and Fire Safety level 2 at 45.28%. Several staff members have booked on to the level 2 training however capacity to release staff from clinical duties is limited as sessions are only available during the busiest time on the ward. The aim is to reach 85% compliance by July 2022.
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	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. 30/11/2021 Awaiting a response.

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 (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.
National Review of Maternity Services - Phase 1	Nov-20	HIW	National Review of Maternity Services - Phase 1	Open	N/A	Women and Children's Services	Women and Children's Services	Julie Jenkins	Director of Nursing, Quality and Patient Experience	NRMS_026	N/A	Consider the implementation of a live PSAG display feed, to enhance patient handover	Process for handover is in place – copied and scanned on a daily basis. Explore an All Wales approach. WG Directive	Mar-22	Mar-22	External	15/03/2021 - this recommendation while raised in the initial report has not been included in the required template for completion by HIW (see p43 of original report) 19/03/2021 Report included as part of normal scheduled request for updates. 19/03/2021 Process for handover is in place – records are copied and scanned on a daily basis. Explore an All Wales approach. WG Directive (outside gift of HB) 26/05/2021 Manual processes in place at HB, this recommendation is changed to external as PSAG is being led by WG. 12/07/2021 No change to recommendation awaiting WG solution. 30/11/2021 No change to recommendation awaiting WG solution.
20136	Apr-21	HIW	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~~ Jan-22	Red	19/05/2021 Operations Manager Confirmed: We commenced the redecoration work in the area on the 11/04/21 , this work is due for completion on the 18/07/21 The bathroom refits required capital funding , which was approved last week 11/05/21 (Completed) Capital funding approved. We are in the process of completing a multi-quote to appoint a contractor for this element of the work. This type of sanitary wear tends to have a significant lead to delivery date , so we have allowed 8 weeks. Anticipated commencement on site 16th August 21 -completion 15th November 21. 31/05/2021 Recommendation revert back to Amber as not completed until Nov 2021. 4/06/2021 Recommendation is now Red. 07/09/2021 - confirmation from ward manager received that no bathroom refits/work had started in August. Recommendation to remain red. 29/11/2021 - confirmation received that redecoration work is now complete, however there has been a delay in receiving new toilet pans due to required specifications. Expected delivery date of end of November, with anticipated completion following delivery of January 2022.
20136	Apr-21	HIW	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. 29/11/2021 - update received that work is due to be complete by March 2022, in line with original completion date provided to HIW. Recommendation therefore to remain Amber.
20136	Apr-21	HIW	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 29/11/2021 - 21 staff of the 30 on the ward have now undertaken the fire training and a further session has been agreed with the Ward Sister and Head of Fire Safety Management scheduled for the week of 29th November 2021 to complete the training for the remaining 9 members of staff.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	Jun-22	Amber	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_001b	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Point of Ligature, Major works to be completed. Plans currently out to tender. Construction Phase 1 on target to be commenced 15/11/21. Phase 2+3 to be commenced 03/01/22, completion expected April 2022.	Apr-22	Apr-22	Amber	16/11/21 - MHLD PoL Capital Works Meeting - Edmunds & Webster have been assigned the contract, and waiting for Finance to approve. Construction Stage to start on the 22/11/21. 22/10/21 - Fire Stopping Meeting - Fire Stopping works are to start on the 08/11/21 and the PoL works to start on the 22/11/21 working parallel with each other, as majority of work is outside with minimal work on the ward. 09/11/21 - Pre-Contract Meeting with Contractors
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_002a	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	To comply with IPC and Fire Safety, all furniture on ward to be replaced, including waste bins and patient mattresses. Procurement process has commenced realistic timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ Dec-21	Red	17/09/21 - Supplier visited ward for list of required furniture for the ward. 20/09/21 - Quotation received from Supplier. 01/10/21 - Meeting with Senior Nurse and Ward Manager to verify everything was on the list. 04/10/21 - Contact with Procurement for placing order on Oracle. 14/10/21 - Chasing Procurement for the delay, checking on the Supplier with the NHS Framework which was verified that day. 25/10/21 - Gareth Rees Final Approver approved procurement order. 28/10/21 - Procurement send through that all had been approved and PO sent to supplier. Supplier contacted that furniture will be delivered end of December/early January.
21037	Aug-21	HIW	St Caradog ward, Withybush Hospital	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	21037_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be re painted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ Jan-22	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022.
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_02	High	WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	There are good working relationships with WAST colleagues and the Pin process is used in practice across all areas of the Health Board. Staff to be made aware of the importance of ensuring this practice is consistently followed.	Nov-21	Nov-21	Red	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03b	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	Audit tool to be introduced to support the evaluation.	Dec-21	Dec-21	Red	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03c	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	• The family liaison officers (FLO's) Are present in ED across the HB, these have a role in ensuring that there is good communication being maintained between the patients, staff and relatives. The Health Board are reviewing these roles and consideration will be given to extending funding	Mar-21	Mar-21	Red	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_03d	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Health Board would look at other organisations practices and roles, which are not embedded into our current service delivery models and would welcome further discussion with WAST, other HB's and HIW in relation to this.	Dec-22	Dec-22	Amber	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been set up chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation.	Mar-22	Mar-22	Amber	17/11/2021 - Working group in place to take forward
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_07b	High	WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	There is a requirement to ensure that information received from these services are constantly reviewed to support identification of themes and trends.	Jan-22	Jan-22	Amber	17/11/2021 - to confirm with Louise O'Connor what the process is on this for feedback from F&F
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy.	Mar-22	Mar-22	Amber	17/11/2021 - Working group in place to take forward
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_010b	High	During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	This document will be reviewed with the Handover Policy.	Mar-22	Mar-22	Amber	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_011b	High	WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	This document will be reviewed with the Handover Policy.	Mar-22	Mar-22	Amber	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	Mar-22	Amber	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_015	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_016	High	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_017	High	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_018	High	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_019	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	N/A – for WAST consideration	N/A	N/A	External	
20175	Sep-21	HIW	WAST	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	20175_020	High	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	N/A – for WAST consideration	N/A	N/A	External	

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21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_001a	High	The health board must ensure that in addition to being offered hand wipes, staff must ensure that patients clean their hands before and after meals and after using the toilets.	Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes of meeting will be circulated to all staff to evidence discussion.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_001b	High	The health board must ensure that in addition to being offered hand wipes, staff must ensure that patients clean their hands before and after meals and after using the toilets.	Implement observational audits on the ward to monitor as part of monthly programme.	Dec-21	Dec-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_004	High	The health board must ensure that a who's who board is installed on the ward.	The Health Board is in the process of implementing who's who boards in all areas. A Who's who board will be put in place on the ward as part of HB roll out.	Feb-22	Feb-22	Amber	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_005	High	The health board must ensure patient documentation is fully completed including transfer of care and discharge planning.	Added to agenda for discussion at next Clinical Development meeting arranged for 10th November 2021. Notes of meeting will be circulated to all staff to evidence discussion. Documentation audits undertaken by senior staff, this will be added to the audit.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_007	High	The health board must ensure that results of the feedback should be made known to patients, in a prominent position on the ward.	This information will be anonymised and displayed on a new ward noticeboard which has been ordered.	Dec-21	Dec-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_008	High	The health board must ensure that staff are made aware of how the feedback process works in practice.	This will be a standing agenda item for staff meetings. Notes will be circulated after the meeting to all staff to evidence discussion and displayed on notice boards. Observational audits are also undertaken by the QAST team and spot checks from nursing teams will provide assurance this is taking place.	Dec-21	Dec-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_014	High	The health board need to ensure that sepsis training is evidenced on the electronic staff record and all staff receive relevant sepsis training.	The e-learning element of Aseptic Anti-Touch Technique training is embedded in ESR but the sepsis training, ALERT, is not recorded there. Staff are now being rostered on to the ALERT training study days as they become available and staff released to attend.	Mar-22	Mar-22	Amber	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_016	High	The health board need to ensure that all daily nursing checks are completed in full.	This will be audited as part of nursing checks to support assurance these are being completed. Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes will be circulated after the meeting to all staff to evidence discussion.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_017	High	The health board must ensure that the use of red trays is made known to staff and the trays are used appropriately.	Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Notes will be circulated after the meeting to all staff to evidence discussion.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_019	High	The health board must ensure that the patient nutrition charts are completed fully after each meal.	Add to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November. Implementation of observational audits and spot checks on the ward to monitor as part of monthly programme.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_021	High	The health board must ensure that medication must be properly controlled when opened, included who has used the medication.	This will be added to monthly medicines management audit. Added to agenda for discussion at next Nursing staff Clinical Development meeting arranged for 10th November 2021 and staff meeting on 24th November and notes made available for all staff.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_023	High	The health board must ensure that processes are in place to allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to.	Health Board policies are communicated and followed on the ward by Nursing management. Datix system used to report all incidents and the Speaking up Safely Policy is also available to all staff should they need to raise any other concerns. All staff have been made aware of the values of the HB and that any instances of discrimination would be treated in line with HB policy. Added to agenda for discussion at next staff meeting on 24th November 2021 and notes of meeting will be released to evidence discussion.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_024	High	The health board must ensure that processes are in place to ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken.	There are policies and procedures within the Health Board to support staff being treated equally and fairly. Speaking up safely policy has been introduced in the Health Board and this will be re-iterated to staff in meetings November 2021.	Nov-21	Nov-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_025	High	The health board must ensure that appraisals are completed for all staff in a timely manner.	At a glance monthly Compliance sheet being devised for Ward Sisters' reference and audit and action accordingly. This will enable ease of monitoring to ensure 100%compliance is achieved. Staff are aware of requirement to complete mandatory training and supported to do so Monthly compliance sheet will support monitoring this.	Dec-21	Dec-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_026	High	The health board must ensure that staff complete their mandatory training in a timely manner.	At a glance monthly Compliance sheet being devised for Ward Sisters' reference and audit and action accordingly. This will enable ease of monitoring to ensure 100% compliance is achieved. Staff are aware of requirement to complete mandatory training and supported to do so Monthly compliance sheet will support monitoring this.	Dec-21	Dec-21	Red	
21113	Nov-21	HIW	Tregaron Community Hospital	Open	N/A	Community and Primary Care (Ceredigion)	Community and Primary Care (Ceredigion)	Tracey Evans	Director of Operations	21113_028	High	The health board must ensure that measures are put in place to improve the wellbeing of staff, in light of some of the less positive responses to the questionnaire.	Staff support services clearly displayed in Staff area and is to be discussed in next staff meeting. Further wellbeing sessions currently being arranged within the ward area.	Sep-22	Sep-22	Amber	
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_1	High	HIW requires details of how the health board will assess and address all risks to fire safety within the unit. HIW is not assured that all environmental risks within the service are managed appropriately.	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Mar-22	Mar-22	Amber	21/12/2021 - Awaiting confirmation from Richard Jupp, Head of LD sent chaser on 21st December. 20/01/2022 - Walk around took place on 19th January, good progress made, some final areas to be addressed once re-decoration is complete. Separate fire assessment completed, with decoration works currently on track 27/01/22 - Walk arounds have been undertaken in January 2022, and fire assessment completed, with noted actions to be addressed once redecoration has been completed. Decoration works are on track for completion by March 2022.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_10	High	The health board must provide assurance that long term segregation or seclusion is appropriately managed within the confines of the Mental Health Act (1983) and in keeping with individual patient care plans, to ensure and allow opportunity for personal skills growth and development.	The unit is divided into 3 independent care areas each with it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired.	Jun-22	Jun-22	Amber	21/12/2021 - Factual accuracy completed to advise that this was incorrect: The unit is divided into 3 independent care areas each with it's own lounge area and bathroom facilities. During covid these were used to prevent risk of cross infection. Dependent on patient mix patients may choose to stay within their area and staff allocated to work with them will also be present in the area. This does not constitute segregation but response to personal preference, patients can mix freely if desired 20/01/2022 - noted that no response from HIW received relating to the comments raised in the factual accuracy form, which queried this recommendation. 26/01/2022 - noted that separate flats are all open access, with no locked doors. 27/01/2022 - The MHLD Seclusion Procedure is currently under review by the Consultant Nurse, Reducing Restricted Practice Lead and Senior Nurses. The procedure will include guidance on long term segregation or seclusion in line with the Mental Health Act. The first draft is expected to be reviewed at the Written Control Group in March 2022, with final ratification expected in May 2022. An implementation plan will also be presented alongside the procedure for ratification, demonstrating how this will be enacted and adopted going forward.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_11	High	The health board must ensure that staff wear appropriate health care uniforms for the role and care needs of the patient group and setting requirements.	Learning disability services do not wear uniforms, as uniforms are regarded as an additional barrier to supporting individuals with a learning disability and emphasise the 'them and us' culture which services are trying to move away from	Mar-22	Mar-22	Amber	21/12/2021 - Factual accuracy completed to advise that this was incorrect: Learning disability services do not wear uniforms, as uniforms are regarded as an additional barrier to supporting individuals with a learning disability and emphasise the 'them and us' culture which services are trying to move away from. 20/01/2022 - noted that no response from HIW received relating to the comments raised in the factual accuracy form, which queried this recommendation. 27/01/2022 - A service specification for Ty Bryn is currently being developed, and the issue and recommendation regarding work wear will be considered and captured within it.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_12a	High	HIW requires assurance from the health board that: • Every effort is made to gather patient voice data on their views of the service provided by the setting • Patients are able to provide feedback on their experiences of physical restraint.	Develop an Easy Read version of the Patient Experience Questionnaire, linked to the friends and family test	Apr-22	01/04/2022 01/06/2022	Amber	21/12/2021 - on track for completion by April 2022 20/01/2022 - On track for completion by April 2022. This pilot form was devised September 2021 and used once (prior to patient moving and subsequent closure of unit). We will continue to use once reopended, and review. The intention is that the form will be used on site and post-discharge. Feedback will be captured and presented to MHLD QSE on a bi-monthly basis. Dream Team (group of individuals with Learning Disabilities who help inform our service developement) have agreed to support gathering patient experience data post discharge. With regards to providing feedback on their experiences of physical restraint, MHLD is in communication with the Reducing Restricted Practice Lead to consider what would be the most effective method of capturing this detail for those with a learning disability.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_2	High	HIW requires details of how the health board will ensure that the environment is adjusted and maintained to ensure that environmental triggers to challenging behaviours are reduced and to allow patients access to suitable outdoor space.	A capital bid was submitted to Welsh Government, this was successful, works have been approved and will commence in January. This includes a secure boundary fence to facilitate access to outside space.	Mar-22	Mar-22	Amber	21/12/2021 - Capital bid agreed, work to commence on new fencing and internal works in the New year 26/01/2022 - start date has been delayed due to contractor requiring isolation due to covid in staff team. Due to recommence early February, and expected to meet the March 22 deadline. 27/01/22 - Work is due to commence early February 2022, with a view for works being completed by March 2022.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_4a	High	HIW requires details of how the health board will ensure the risk to patients from ligature within the setting will be managed and avoided to prevent harm to patients at the setting.	A capital bid was submitted to Welsh Government, this was successful, works have been approved and will commence in January. This includes a ligature free secure boundary fence to facilitate access to outside space.	Mar-22	Mar-22	Amber	27/01/2022 - Work is due to commence early February 2022, with a view for works being completed by March 2022.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_5	High	HIW requires details of how the health board will ensure the building is property maintained in order to prevent the risk of harm to patients and staff.	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Mar-22	Mar-22	Amber	21/12/2021 - A detailed action log has been developed: remaining works: Replacement doors, delivery est 8-10 weeks, completion date end Feb 22 Emergency lighting has been reviewed and minor works costed to be completed end Feb 22 Assessment of Trees – new fence will come inside of the tree line, so preventing access by patients. Additional works: New sink and cladding to shower in bathroom Guttering has been repaired/replaced as required. 26/01/2022 - updated fire assessment completed. 27/01/2022 - Works are ongoing, with completion expected by March 2022
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_6a	High	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	A full training needs analysis will be completed once the inpatient model has been developed and approved. This work is currently ongoing.	Feb-22	Feb-22	Amber	21/12/2021 - Workshop held to scope new service model, further work ongoing to develop a service specification, workforce plan and training needs analysis. 20/01/2022 - Draft service specification for approval at writen control group 25th January 2022 (approved). 26/01/2022 - All staff in work completed fire training and dedicated time to be secured for returning staff. Staff training plan in place currently booking speakers will commence mid Februay. 27/01/2022 - Training needs analysis has been drafted and currently out for consultation with staff.

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-	Progress update/Reason overdue
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_6b	High	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	All staff will update their mandatory training and be given experience of other services to inform future practice.	Mar-22	Mar-22	Amber	21/12/2021 - Temporary deployment of staff commenced, training given in PBM and other training needs will also be met. Some staff now also deployed to support vaccination programme 26/01/2022 - Staff meeting fortnightly to update on progress still working to March date but dependent on works. 27/01/2022 - All staff currently in work have completed fire training, and dedicated time is to be secured for returning staff. Staff meet fortnightly to update on progress being made on training.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_8	High	The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients at the setting.	Once the purpose and function of the unit is established, staffing levels will be assessed, reviewed and implemented as part of the workforce review.	Feb-22	~~Feb-22~~ Mar-22	Red	21/12/2021 - no update provided. 20/01/2022 - Draft service specification completed for approval at written control group and consultation will commence, with the aim of finalising by end March 2022. 27/01/2022 - A draft service specification has been completed and submitted to Written Control Group, and approved in January 2022. The specification is now within a consultation period, with the aim of finalising by March 2022.
21003	Nov-21	HIW	Ty Bryn	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	21003_9b	High	The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.	Staff wellbeing are developing a structured programme of support for the staff ongoing, these will be in the form of reflect and act sessions. These are opportunities to listen to staff and learn from their experiences be able to understand what underlying needs there are, and look at how best to support.	Feb-22	01/02/2022 01/06/2022	Amber	21/12/2021 - Planned, commencing in January 2022 Relationships Manager supporting HoS to look at other ways to improve support for staff. 26/01/2022 - Workforce and Organisational Development are conducting 1:1 meeting with staff, and this will be a continual process so as to allow staff to air concerns. In addition, fortnightly staff meetings are being held with good attendance, and staff are also being asked to comment and shape the future service model. Workforce modelling has commenced, with draft job roles and descriptions being defined. Once finalised, these will be required to go through the formal health board processes for approval.
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_01a	High	The Health Board must ensure that cleaning schedules include a brief comment to explain any exceptions or omissions	Ward cleaning schedules have been amended to include comments and will be operationalised from January 2022	Jan-22	Jan-22	Amber	
21066	Jan-22	HIW	Ward 7, Prince Philip Hospital	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Deputy Head of Nursing	Director of Nursing, Quality and Patient Experience	21066_03b	High	The Health Board must ensure: • The reason why medication is not administered is recorded appropriately • That oxygen is prescribed and recorded • That controlled drugs are countersigned at all times.	Oxygen to be prescribed to be addressed in the next scrutiny assurance meeting 21st December 2021 and Hospital Governance meeting 8th February 2022	Feb-22	Feb-22	Amber	
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	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	Head of Radiology	Director of Therapies and Health Sciences	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	Head of Radiology	Director of Therapies and Health Sciences	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	Head of Radiology	Director of Therapies and Health Sciences	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	Head of Radiology	Director of Therapies and Health Sciences	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	Head of Radiology	Director of Therapies and Health Sciences	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 Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_011	High	The employer must ensure that the relevant written procedures relating to accidental or unintended exposures are updated to accurately reflect current guidance and HIW incident reporting process requirements	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	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
20255	Apr-21	HIW IRMER	Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Therapies and Health Sciences	20255_012	High	The employer must ensure that the employers procedures for theatres are updated to include how benefit and risk information is communicated to patients prior to the exposure.	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	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
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	CEOs Office (Welsh Language)	Head of Radiology	Director of Operations	21021_001	High	Quality of the patient experience - The health board is required to ensure that action is taken to promote the availability of Welsh speaking staff / support within the department to help deliver the 'Active Offer'.	To utilise Welsh speaking staff for patients who request to speak Welsh, and deliver 'Active Offer' whenever possible. Promote the wearing of badges to display Welsh speakers and those learning Welsh. Continue to follow HB guidelines regarding the employment of Welsh Speakers. To better promote the learning of Welsh within the department amongst staff and engage with Health Board Welsh Language team	Dec-21	Dec-21	Red	16/11/2021 - Site lead has engaged with the Welsh language team, all staff who are either Welsh speaking or learning Welsh are wearing badges and lanyards. Useful phrases posters on display around the office and staff areas. Having an 'active officer' within the department, as we currently have no staff who are confident enough speaking Welsh to take on this role on a full time basis. Site lead is acting as an advocate for the promotion of the use of Welsh Language, and offering where possible to patients. Patient information that needs updating has been sent it to translation services. We are trying to display information within the waiting room bilingually - including signage for the new projects MRI and CT, with December 21 timescale expected to be achieved.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	CEOs Office (Welsh Language)	Head of Radiology	Director of Operations	21021_002	High	Quality of the patient experience - The health board must ensure that arrangements are in place to provide written information to patients in Welsh when required.	Review of written patient information and translate into Welsh. Engagement with the HB Welsh Services Manager to develop culture where Welsh is seen equally to English within the department	Mar-22	Mar-22	Amber	16/11/2021 - Site lead has engaged with the Welsh language team. Patient information that needs updating has been sent to translation services. We are trying to display information within the waiting room bilingually - including signage for the new projects MRI and CT.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_003	High	Quality of the patient experience - The health board should ensure that arrangements are in place to routinely collate patient feedback on the services provided within the department.	Engage with the Health Board patient experience team. Ensure staff are aware of how to report patient feedback through the HB service via the Radiology staff forum, which is held monthly. Modality leads will also be e-mailed to inform staff of this requirement. Ask for regular feedback from patients and act where necessary.	Dec-21	Dec-21	Red	16/11/2021 - Instructions have been received as to submitting electronically patient feedback to the patient feedback service, and has been diseminated to staff. Work ongoing regarding patient areas, which is expected to be completed by December 21.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_004	High	Quality of the patient experience - The health board should ensure that arrangements are in place to provide staff and patients with regular updates on the patient experience feedback received by the service, as well as any subsequent actions taken.	Arrange and display information of the patient feedback service on the waiting room notice board. 'you said, we did' section in response to comments/feedback. To communicate with staff at regular staff meetings	Dec-21	Dec-21	Red	16/11/2021 - Still updating the display within the waiting room, now have access to patient feedback service where staff can electronically upload feedback including cards. On target for December completion
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_005	High	Delivery of safe and effective care - The employer must ensure that staff are reminded of the importance of routinely updating relevant documentation to demonstrate that patient identification checks have been undertaken prior to exposures.	Make staff aware of their responsibility regarding I.D. checks via Radiology Forum, and poster campaigns which will be displayed in prominent areas. Conduct regular audits via Picture Archiving Communication System (PACS) of the recording of request information and act where necessary.	Dec-21	~~Dec-21~~ Feb-22	Red	16/11/2021 - Discussed I.D.Checks and request forms via email and staff meetings this has been unified across the HB. Posters reminding of ID checks are in place. An audit has not yet been done via PACS - this will be done 3 months post issue of the updated employers procedures. Revised timescale for completion therefore of February 2022 as EPs agreed in November 2021.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_012	High	Delivery of safe and effective care - The employer must ensure that training and competency records are maintained for all duty holders working within the department, including practitioners, non-medical referrers and those staff providing medical physics support	Ensure that practitioner and non-medical referrer and medical physics training records meet competency requirements and undergo regular review. Work to develop an electronic version which can be both read, updated and signed by users	Oct-22	Oct-22	Amber	16/11/2021 - Risk raised on Datix in relation to electronic document management (1269). In lieu of a central electronic document management system, the service is uploading items to Teams as a file, with the same approach expected to be taken for EPs.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Estates	Head of Radiology	Director of Operations	21021_020	High	Delivery of safe and effective care - The health board must ensure that electrical safety tests are completed for all equipment listed on the inventory as being overdue.	This recommendation is currently being actioned, with the majority of equipment PAT tested. Completion expected by December 2021	Dec-21	~~Dec-21~~ Mar-22	Red	16/11/2021 - work underway with Estates regarding the set up of a Radiographer Reporting Hub
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_022	High	Delivery of safe and effective care - The health board must ensure that remedial actions are taken to address the issues highlighted in the department waiting room area.	Damaged chairs have been removed and replaced. Estates have been contacted in order to repair plaster, with expected completion in December 2021	Dec-21	Dec-21	Red	16/11/2021 - work underway with Estates regarding the set up of a Radiographer Reporting Hub
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Estates	Head of Radiology	Director of Operations	21021_023	High	Delivery of safe and effective care - The health board should ensure that the views of department staff are collated to ensure that, where possible, the necessary adaptations have been made to the environment and practise undertaken, in regards to COVID-19.	New site lead in post, this is currently under review. Site lead is engaging with staff to ensure they feel safe within their working environment given current social distancing requirements. Advice has been sought from Health Board H&S advisor. New reporting room actioned currently awaiting works from Estates in order to adhere to social distancing requirements	Nov-21	~~Nov-21~~ Mar-22	Red	16/11/2021 - work underway with Estates regarding the set up of a Radiographer Reporting Hub
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Estates	Head of Radiology	Director of Operations	21021_024	High	Delivery of safe and effective care - The employer should ensure that there is a written procedure in place that accurately reflects and formalises the clinical audit arrangements in place within the nuclear medicine department.	Health Board will adopt a clinical audit schedule within employers procedures	Nov-21	~~Nov-21~~ Feb-22	Red	16/11/2021 - Employers Procedures will be updated with a new audit schedule and in place by the end of Nov. It is expected that the new schedule will be fully rolled out over the coming months. Revised timescale proposed of Feb-22.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_026	High	Delivery of safe and effective care - The employer should ensure that information is available setting out the capacity requirements and scope of practice for MPEs that provide advice and support to the department.	This is currently in progress, with completion of the recommendation expected by March 2022.	Mar-22	Mar-22	Amber	16/11/2021 - New Head of Radiology to determine the role of the MPE within the Health Board
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_028	High	Quality of management and leadership - The employer must ensure that evidence is available to demonstrate that all duty holders have been entitled, in line with the agreed written procedure in place.	Review of duty holder's entitlement of currently underway, and requests for additional documentary evidence to be asked from staff where necessary to prove competency.	Mar-22	Mar-22	Amber	16/11/2021 - New Head of Radiology to determine the role of the MPE within the Health Board. Entitlement is currently under review.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_029	High	Quality of management and leadership - The employer must ensure that a review of the entitlement documentation is undertaken to confirm that detail accurately reflects the agreed procedure, and to reduce the level of duplication within relevant documents.	Review of duty holder's entitlement currently underway, and requests for additional documentary evidence to be asked from staff where necessary to prove competency,	Mar-22	Mar-22	Amber	16/11/2021 - Entitlement is still under review, with proforma template being used to ensure uniformity of approach across all sites.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_031b	High	Quality of management and leadership - The employer must ensure that written procedures in place are reviewed to ensure that they are accurate and reflective of actual practises in operation within the nuclear medicine department.	All staff have been facilitated to read and sign declaration.	Nov-21	~~Nov-21~~ Dec-21	Red	16/11/2021 - staff have read and sign the existing declaration, however will need to be re-signed in light of the newly ratified EPs. Extension to completion date given to Dec-21.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Estates	Head of Radiology	Director of Operations	21021_034	High	Quality of management and leadership - The health board must undertake a workforce capacity review to ensure that all staff working within the nuclear medicine department have sufficient capacity to undertake their relevant roles.	This will be escalated as a risk by site lead for the attention of the radiology services manager for review to be undertaken. Current managerial changes are on-going. New Radiology services manager in post November 2021	Mar-22	Mar-22	Amber	16/11/2021 - work underway with Estates regarding the set up of a Radiographer Reporting Hub. There is a staff member going through retire and return. Their hours will be back filled by a radiographer who has a MSC in nuclear medicine. This radiographer also wishes to report on Nuclear Medicine studies. This is something supported by the site lead and will assist with capacity issues
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Estates	Head of Radiology	Director of Operations	21021_035	High	Quality of management and leadership - The health board should ensure that adequate space is available to enable relevant staff to undertake reporting tasks as part of their roles.	A new reporting room has been allocated and works have been approved and financed	Nov-21	~~Nov-21~~ Mar-22	Red	16/11/2021 - work underway with Estates regarding the set up of a Radiographer Reporting Hub
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_036	High	Quality of management and leadership - The health board must ensure that all staff working within the department receive regular appraisal discussions with their line manager, which cover their training and development requirements.	This statement has been challenged within the factual accuracy. New site lead in post who is attending PDR training 14.10.21, after which a programme will be rolled out to update all outstanding PDRs within Radiology WGH	Mar-22	Mar-22	Amber	16/11/2021 - Site Lead has received PADR training, and therefore able to undertake PADR training for staff on site.
21021	Oct-21	HIW IRMER	Nuclear Medicine Department, Withybush General Hospital	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	21021_037	High	Quality of management and leadership - The health board must ensure that all department staff are up to date with mandatory training requirements.	New site lead to perform performance review and allocate time to staff to complete mandatory training. To liaise with course leaders regarding face to face training courses which were halted due to Covid 19 – staff are currently enrolled and on waiting lists for courses where face to face training options are available, with other face to face training (such as fire training) being held virtually due to Covid restrictions. Management monitor the uptake of training via ESR metrics	Mar-22	Mar-22	Amber	16/11/2021 - Service demands are worse than ever, with significant operational pressures. Several members of staff are on sick leave, and on call. Site lead is looking at reducing services in order for staff to complete mandatory training.

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-	Progress update/Reason overdue
HDUHB-1718-34	Feb-18	Internal Audit	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	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 cateering / 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. 18/11/2021- Update being requested from Informatics service. 05/01/2022- Chaser email sent to Digital Director for progress update by 21/01/2022 for next ARAC meeting. 12/01/2022- update from Head of Operations- There is a risk to the full implementation of our CAFM system by the end of this financial year, due to IT delays on the procurement and set up of the hardware. Estates are chasing the IT team regularly, however a firm date for full implementation cannot be provided at present, other than BGH will be live by the end of January 2022.
HDUHB 1819-32	Oct-19	Internal Audit	Radiology Directorate	Open	Reasonable	Radiology	Radiology	Head of Radiology	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.
HDUHB-1920-05	Oct-19	Internal Audit	Welsh Language Standards Implementation	Open (external rec)	Reasonable	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Enfys Williams	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~~ Dec-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. 02/11/2021-Demo has been provided of the new e-learning module, should be ready by December 2021.
HDUHB_1920_40	Mar-20	Internal Audit	IM&T Assurance – Follow Up	Open	Reasonable	Digital and Performance	Digital and Performance	Anthony Tracey / Sarah Brain	Director of Finance	HDUHB_1920_40_03	Medium	R3. WOD advice should be sought on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to.	The business manager was able to supply a paper which was produced for the Executive Team in June 2019, this paper evidences that work is underway to address the noncompliance of the original recommendation. The paper lists under option 4, temporary measures the health board is implementing while the permanent measures are implemented. The paper being explored, and further work to progress an OCP and Executive Paper in March 2020 evidence that this recommendation, to seek advice on the matter of compulsory breaks to ensure the European Working Time Directive is appropriately adhered to is in train.	May-19	~~May-21~~ ~~Aug-21~~ ~~Oct-21~~ ~~Nov-21~~ Feb-22	Red	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. 22/10/2021 - We are still experiencing some technical issues with a 3rd party supplier, however we have started the roll out of the tests switchboards across all 4 sites and are currently working closely with our supplier to resolve the technical issues, part of the delay has been trying to upgrade some existing live equipment to be compatible with the new solution. We envisage the technical solution to be in place by the 30/10/2021 when testing of the new solution can begin in earnest. We envisage the new solution to be in place and fully functioning by the end of February 2022, taking into account the feedback from existing operators with regard to making software tweaks and the training of, in excess of, 60 members of staff on the new switchboard solution. 04/11/2021 - Contract with third party supplier now finalised (29th October 2021) therefore HB now in position to move forward. Meeting has been scheduled for the w/e 5th November 2021 to discuss rollout plans - still on schedule for Feb 22 delivery. 11/01/2022 - still on course for Feb 22 completion
HDUHB-1920-10	Jun-20	Internal Audit	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	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.
SSU-HDU-1920-02	Jun-20	Internal Audit	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~~ Feb-22	Red	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. 06/10/2021- end of Section 2 is further delayed, quantum of latest delay needs to be assessed prior to completion of report. Revised date of November 2022 provided. 29/10/2021 It is estimated that Section 2 will not be complete until December 2021 at the earliest the report completion will be undertaken at this point. 05/01/2022- Report now being prepared by the project manager, which will pick up the questions asked by Internal Audit, which will be completed by November 2022. Assurance & Risk Officer to seek clarification from Head of Capital Planning that November 2022 date is correct. 06/01/2022- Head of Capital Planning confirmed this recommendation should be completed by February 2022.
HDUHB-1920-04	Jun-20	Internal Audit	Health & Safety	Open	Reasonable	Nursing	Nursing (Health & Safety)	Tim Harrison	Director of Nursing, Quality and Patient Experience	HDUHB-1920-04_003	Medium	R3: Management should liaise with directorates and services to ensure that arrangement currently in place meet the requirements set out in the Health & Safety Policy.	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~~ N/K	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. 29/11/2021- Update from Head of Health, Safety & Security- In discussions with and support from the Trade Union H&S Reps the identification and development of Departmental H&S Champions will be looked at during 2022 however given the staffing levels and general fatigue being experienced it is difficult to set a target number for these individuals.

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-	Progress update/Reason overdue
HDUHB2021-11	Sep-20	Internal Audit	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	Red	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	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.
SSU-HDU-2021-08	Dec-20	Internal Audit	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~~ Jan-22	Red	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. 08/11/2021- Meeting arranged to discuss ownership of recommendation. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog) and Assistant Director of Strategy & Planning is responsible for everything which is within the AHMMW programme. The PBC for AHMMW is being drafted for Board. The PBC for the Major Infrastructure (keeping existing Estates safe) are to be drafted. Once PBCs confirmed this recommendation can be closed. 06/01/022- Revised date of February 2022, hopeful information to be reported to Board in January 2022 on the PBC for AHMMW will allow this to be closed. This recommendation will be reviewed with Internal Audit following the Board meeting.
SSU-HDU-2021-08	Dec-20	Internal Audit	Backlog Maintenance	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	SSU-HDU-2021-08_002	Medium	R2. The PBCs and as they progress to Outline and Full business case stages will need to determine the in-house Estates staff requirements, and how these will be satisfied given current pressures.	Agreed. The Health Board will need to determine how the necessary Estate in-house staff resources is established in order to successfully deliver the AHMWW and Business Continuity/Major Infrastructure PBCs.	Feb-21	~~Feb-21~~ N/K	Amber	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. 08/11/2021- Meeting arranged to discuss ownership of recommendation. Action to be changed from external to amber as this is a future action that cannot yet be evidence as completed, but is within the gift of the HB to implement. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022.
SSU-HDU-2021-08	Dec-20	Internal Audit	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~~ N/K	Amber	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 therefore will remain amber. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022.
SSU-HDU-2021-08	Dec-20	Internal Audit	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~~ N/K	Amber	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, therefore will remain amber. 05/01/2022- Estates will be responsible for this on the Major Infrastructure work (and existing backlog). Currently seeking internal approval for the resource need to deliver the next stage of this programme, which will then need to be supported at WG level. Subject to approval from WG the UHB will immediately appoint staff required. Assuming a prompt response from WG, the UHB envisages commencement of this work in autumn 2022.
SSU_HDA_1920_01.1	Feb-21	Internal Audit	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~~ Mar-22	Red	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. 29/10/2021- Internal PPE report will be presented to CEIM&T in November 2021. 05/01/2022- Report presented to CEIM&T in November 2021. Gateway 5 PPE evaluation to be carried out in March 2022. Internal Audit confirmed this recommendation remains open until evidence can be provided following the evaluation.
SSU_HDA_1920_01.1	Feb-21	Internal Audit	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~~ Mar-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. 05/01/2022- this is in the initial stages with an update being provided to CEIM&T in January 2022. Approx. completion date of March 2022 (date of following CEIM&T meeting).
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lisa Humphrey/Project Director	Director of Operations	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP:SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ N/K	Amber	26/05/2021 no update. 09/06/2021 in progress. Escalated 12/08/ 2021 to GM and follow up email 26/08/2021 Head of Capital Planning for update and new dates. 07/09/2021 follow up email requesting update. Awaiting a response. 07/09/2021 Head of Capital Planning responded meeting on Thursday with Project Manager and Estates will update following meeting. 10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract.
HDUHB-2021-01	Apr-21	Internal Audit	Health & Safety	Open	Reasonable	Nursing	Nursing (Health & Safety)	Sian Passey / Tim Harrison	Director of Nursing, Quality and 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	Apr-22	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. 21/11/2021- progress update requested 08/11/2021, no update received as yet. 29/11/2021- Head of Health, Safety & Security doesn't recall that this has been implemented. Will check if this has been completed at the next agenda setting meeting in March/April 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-	Progress update/Reason overdue
HDUHB-2122-07	Aug-21	Internal Audit	Field Hospital Decommissioning	Open	Advisory	Central Operations	Central Operations	N/K	Operations Director	HDUHB-2122-07_001	N/A	Management should undertake a 'lessons learned' exercise with key individuals across the field hospital commissioning, operation and decommissioning phases in order to identify what went well and what could be done differently, not only for similar projects but potentially also in the operation of acute hospital settings.	The Executive Director of Operations, the Field Hospital management team and other Health Board senior managers welcome this Internal Audit advisory report into the decommissioning processes relating to the field hospital portfolio. The opportunity to embed the learning recorded in this report into future practice in whatever form that might take is an opportunity not to be missed if the Health Board is to improve on similar processes in the future. It is worth noting that whilst this audit focused on the decommissioning phase of the nine field hospitals set-up and commissioned in April 2020, the record should not lose sight of the fact that decisions taken during the planning phase, which were invariably made whilst the country faced an uncertain prospect as to the impact of the COVID pandemic, may have been less than optimum for the sake of expediency. The consequence of this was that the Health Board found itself facing far from desirable situations at the decommissioning stages and whilst it is easy to critically reflect on the early decisions that led to these predicaments it needs to be reminded that the pressure to deliver facilities in a matter of weeks was nothing short of significant at the time. The three local authorities that supported the Health Board will have faced similar pressures in identifying suitable sites and supplying the resources to convert these into working field hospitals and whilst under such time pressures with hindsight the final site nominations may not have served the interests of the Health Board in line with its service delivery objectives as well as they might. That said it needs to be noted that even in the face of some highly undesirable reinstatement obligations which only became apparent at the decommissioning phase that material mitigation of expense has been achieved where some of the Health Board's costs are concerned. Most notable these apply at the Stadium at Parc y Scarlets, Llanelli and the Leisure Centre at Plas Crug, Aberystwyth. It is also worth reminding that eighteen months ago the prospect of establishing 950 field hospital beds in a matter of weeks at sites yet to be unidentified was beyond the realms of reality and yet by early April 2020 this was precisely what had been achieved. The availability of the additional beds helped each of the acute hospitals navigate a difficult winter which was exacerbated by the impact of the second coronavirus wave. It was not until June 2021 that the position had settled down to a point where the added capacity could be stood down. Building on the content of the advisory report at a time when only two field hospitals remain in the portfolio and none of the beds operational that the Health Board is taking its experience of operationalising three sites forward and this is illustrated by the retention of the senior management team with a light touch commitment such that in the event that these beds are called for that the service can react without having to overcome the avoidable inertia of identifying that triumvirate.	Jun-22	Jun-22	Amber	13/09/2021- Agreed at ARAC August 2021 that the management lead and timescale for the 'lessons learnt' exercise to be undertaken would be provided in the Table of Actions. Tracker to be updated once Table of Actions are shared. 19/10/2021 - Update for October 2021 ARAC meeting: The Deputy Director of Operations was party to an initial planning meeting, on 6th October 2021, where the approach to a follow-up workshop involving a broader representation of colleagues involved in the Field Hospital campaign was determined. The workshop is expected to take place in October 2021; the output will be a short report on lessons learned. A recap will follow after the Selwyn Samuel Centre is fully decommissioned in 2022.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_001	High	R1. The WLS Team should support directorates and services that have engaged with them to ensure the requirements of the Standards are embedded within their individual plans.	The Welsh Language Team to contact all directorates to offer support directorates to ensure that the Standards are embedded within their individual plans. The Health Board IMTP for 2022/23 – 2024/25 will include planning objectives in relation to compliance with the standards and are currently exploring through the transformation steering group where we want to go further to embrace Welsh Language and Culture.	Oct-21	~~Oct-21~~ Dec-21	Red	25/09/2021- update requested from lead officer to confirm if this recommendation is on track to be implemented by October 2021. 02/11/2021- email has been sent to services and support has been offered but nothing forthcoming. CEO has requested an overarching strategic objective which is to be agreed. Update to People, Organisational Development and Culture Committee (PODCC) on 13/10/2021 confirmed work has commenced with regard to the strategic approach and ambition in terms of the Welsh language and would be incorporated within the next iteration of the HDdUHB Annual Plan as a planning objective which can be measured.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_002	High	R2. Management should assess the financial and reputational risk of non-compliance with the Welsh Language Standards on the risk register.	An assessment will be undertaken to establish whether the financial and reputational risk of non-compliance with the Welsh Language Standards have been captured on Health Board risk registers.	Mar-22	Mar-22	Amber	02/11/2021- A risk has been added to the Welsh Language risk register regarding compliance with the Welsh Language Standards. The UHB is not aware if all Directorates are complying with the standards, as not all Directorates have responded to the self assessment due to Covid-19 and other operational pressures.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_003a	High	R3.1 The WLS Team should chase up the outstanding directorates and service for their self assessment tool and escalate areas of non-engagement to the appropriate Executive Director	The WLS Team to chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director, and support directorates and services, who request it, in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	Sep-22	Amber	02/11/2021- it was advised by the CEO to stand down anything not absolutely critical to support the front-line teams. The Planning day for strategic objectives was called off.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_003b	High	R3.2 The WLS Team should support directorates and services in their development of action plans to address areas of non-compliance with the Standards.	The WLS Team will support directorates and services that engage with them in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	Sep-22	Amber	02/11/2021- The Welsh language team are supporting those teams who are engaging, in the development of their action plans.
HDUHB-2122-12	Aug-21	Internal Audit	Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Steve Moore (Chief Executive)	HDUHB-2122-12_004	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	Mar-22	Amber	02/11/2021- Welsh Language Steering Group to be established once new Director is in post, who is due to join the UHB January 2022.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	HDUHB-2122-06_001	Low	R1. Management should ensure all planning objectives are referenced in future annual plans for completeness.	The planning process for the 2022/25 Integrated Medium Term Plan has begun. This includes a review of all Planning Objectives, and these will form the key deliverables for the Plan. The Health Board will ensure that all Planning Objectives are included in future iterations of the Plan.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- Paper going to Public Board 27/01/2022 for Planning Objectives 2022-25 for approval, which is the first part of the process. All of these planning objectives will feature in the IMTP, for onward submission to WG by end of March 2022.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	HDUHB-2122-06_002	Medium	R2. Management should ensure the structure and contents of submitted technical documents are consistent to enable key information to be aligned to the current year's strategic and planning objectives.	As part of the development of the technical documents to support the Integrated Medium Term plan, the Health Board will ensure that there is greater alignment to the strategic and planning objectives. To support this, guidance will be provided to all authors of the technical documents to ensure better alignment with the strategic and planning objectives.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- Guidance has been provided for the Technical docs supporting the IMTP, which will be clearly linked to the planning objectives, for onward submission to WG by end of March 2022.
HDUHB-2122-06	Oct-21	Internal Audit	Annual Recovery Plan and Planning Objectives Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Daniel Warm	Director of Strategic Development and Operational Planning	HDUHB-2122-06_003	Medium	R3. Management should ensure that 'Plans on a Page' for every planning objective is promptly developed and fully completed with key information before their submission.	The plans on a page for the 2021/22 Annual Plan will be reviewed to ensure all key information is completed. All new or revised Planning Objectives for the 2022/25 Integrated Medium Term Plan, will be supported by 'plans on a page'. The Health Board will ensure that all key information is completed prior to submission.	Jan-22	~~Jan-22~~ Mar-22	Red	26/01/2022- 'Plans on a Page' being drafted for each planning objective, which will be completed by end of March 2022 for submission with the IMTP.
HDUHB-2122-20	Oct-21	Internal Audit	Mental Health and Learning Disabilities Directorate Governance Review Final Internal Audit Report	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll / Sara Rees / Warren Lloyd	Director of Operations	HDUHB-2122-20_001	Medium	Management should ensure complete and accurate terms of reference for the BPPAG and QS&EG meetings and supporting sub-groups are maintained and approved.	Agreed – The BPPAG will be reviewed and ratified, whilst the QS&EG TOR will be amended to reflect bi-monthly meeting in the coming weeks. In addition, a sub group TOR tracker will be developed.	Oct-21	Jan-22	Red	11/11/2021 - The Terms of reference have been reviewed and updated and will be signed off at BPPAG meeting on the 25th November. QSEG TOR to be ratified at the next meeting. Work to be undertaken on sub group TOR 25/11/2021 - TOR agreed at signed off at BPPAG meeting today, with a review of TOR scheduled for the April BPPAG meeting, and on an annual basis thereafter
HDUHB-2122-20	Oct-21	Internal Audit	Mental Health and Learning Disabilities Directorate Governance Review Final Internal Audit Report	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll / Sara Rees / Warren Lloyd	Director of Operations	HDUHB-2122-20_003	Medium	Management should ensure a review and identification of potential saving schemes is undertaken to contribute to addressing the Directorate's financial deficit.	Whilst the directorate is currently underspent against budget, work is ongoing with Finance colleagues to scope and identify savings opportunities during 2021/22 and beyond.	Mar-22	Mar-22	Amber	07/12/2021 - IMTP process has been undertaken, to confirm progress with Liz C and Leon P.
HDUHB-2122-33	Oct-21	Internal Audit	Prince Philip Hospital Directorate Governance Review	Open	Reasonable	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Brett Denning / Melanie Long	Director of Operations	HDUHB-2122-33_001	Medium	Management should ensure complete and accurate terms of reference for the Governance Meeting and supporting sub-groups are maintained and approved.	Accepted – Management will ensure the terms of reference for the Governance Meeting and supporting sub-groups are updated and approved.	Dec-21	Dec-21	Red	
HDUHB-2122-33	Oct-21	Internal Audit	Prince Philip Hospital Directorate Governance Review	Open	Reasonable	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Brett Denning / Melanie Long	Director of Operations	HDUHB-2122-33_002	Medium	Management must ensure the progress of actions recorded on the Directorate's risk register are updated and reviewed on a regular basis.	Accepted – Management will update the progress of actions recorded on the Directorate's risk register and ensure they are updated and reviewed on a regular basis.	Dec-21	Dec-21	Red	
HDUHB-2122-33	Oct-21	Internal Audit	Prince Philip Hospital Directorate Governance Review	Open	Reasonable	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Brett Denning / Melanie Long	Director of Operations	HDUHB-2122-33_003	Low	Management must ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.	Accepted – We will continue to ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.	Dec-21	Dec-21	Red	
HDUHB-2122-33	Oct-21	Internal Audit	Prince Philip Hospital Directorate Governance Review	Open	Reasonable	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Brett Denning / Melanie Long	Director of Operations	HDUHB-2122-33_005	Low	Steps should be taken to reintroduce the complaints group to facilitate the reporting within the directorate.	Accepted – Discussions to take place with PPH team as to the benefit of re starting the complaints specific governance meeting.	Oct-21	Oct-21	Red	
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_001	High	In the absence of an initial internal business case, Management should ensure that the following is undertaken prior to embarking on the third phase of the project: • project ownership, roles and responsibilities are agreed and documented; and • risks relating to rollout are identified, analysed and documented.	Agree, and suitable governance arrangements will be established for the remainder of the project as per previous projects, following PRINCE or Agile methodologies. For example: • Project Group / Project Team • Project Initial Documentation, • Project Plan	Dec-21	Dec-21	Red	11/01/2022 - documentation has been prepared, to be reviewed and signed off on 14th January 2022 between Digital Director and Director of MHLD
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_002	High	Whilst recognising that the project is embarking on its third phase, Management should ensure that the Project Initiation Document is updated to reflect the arrangements in place, including: o project ownership and agreed project roles and responsibilities; o communication management approach; and o detailed training plan.	Agreed, and the completion of the PID will form part of the achievement of recommendation 1	Dec-21	Dec-21	Red	11/01/2022 - documentation has been prepared, to be reviewed and signed off on 14th January 2022 between Digital Director and Director of MHLD
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_003	High	A risk analysis exercise is undertaken prior to the third phase and any identified risks are assigned ownership.	Agreed, and the completion of the risk analysis will form part of the achievement of recommendation 1 and will be a key element of the project initiation	Dec-21	Dec-21	Red	11/01/2022 - risk analysis exercise has been undertaken, with identified risks noted in the PID. The risks currently identified have been assigned to Digital Director and Director of MHLD as appropriate. Risks will be reviewed and updated during the course of the project. Risks to be approved at meeting on 14th January 2022.
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_004	High	The project plan should accurately reflect activities to be undertaken in the third phase, including timescales for delivery.	Agreed, and the completion of the project plan will form part of the achievement of recommendation 1	Dec-21	Dec-21	Red	11/01/2022 - outline project plan devised including specific tasks, however specific dates to be refined with services. Project plan to be reviewed on the 14th January 2022, with project group to confirm the order of services implementing the project.

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-	Progress update/Reason overdue
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_005	High	A detailed testing plan for the third phase should be developed, upon which an assessment of readiness can be determined prior to go-live.	Agreed, and the completion of the testing plan will be an iterative development and will be refined after each milestone. However, an outline testing plan will be designed	Apr-22	Apr-22	Amber	11/01/2022 - once outline project plan agreed by services, testing plans will be developed with a consistent approach taken for each service. Project plan to be reviewed on the 14th January 2022, with project group to confirm the order of services implementing the project.
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_006	High	Management should ensure that prior to the third phase, a project / implementation group is established in line with agreed roles and responsibilities, and that Executive sign-off is received and documented prior to initiation.	Noted and agreed. A new project group will be established with suitable representation from the Mental Health and Learning Disabilities Directorate and Digital Services	Dec-21	Dec-21	Red	11/01/2022 - TOR devised for larger project group, and operational group TOR by MHLD in December 2021 - to be reviewed and approved on 14th January 2022.
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_007	Medium	Management should ensure that staff assigned to the third phase of the project meet regularly, with decisions, actions and issues monitored and documented.	A Project Group will be re-established with ToR that will set out membership, frequency of meetings, and key role and responsibilities of the Group, and the reporting arrangements	Jan-22	Jan-22	Amber	11/01/2022 - TOR devised for larger project group, and operational group TOR by MHLD in December 2021 - to be reviewed and approved on 14th January 2022. Meetings set up for WPAS, and another wider meeting on informatics for MHLD - both are scheduled to meet fortnightly during the course of the project.
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_008	High	Management should ensure that appropriately skilled and dedicated resources are assigned to the third phase of the project to ensure accurate system mapping and effective implementation.	The Mental Health and Learning Disabilities Team have assigned funding to recruit a Band 5 – Application Specialist, and a Band 6 – Business Analyst to assist with the third phase of the project	May-22	May-22	Amber	11/01/2022 - roles currently being advertised, further update to be provided at next review.
HDUHB-2122-16	Nov-21	Internal Audit	Deployment of WPAS into MH&LD	Open	Limited	Digital and Performance	Mental Health & Learning Disabilities	Digital Director, Head of Information Services and Directorate Support Manager	Director of Finance	HDUHB-2122-16_009	High	Management should ensure that a post-implementation review is undertaken with a focus on evaluating project objectives and implementation effectiveness of the first two phases, to identify lessons learned to be implemented during the third phase.	To undertake a post-implementation review of the first 2 phases, and use the learning to inform the PID and Project Plan for Phase 3	Dec-21	Dec-21	Red	11/01/2022 - lessons learned have been incorporated in to the PID, which is to be reviewed and signed off on the 14th January.
HDUHB-2122-23	Nov-21	Internal Audit	Therapies Directorate Review	Open	Reasonable	Therapies	Therapies	Clinical Director of Therapies	Executive Director of Therapies and Health Science	HDUHB-2122-23_001	Medium	Formal monitoring and reporting arrangements for workforce, finance and performance matters should be established.	A dedicated workforce meeting is in place on an alternate week process as part of the bi-weekly heads of service meeting, and includes attendance of the dedicated Workforce & Employee Relations Officer and the assistant Director of Therapies & Health Sciences. This dedicated meeting covers areas such as employee relations, agency usage, apprenticeship programme, workforce commissioning and development. However, we accept that these arrangements require formalisation with an agreed terms of reference and action log. Monthly finance meetings will also been established from 14th Dec 21 as part of the twice weekly meetings, this will be reflected in the terms of reference and incorporated into the action log.	Dec-21	Dec-21	Red	
HDUHB-2122-23	Nov-21	Internal Audit	Therapies Directorate Review	Open	Reasonable	Therapies	Therapies	Clinical Director of Therapies	Executive Director of Therapies and Health Science	HDUHB-2122-23_002	Medium	In line with the Standards of Behaviour Policy, all senior managers within the Directorate should submit a declaration of interest form (including a nil return if appropriate) for inclusion on the declaration on interests register.	All appropriate senior managers and clinicians within the Directorate will submit an annual declaration of interest form (including a nil return if appropriate) for inclusion on the declaration on interests register.	Mar-22	Mar-22	Amber	
HDUHB-2122-23	Nov-21	Internal Audit	Therapies Directorate Review	Open	Reasonable	Therapies	Therapies	Clinical Director of Therapies	Executive Director of Therapies and Health Science	HDUHB-2122-23_003	High	Management must prioritise the review and closure of open incidents predating April 2021.	All open incidents have been reviewed at QSER Group meeting on 29th of October 2021 and identified areas for review tasked to Heads of Service to have been actioned by January meeting. Some of these were attributed to turnover in the Head of Service posts with delays in reassigning responsibilities for open incidents. Bi-monthly directorate review structure in place to monitor open incidents in addition to Head of Service responsibility.	Jan-22	Jan-22	Amber	
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001a	N/A	Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	Mar-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001b	N/A	Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Task and Finish group to be established as part of the UEC programme under policy goal 6, to set consistent principles and standards, with staff reps from across HB community and acute and work through the recommendations together – appreciating that localities may have differing processes this group could share best practice and consideration given as to whether these practices can be taken forward across HB. This approach may also aid identifying training required.	Mar-22	Mar-22	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002a	N/A	The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. Providing we are able to demonstrate delivery of those standards how the services are constructed should not matter. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	N/K	N/K	Amber	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002b	N/A	The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002c	N/A	The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PGS & 6 workstream.	Jan-22	Jan-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003a	N/A	Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days	N/K	N/K	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003b	N/A	Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care	Important to note that there is still work to be done on data quality. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can commence on admission and information can be provided to facilitate a conversation.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_006	N/A	Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.

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-	Progress update/Reason overdue
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. It is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion. EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Sian Passey	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_008	N/A	A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	Apr-22	Amber	08/12/2021 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001a	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Continue to deliver formal training at the New Consultant Development Programme and any other relevant leadership/management development programmes for those responsible for staff in the Medical & Dental staff group to ensure recruiting managers are aware of their responsibilities and key performance indicators.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001b	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	In addition to formal delivery of training, continue to promote access to virtual training which is already available on the intranet in '10 top tips' which covers preparing to recruit.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001c	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Develop further training including virtual Trac training which will reinforce the need to place vacancies on Trac at the earliest opportunity.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001d	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Share Medical Recruitment KPI performance with other officers in the W&OD Directorate e.g. OD Relationship Managers, Medical Workforce Team, Workforce Efficiency team, Workforce Planning Team etc to encourage them to support the importance of timely recruitment when they liaise with managers	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001e	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Explore the option of electronic leaver forms to trigger prompt actions to recruit in a more timely manner.	Mar-22	Mar-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001f	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Medical Recruitment Team to routinely share monthly KPI performance on Medical Recruitment with the Director of Operations highlighting areas of improvement or deterioration and service areas where performance requires improvement.	Dec-21	Dec-21	Red	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_001g	High	The Director of Operations should ensure that recruiting managers are made aware of their need to undertake the recruitment process in a timely and efficient manner in order to avoid delays in appoint new starters. Where delays are incurred, the Medical Recruitment Team should inform directorate or service management.	Director of Operations to routinely address monthly KPI performance on Medical Recruitment at the Operational Leads Delivery meeting highlighting areas of improvement or deterioration and service areas where performance requires improvement.	Dec-21	Dec-21	Red	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_002	Medium	Management should undertake a targeted review of consistent bottleneck areas within the recruitment process and develop actions in order to promptly address medical staff vacancies.	Medical Recruitment Team to review consistent 'bottleneck' areas and develop an action plan to address them. Example areas will include a) starting salary process b) occupational health process c) notice periods d) immigration process. This list is not exhaustive as the review may identify other bottleneck areas which need to be addressed.	Jan-22	Jan-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-29	Dec-21	Internal Audit	Medical Staff Recruitment Final Internal Audit Report	Open	Reasonable	Workforce & OD	Workforce & OD	Annmarie Thomas / Sally Owen	Director of Operations	HDUHB-2122-29_003	Low	Management should undertake a review of the onboarding process and engage with key stakeholders to establish whether enhancements can be made to the current system.	As part of the recruitment pathway strategic objective the recruitment team are reviewing information shared with key stakeholders in a bid to improve the recruitment journey including onboarding/pastoral care. The medical recruitment team are also supporting the Medical Directorate in a piece of work to further explore candidate connections pre Day 1 and on/around Day 1 for the M&D staff group. The findings of this audit and the outcomes of the discovery stages of the above workstreams will be consolidated to develop an action plan which focusses on improvement to the onboarding process.	May-22	May-22	Amber	08/12/21 - The original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. Revised management response reported to ARAC December 2021, audit tracker has been revised to reflect this.
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_001	Medium	The Health Board should ensure that all budget holders sign the Accountability Agreement letters, as evidence of accepting ownership of their individual budgets, in order that they can be held to account for the financial performance.	Through the annual financial planning process, all Accountability Agreement Letters should be signed no later than the end of two months into the new financial year.	Jun-22	Jun-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_002	Medium	Budget holders should be reminded of their responsibility to monitor and manage their budgets, and make use of the available tools to do this. Management should consider monitoring budget holder use of the BI Dashboards and QlikView systems.	Recognising the need for familiarisation with the reports and systems across budget holders, there are different methods employed by Finance Business Partnering teams to support their budget holders with how to access and review their financial information. Each FBP team should review the financial position monthly with their budget holders, in an appropriate manner, and ongoing training provided to ensure budget holders move towards a self-service approach.	Jul-22	Jul-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
HDUHB-2122-04	Dec-21	Internal Audit	Financial Planning, Monitoring and Reporting	Open	Reasonable	Finance	Finance	Deputy Director of Finance and Assistant Director of Finance	Director of Finance	HDUHB-2122-04_003	Medium	All virements should be appropriately authorised in line with the stipulations of the Budgetary Control procedure, subject to a review of the current criteria within the procedure. Management should ensure that Section 3 of the Virement form is fully completed in line with the requirements of the Budgetary Control procedure.	All virements transacted across directorates, excluding funding allocations from reserves, should be accompanied by a fully completed and approved virement form, in line with Budgetary Control procedures, which will be managed by the Financial Officer within the Corporate Reporting and Planning team, who will store the forms at the same time as approving the budget adjusted in the budget system.	Apr-22	Apr-22	Amber	06/01/2022 - request for update sent as part of service update e-mail
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_001	N/A	R1. Develop a Capital Project Management Framework	Work in progress	Feb-22	~~Feb-22~~ Mar-22	Red	07/01/2022- Completion date moved to align with appropriate CEIM&T date in March 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_002	N/A	R2. Develop Standardised Project Governance Documentation including a checklist for sign off and assurance	Work in progress	Feb-22	~~Feb-22~~ Mar-22	Red	07/01/2022- Completion date moved to align with appropriate CEIM&T date in March 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_006	N/A	R6. Terms of Reference for CEIM&T to be reviewed	For November CEIM&T	Jan-22	~~Jan-22~~ Feb-22	Red	05/01/2022- Draft TORs reported to November 2021 CEIM&T. A revised draft is now being prepared to incorporate comments made and will be reported to January 2022 CEIM&T and SDODC in February 2022. 07/01/2022- align with TOR sign off at Strategic Development and Operational Delivery Committee (SDODC).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_007	N/A	R7. Setting up of an internal scrutiny process for business cases prior to them being finalised and presented to CEIM&T for approval	Develop a proposal and draft terms of reference for Executive Team discussion. This will cover how the process will be resourced and ensure upfront scrutiny and approval prior to CEIM&T submission	Mar-22	Mar-22	Amber	07/01/2022- In progress for discussion by Executive Team by March 2022.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_008	N/A	R8. Consideration be given if CEIM&T and the Groups that sit underneath it should have delegated approval limit	Review the current capital approval framework documentation and delegated capital approval limits with the Governance Team. SBAR to May CEIM&T	May-22	May-22	Amber	07/01/2022- in progress.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_009b	N/A	R9 The current and future capacity of the existing core teams who support the capital process to deliver the UHB's ambitious capital agenda	SBAR to be reported to Executive Team containing gap analysis for consideration This gap analysis will inform our discussions with Welsh Government to enable us to take the PBC onto OBC development.	Feb-22	Feb-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021, with recommendation split into three separate actions.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0010	N/A	R10. For future complex schemes the UHB might want to consider the resourcing the additional scrutiny of the SCP	The Health Board will assess the risk at the commencement of the project FBC stage. The availability of funding from WG would also need to be tested and approved as part of the resource schedule for FBC development. This approach will be incorporated into the Capital Project Management Framework (see action 1) which will be used for all future complex schemes.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).

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-	Progress update/Reason overdue
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0011	N/A	R11. Consideration of Project Director role	Given the significant step up in the UHB's aspiration to deliver capital projects over the next few years Project Director roles for specific projects will be full or part time roles. On their appointment specific agreement for time allocation and resourcing and backfill will be agreed. The operational impact on costs will be reflected in the appropriate Appointment Certificates and the Executive Director signature whose portfolio the Project Director sits will confirm that they are satisfied with these arrangements if they are not the Senior Responsible Owner. The above steps will be incorporated into the Standardised Project Governance Documentation (see action 2).	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 2 (Standardised Project Governance Documentation).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012a	N/A	R12. Training for Project Director	For the Project Directors that will be appointed for the specific AHMWW projects specific training sessions will be organised and facilitated to include the WG Assurance Hub, NWSSP Audit and Assurance input. This approach will be incorporated into the Capital Project Management Framework.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012b	N/A	R12. Training for Project Director	For smaller Projects specific SRO/PD facilitated sessions with NWSSP Audit and Assurance will be organised. This approach will be incorporated into the Capital Project Management Framework.	Mar-22	Mar-22	Amber	07/01/2022- management response reworded as requested by ARAC December 2021. Timescale aligned with completion of recommendation 1 (Capital Project Management Framework).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0012c	N/A	R12. Training for Project Director	Develop a PD Pocket Guide	May-22	May-22	Amber	07/01/2022- in progress.
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0013	N/A	R13. Review the resourcing of capital projects for Project Director	As point 11 above- This will be incorporated into the Standardised Project Governance Documentation (see action 2).	Mar-22	Mar-22	Amber	07/01/2022- Timescale aligned with completion of recommendation 2 (Standardised Project Governance Documentation).
Capital Governance Review	Dec-21	Internal Review	Capital Governance Review	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Head of Capital Planning	Director of Operational Planning & Strategic Development	HDUHB-2021-11_0014	N/A	R14. The process for the prioritisation of schemes for the Infrastructure Investment Enabling Plan	Work has already been undertaken on the development of a prioritisation matrix for the allocation of part of the UHB's discretionary programme. WG Planning Framework call out the need to prioritise the bids for All Wales Capital. The prioritisation framework will need to link with the • UHB Strategic objectives • UHB's Planning Objectives • Implementation of AHMWW Strategy • Business continuity	Jan-22	Jan-22 Feb-22	Amber	07/01/2022- Completion date moved to align with sign off as part of IMTP.
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	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). 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
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	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). 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. 15/11/2021- Report to Health & Safety Committee notes this work is hugely challenging given the clinical pressures in place on our acute sites, however the whole Team is doing everything possible to mitigate any delays. MWWFRS continues to be kept fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the above timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension needed. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the	Full action plan held by Estates.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. 15/11/2021- Report to Health & Safety Committee notes this work is hugely challenging given the clinical pressures in place on our acute sites, however the whole Team is doing everything possible to mitigate any delays. MWWFRS continues to be kept fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the above timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension needed. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. The Regulatory Reform (Fire Safety) Order 2005. Withybush General Hospital, Kensington, St Thomas, etc.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_003	High	R3. Improve Fire Detection System The detection within the means of escape from the flats and bedrooms should be changed from heat detection to smoke detection to allow the maximum amount of time between detection alert and escape. It was noted that there was heat detection in the bedrooms and entrance halls into the flats and within the lounge areas where smoke detection would be the preferred safer option, it was explained to me that this was due to the residents being able to smoke within the premises before the smoking ban to reduce the false alarm calls. • It was noted that there was a detector being covered at time of inspection within the kitchen of the Pembroke county block (First floor flat F block). You must ensure that this practice is not repeated, information must be given to the occupants explaining the severity of this action. • Due to the Server within the Means of escape an additional detector within the area of the device is required (due to the lintel between the detector and the server) noted within the Pembroke county and St Thomas block (but this should include all blocks if server is on escape route in the same way). The changes should be carried out and commissioned by a competent person.	Full action plan held by Estates.	Jul-20 Dec-21 Apr-22	Dec-21 Apr-22	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. 15/11/2021- Report to Health & Safety Committee notes this work is hugely challenging given the clinical pressures in place on our acute sites, however the whole Team is doing everything possible to mitigate any delays. MWWFRS continues to be kept fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the above timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension needed. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.

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/001135 73- 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/00113 573_ 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	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. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/001147 19- /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/00114 719_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~~ Nov-21	Red	This work is part of the Advanced Works WGH Fire Enforcement Programme. 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. 18/11/2021- update to Health & Safety Committee 15/11/2021- It is anticipated that this will be completed by late November 2021. All doors completed with the exception of one (delayed by asbestos issue), once this is completed the commencement of the three stage compliance assessment for door and workmanship quality will be undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- Work complete. The Mid and West Wales Fire & Rescue Service (MWWFRS) will be invited to inspect the doors which is envisaged will be undertaken in January 2022, subject to their availability. Subject to the above being completed satisfactorily, this Fire Enforcement Notice will be removed by MWWFRS.
BFS/KS/SJM/001147 19- /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/00114 719_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~~ Nov-21	Red	Estates colleagues are meeting with MWWFRS on 16/06/2020 to agree revised date of December 2021 (delayed by 4 months due to impact of COVID-19). MWWFRS have been verbally supportive of these revised dates. 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. 18/11/2021- update to Health & Safety Committee 15/11/2021- It is anticipated that this will be completed by late November 2021. All doors completed with the exception of one (delayed by asbestos issue), once this is completed the commencement of the three stage compliance assessment for door and workmanship quality will be undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- Work complete. The Mid and West Wales Fire & Rescue Service (MWWFRS) will be invited to inspect the doors which is envisaged will be undertaken in January 2022, subject to their availability. Subject to the above being completed satisfactorily, this Fire Enforcement Notice will be removed by MWWFRS.
BFS/KS/SJM/001147 19 - 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/00114 719_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. 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). 18/11/2021- update to Health & Safety Committee 15/11/2021- The current programme completion date is late August 2022. MWWFRS continues to be kept fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension needed. Audit tracker will be revised following the visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/001147 19 - 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/00114 719_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. 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). 18/11/2021- update to Health & Safety Committee 15/11/2021- The current programme completion date is late August 2022. MWWFRS continues to be kept fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension needed. Audit tracker will be revised following the visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- As a result of the significant additional works, the anticipated completion date for the works has been assessed by the Project Management Team as the end of December 2022. COVID-19 continues to impact on progressing the work due to the close proximity of some aspects of this fire work to clinical areas. The MWWFRS has been fully briefed on this programme adjustment required to support their decision on overboarding, and are fully supportive of the adjustment to the compliance dates and will provide written confirmation of this in early 2022. The completion date will be revised on the audit tracker following written confirmation from MWWFRS.
BFS/KS/SJM/001147 19- KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: Withybush General Hospital. The serving of this Notice dated 09 February 2020 and numbered KS/890/04	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114 719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Apr-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 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. 18/11/2021- update to Health & Safety Committee 15/11/2021- At the current time, HDdUHB remains confident that the April 2025 date can be achieved, however this will be reviewed upon completion of the Business Case work. The matter has been discussed with MWWFRS, who appreciate that a revision may be required to this programme should the nature of the works dictate that an additional period becomes necessary. 05/01/2022- update being reported to Health & Safety Committee January 2022-At this point, confidence remains that the April 2025 date can be achieved, however this will be required to be reviewed when the Business Case work is completed. The matter has been discussed with MWWFRS and they appreciate that a revision may be required to this programme should the nature of the works dictate that an additional period becomes necessary.
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, Dolgwill 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~~ N/K	Red	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. 05/08/2021- email received from MWWFRS confirming revised deadline of end of Spetember 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. 18/11/2021- update to Health & Safety Committee 15/11/2021- all doors have now been completed, with the exception of three individual doors. Currently it is unclear when we will be able to allow access to these areas to complete the three outstanding fire doors due to the ongoing COVID-19 position. In order to continue to make progress on appropriate validation and sign-off, HDdUHB is now progressing the three phase approval process as used in WGH. The three remaining doors will be managed in the same way when access becomes available. HDdUHB is keeping MWWFRS fully updated on the current status. 05/01/2022- update being reported to Health & Safety Committee January 2022- the completion of the three outstanding doorsets which were reported at the November 2021 HSC meeting remain outstanding, due to restrictions on contractors access due to their proximity to COVID-19 related facilities. A completion date is not in place in light of the lack of access to these areas due to the ongoing COVID-19 position. Discussions are being undertaken with MWWFRS to ascertain whether it is possible to take a pragmatic approach to this and in effect sign off the Enforcement Notices associated with these works and move these three doors to be included in the formal Phase 1 works.

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-	Progress update/Reason overdue
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice The Regulatory Reform (Fire Safety) Order 2005: Article 30 Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 18/11/2021- update to Health & Safety Committee 15/11/2021-WG has scrutinised the BJC and submitted two sets of queries to HDdUHB, which have been fully responded to. HDdUHB is currently awaiting a response to the information provided to WG in order for them to fully approve the project. On a positive note, WG have requested cash flow forecasting, working to an approval date of early November 2021, in order to forecast expenditure to 31st March 2022. It is currently programmed, subject to the above approval, that site set up will be underway during December 2021 with work commencing in January 2022. This will indicate a completion date of circa December 2022/January 2023. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. MWWFRS are fully aware of the above timescales and have advised they are planning to visit the site at an appropriate time in 2022 to confirm any extension needed. Audit tracker will be updated following this visit. 05/01/2022- update being reported to Health & Safety Committee January 2022-The current forecast completion date for Phase 1 is February 2023, however this will need to be reviewed when site set up is completed and physical works commence on the Fire Safety programme. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the above timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension required. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023.
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~~ Feb-23	~~Jul-22~~ Feb-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 18/11/2021- update to Health & Safety Committee 15/11/2021-WG has scrutinised the BJC and submitted two sets of queries to HDdUHB, which have been fully responded to. HDdUHB is currently awaiting a response to the information provided to WG in order for them to fully approve the project. On a positive note, WG have requested cash flow forecasting, working to an approval date of early November 2021, in order to forecast expenditure to 31st March 2022. It is currently programmed, subject to the above approval, that site set up will be underway during December 2021 with work commencing in January 2022. This will indicate a completion date of circa December 2022/January 2023. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. MWWFRS are fully aware of the above timescales and have advised they are planning to visit the site at an appropriate time in 2022 to confirm any extension needed. Audit tracker will be updated following this visit. 05/01/2022- update being reported to Health & Safety Committee January 2022-The current forecast completion date for Phase 1 is February 2023, however this will need to be reviewed when site set up is completed and physical works commence on the Fire Safety programme. HDdUHB continues to keep MWWFRS fully up-to-date with any adjustments to programme on this phase of works. They are fully aware of the above timescales and have advised that they are planning a site visit at an appropriate time in 2022 to confirm any extension required. 17/01/2022- email received from MWWFRS "Thanks for the update on the phase 1 works at GGH, we understand that the BJC took considerably longer than we expected and that this has caused the completion date of this phase of the works to the start of 2023. We are happy at this time to verbally extend the EN KS 890 08 to Feb 2023, I will not be able to physically change the current Notice until it is up for review in July 2022". Completion date revised to February 2023.
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. 18/11/2021- update to Health & Safety Committee 15/11/2021-At this point, HDdUHB remains confident that the April 2024 date can be achieved, however understands that this will be reviewed once the Business Case work is completed. This has been discussed with MWWFRS who appreciate that a revision may be needed to this programme, should the nature of the works dictate that an additional period of time becomes necessary. 05/01/2022- update being reported to Health & Safety Committee January 2022- At this point, confidence remains that the April 2024 completion date is achievable, however this will be confirmed upon completion of the detailed Business Case work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme should the nature of the works dictate that an additional period becomes necessary.
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~~ Dec-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). 18/11/2021- Revised action plan dated 09/11/2021 provides revised date of mid December 2021- contractor has now been procured to undertake the work. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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~~ Dec-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. 18/11/2021- Revised action plan dated 09/11/2021 provides revised date of mid December 2021- contractor has now been procured to undertake the work. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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~~ Dec-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 26/11/2021. 18/11/2021- Revised action plan dated 09/11/2021 shows revised completion date mid December 2021. Delay due to materials –Contractors currently on site mid November 2021. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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~~ Dec-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. 18/11/2021- Revised action plan dated 09/11/2021 shows work completed, however revised date of December 2021 provided, by which point an exercise will be held to confirm evacuation process timings. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
BFS/KS/SIM/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/SIM/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. 18/11/2021- Assistant Head of Operational Facilities Management confirmed residents have been written to and contractor has been confirmed to carry out work from end of November 2021 to March 2022. 10/01/2022- Survey work to be completed by March 2022.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Article 8, Item 1.1 Fire Doors- 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.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_001	High	Item 1.2 Fire Doors- Self-closing devices on all fire resisting doors are to be checked and, if necessary, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.

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/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 001	High	Item 1.3 Fire Doors- All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 001	High	Item 1.4 Fire Doors- All Fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 001	High	Item 1.5 Fire Doors-. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 003	High	3.1. Item 3 Compartmentation. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout green block. This should include: - • All the vents above the fire doors	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee states further clarity needed from MWWFRS. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 003	High	3.3 Item 3 Compartmentation. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout green block. This should include: - • Fire stopping within the plant room level 1 and the dry risers	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee states further clarity needed from MWWFRS. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022-remains on programme for a January 2022 completion date.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 005	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure there is a suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Sep-21	~~Sep-21~~ ~~Nov-21~~ Feb-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of end August 2021. 15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore chaser to be sent, assuming if no response received plan will be agreed by February 2022.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 007	High	Item 2 Emergency Lighting - An assessment should be undertaken to ensure that escape routes within the Green block escape routes and external staircase is illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Sep-21	~~Nov21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of mid November 2021. 23/09/2021- Revised action plan states 8/12 weeks required completion date, February 2022. 15/11/2021- Revised action plan dated 09/11/2021 confirms tender process is taking place with work to be undertaken by end of March 2022. Report to Health & Safety Committee 15/11/2021 confirm this is due to linkage of work to a wider HDdUHB programme to introduce energy efficient lighting within the estate. An action plan has been submitted to MWWFRS. 05/01/2022- update being reported to Health & Safety Committee January 2022- This remains on programme to be delivered by March 2022.
Admin - General/00329501	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329501_ 0011	High	Article 17, Item 1 Maintenance - Records must be kept of events, tests, or maintenance of the following equipment / installations. Records must be made available to an inspector during an audit: •Fire alarm system (and the link to maglocks) •Dry risers •Dampers •Suppression system •Roller shutter doors •It is recommended the records are kept in a logbook	Full action plan held by Estates.	Sep-21	~~Sep-21~~ Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. 15/11/2021- Revised action plan dated 09/11/2021 confirms work has been completed and estates now liaising with MWWFRS to sign off this work as complete, at which point this recommendation will turn to green. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.

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-	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_ 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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_001	High	Item number 1 Alternative Escape Route (Distances). Provide an alternative means of escape as the overall travel distance from Lizzy's and Norma's Rooms is excessive. This new exit would need to be constructed within one of the rooms mentioned, the LABC and Planning department need to be contacted prior to any works undertaken (follow the recommendations within items 2 & 3 and this item will then no longer be required to be undertaken as we will accept item 2 and 3 as a compensatory	Full action plan held by Estates.	Mar-22	Mar-22	External	24/08/2021- Action plan submitted to Health & Safety Committee does not include a timescale against this recommendation. To be clarified with the team. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022.
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BFS/KS/SJM/00115877	Jun-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: GREVILLE COURT, ALBION SQUARE, PEMBROKE DOCK, SA72 6XF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00115877_003	High	3.4 Item number 3 Fire Resisting Doors The sonic door guards installed are not practical in this type of premises. We recommend the installation of a free swing self-closing device within this type of residential care facility as the occupants may not be able to open a door fitted with a self-closer, also the non-ambulant residents are moved around on special equipment therefore having this type of closer assists staff with the movement of the resident. You must ensure that all fire doors are closed during the period between 2300 hours and 0700 hours, or when staffing levels are reduced to a minimum. • • Kitchen door • • Lounge Door • • Office Door • • All bedroom Doors • • Utility room Door (this door does not require free swing only a standard self-closer) • • Boiler room (this door does not require Free swing only a standard self-closer)	Full action plan held by Estates.	Nov-21	~~Nov-21~~ Mar-22	External	24/08/2021- Action plan submitted to Health & Safety Committee shows timescale of November 2021. No time limit associated with letter from MWWFRS. 18/11/2021- Report to Health & Safety Committee 15/11/2021 confirms property owner, ATEB, are fully responsible for completing all of these required works and are committed to doing so by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- Remaining items are fully the responsibility of ATEB (Housing Association). MWWFRS are fully aware of the above, and formal visits are awaited from MWWFRS and formal sign off is expected early in 2022.
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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~~ Jun-22	Red	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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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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~~ Jun-22	Red	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 pkan 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-Action plan submitted to Fire Plans meeting shows works programmed to be completed end March 2022. 15/11/2021- Action plan provided shows completion date of work revised to June 2022. Report to Health & Safety Committee 15/11/2021 - Whilst the original programme for this element of work indicated completion by February 2022, it has needed to be revised due to the extent of the work (circa 97 doors to be either replaced or repaired) and the usual challenges relating to fire door delivery timescales. When the overall programme is finalised, a meeting will be convened to formally agree this with the MWWFRS. HDdUHB continues to work in close contact with the MWWFRS in order to confirm and agree any update to delivery dates as required. 05/01/2022- update being reported to Health & Safety Committee January 2022- Plans are in place to commence on site with the project in April 2022, with a forecast completion date of June 2022. Collaborative working is continuing with the MWWFRS in order to confirm and agree any update to delivery dates as required.
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Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500_ 001	High	Article 8, Item 1.1 Fire Doors - A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 07/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 07/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500_ 001	High	Article 8, Item 1.5 Fire Doors - All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500_ 003	High	Article 8, Item 3 Compartmentation - An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Blue block. For example: -	Full action plan held by Estates.	Oct-21	Mar-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of end September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Admin - General/00329500	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329500_ 008	High	Article 14, Item 1 Storage of Combustibles and Obstructions - All combustible materials and obstructions should be removed from the means of escape routes, internally and externally.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Jan-22	Red	Letter 30/06/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 30/09/2021). 24/08/2021- Action plan submitted to Health & Safety Committee provides target date of end August 2021. 15/11/2021- Revised action plan dated 09/11/2021 shows completion date of January 2022- RCD been installed as mitigation until further works completed. 10/01/2022- final checks being undertaken to close this recommendation.
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498_ 001	High	Article 8, Item 1.1 Fire Doors - A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process.
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498_ 001	High	Item 1.2 Fire Doors - 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.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green-	Progress update/Reason overdue
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498_001	High	Item 1.4 Fire Doors - All Fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498_004	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure there is a suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Oct-21	~~Sep-21~~ ~~Nov-21~~ Feb-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore chaser to be sent, assuming if no response received plan will be agreed by February 2022.
Admin - General/00329498	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329498_007	High	Item 2 Emergency Lighting - An assessment should be undertaken to ensure all external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Mar-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 23/09/2021- Action plan states target completion date 11/03/2022. 15/11/2021- Revised action plan dated 09/11/2021 confirms tender process is taking place with work to be undertaken by end of March 2022. Report to Health & Safety Committee 15/11/2021 confirm this is due to linkage of work to a wider HDdUHB programme to introduce energy efficient lighting within the estate. An action plan has been submitted to MWWFRS. 05/01/2022- update being reported to Health & Safety Committee January 2022- This remains on programme to be delivered by March 2022. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499_001	High	Article 8, Item 1.1 Fire Doors - 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.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499_001	High	Item 1.3 Fire Doors - All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-21	~~Oct-21~~ Apr-22	Red	Letter 02/07/2021 states all recommendations to be completed within 3 months of date of letter (i.e. 02/10/2021). 24/08/2021- Action plan submitted to Health & Safety Committee includes completion date of end of September 2021. 15/11/2021- Revised action plan dated 09/11/2021 provides Construction Phase 17/01/22 to 08/04/22. Report to Health & Safety Committee 15/11/2021 confirms HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement . At the conclusion of this agreement with MWWFRS, further discussion will be held with WG as to how we resource and deliver on these requirements through the Business Case process. 05/01/2022- update being reported to Health & Safety Committee January 2022- HDdUHB is currently discussing with MWWFRS the phasing of this work in order to deliver on their requirement within this LoFSM. When this agreement has been concluded with MWWFRS, further discussion will be undertaken with WG concerning resource and delivery on these requirements through the Business Case process.
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Admin - General/00329499	Jul-21	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	Admin - General/00329499_005	High	Article 11, Item 1 Fire Safety Management - An assessment should be undertaken to ensure that there is suitable and up to date Fire defence plan. The fire defence plan should be reviewed when situations or circumstances change within the building.	Full action plan held by Estates.	Oct-21	~~Sep-21~~ ~~Nov-21~~ Feb-22	Red	15/11/2021- Revised action plan dated 09/11/2021 confirms documents have been completed and issues, with ratification to take place by end of November 2021, at which time the recommendation can be closed. 10/01/2022- Fire defence plan issued to site management team requesting response by end of November 2021. No response received therefore chaser to be sent, assuming if no response received plan will be agreed by February 2022.
874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_001	High	ARTICLE 8 - Item 1.1 - 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.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_001	High	ARTICLE 8 - Item 1.4 - Fire Doors: 4. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_002	High	ARTICLE 8 - Item 2.2 - 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.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.

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-	Progress update/Reason overdue
874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_002	High	ARTICLE 8 - Item 2.3 - 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.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
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874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_007	High	ARTICLE 14 - Item 3 - Door Fastening: Ensure that the doors exiting the boiler room, storage building and the Mortuary can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency.	Full action plan held by Estates.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/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.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/00111720_009	High	ARTICLE 14 - Item 5 - Combustible Materials and Ignition sources: An assessment should be undertaken to remove all ignition sources and combustible materials from the means of escape.	Full action plan held by Estates.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
874/HLR/BFS/00111720	Oct-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: TREGARON COMMUNITY HOSPITAL, DEWI ROAD, TREGARON, SY25 6JP	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	874/HLR/BFS/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.	Jan-22	Jan-22	Amber	19/11/2021- Letter dated 12/10/2021 confirms actions to be completed in the next 3 months (12/01/2022). These actions match those from the previous Tregaron Letter of Fire Safety Matters General/00111720, dated 12/05/2021. Estates services believe vast majority of actions are already complete and are liaising with MWWFRS for them to acknowledge the work undertaken. 05/01/2022- update being reported to Health & Safety Committee January 2022- All actions have now been completed as required on the LOFSM from MWWFRS. Arrangements are being undertaken for MWWFRS to confirm sign off appropriately.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_001	High	Item number 1 Doors: Ensure that all doors on exit routes are available and can be easily and immediately opened, without the use of a key, by anyone who might need to use them in an emergency. Door from stairwell to EBME requires to have a locking device linked into the	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_002	High	Item number 2 Fire Resisting Corridors and Stairs: Ensure that all escape routes are kept free from fire and smoke at all material times by Moving the server unit from the staircase between the EBME and the access to hospital care and coordination (as mentioned in the previous FSM letter).	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_003	High	Item number 3 Compartment: Reinstate the fire resistance in the following location(s) insert details so that fire and smoke cannot pass. • Electrical room within the plant rooms for both A+E and Theatres. • All under stairs cupboards (witnessed in Post grad to wd1 stairs, this includes the transom light and door to this cupboard (ADV Works??) and the cupboard under the stairs within the EBME).	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	Item number 4 Combustibles near Heat Source: General housekeeping within the room LGF049 was to a poor standard due to combustible items stored close to a source of ignition.	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year.
BFS/KS/SJM/00114719	Dec-21	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_005	High	Item number 5 Add Device to Alarm: Provide detection complying with BS 5839 part 1 – L1 linked to the existing fire alarm system in all under stair store cupboards. The changes should be carried out and commissioned by a competent person.	Management response being prepared by the Estates & Facilities Directorate	Mar-22	Mar-22	Amber	16/12/2021- Letter dated 13/12/2021 states the MWWFRS will visit approx. 3 months from date of letter to arrange visit. The UHB should complete the actions and outcomes before that visit. 05/01/2022- update being reported to Health & Safety Committee January 2022- An action plan is currently being developed to address the small number of items identified in the LOFSM and will be discussed with the MWWFRS in the New Year.
RJD/KLI/00106219	Jan-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Prince Philip Hospital, Dafen Road, Llanelli, SA14 8QF	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	RJD/KLI/00106219_001	High	Breaches in Compartmentation During the inspection breaches in compartmentation were identified above cross corridor doors and from services riser cupboard to protected means of escape. The breaches in compartmentation would not appear to support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. Information held on the compartmentation within the premises is to be shared with the fire authority and the proposed schedule for undertaking repairs. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations.	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	Management response being prepared by the Estates & Facilities Directorate

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-	Progress update/Reason overdue
RJD/KLI/00106219	Jan-22	Mid and West Wales Fire and Rescue Service	The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Prince Philip Hospital, Dafen Road, Llanelli, SA14 8QF	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	RJD/KLI/00106219_ 002	High	Fire resisting doors The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. Main Kitchen trolley doors Street Doors to Wards three & four Door 20857 Door 20727 Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies - Code of Practice. Compliance with this or an equivalent standard will normally satisfy the	Management response being prepared by the Estates & Facilities Directorate	N/K	N/K	Amber	Management response being prepared by the Estates & Facilities Directorate
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	Dec-22	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.
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. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH.
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. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if
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. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH.
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. 09/11/2021 - no progress since previous update. The recommendations have been linked to the actions listed within corporate risk 129, and agreed with SDM to review the recommendations raised in the Peer Review report with the Deputy Director of Operations to determine if they are still valid given the new service model being developed for OOH.
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_001b	N/A	Each Local Children's Cardiology Centre will provide appropriate managerial and administrative support for the effective operation of the network.	IT system development under way.	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_002	N/A	e. address how paediatric cardiologists and paediatricians with expertise in cardiology (PECs) will work across the network, including at the Specialised Children's Surgical Centre, the Specialist Children's Cardiology Centres and Local Children's Cardiology Centres, according to local circumstances;	Review of job plans - EMBED IN PROCESS	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_003	N/A	There will be specific protocols within each Congenital Heart Network for the transfer of children and young people requiring interventional treatment.	Revise protocols and ensure right people aware	Jan-22	Jan-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_004	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_005	N/A	d. allow a timely and reliable transfer and receipt of images (including echo, CT, MRI) across the various ACHD services.	Action from Cardiff in terms of individual access. National imaging strategy may help overall problem? Service to make sure paediatrics included in upgrade discussions with adult service	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_007	N/A	Each designated paediatrician with expertise in cardiology will attend (in person or by VC link) the weekly network MDT meeting at least six times per year, and must also attend the annual network meeting. This requirement will be reflected in job plans.	Job plan review	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_008	N/A	Each Local Children's Cardiology Centre must have identified registered children's nurses with an interest and training in children's and young people's cardiology.	Ensure link nurse business case includes time needed to meet these standards. ODN can provide letter of support.	Jun-22	Jun-22	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green-	Progress update/Reason overdue
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_009	N/A	Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health professionals.	Job plan review	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_010	N/A	Local Children's Cardiology Centres must have locally designated registered children's nurses with a specialist interest in paediatric cardiology, trained and educated in the assessment, treatment and care of cardiac children and young people.	[ND to discuss with nurse leads]	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_011	N/A	Each Local Children's Cardiology Centre must have a locally designated 0.25 WTE registered children's nurse with a specialist interest to participate in cardiology clinics, provide support to inpatients and deal with requests for telephone advice.	Ensure link nurse business case includes time needed to meet these standards. ODN can provide letter of support.	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_014	N/A	There must be the facility to store and transfer digital recordings of radiological and echocardiographic images.	See comments above, Cardiff to take action to access via current systems. CDs to no longer be posted.	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_015	N/A	Governance arrangements across the Children's Congenital Heart Network must ensure that the training and skills of all echocardiographic practitioners undertaking paediatric echocardiograms are kept up to date.	Revise current governance process around this.	Nov-22	Nov-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_016	N/A	Nurses working within Local Children's Cardiology Centres must be offered allocated rotational time working in the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre, to enhance development of clinical knowledge and skills enabling professional development and career progression. A formal annual training plan should be in place.	Revise current governance process around this.	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_017	N/A	Paediatricians with expertise in cardiology (PECs) should have a named cardiologist within the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre who acts as a mentor; this mentor would normally be the link cardiologist	Names to be formalised	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_018	N/A	Each Local Children's Cardiology Centre will have a robust internal database for congenital cardiac practice with seamless links to that of the Specialist Children's Surgical Centre.	Needs to be developed/improved	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_019	N/A	A Children's Cardiac Nurse Specialist must be available at all outpatient appointments to help explain the diagnosis and management of the child/young person's condition and to provide relevant literature.	(as above - linked nurse case, just need local named nurse to progress this to Amber - this will be sufficient)	Jun-22	Jun-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_020a	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Information boards to be progressed in all sites	N/K	N/K	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_020b	N/A	Parents and carers must be given details of available local and national support groups at the earliest opportunity.	Ensure patients provided with information/contact of named CNS (in L1/2)	Mar-22	Mar-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_021	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	Nov-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_022	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.		Nov-22	Nov-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_023	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment		Nov-22	Nov-22	Amber	
Peer review - CHD Provider	Oct-21	Peer Review	Peer Review - CHD Provider 18/10/2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	Peer Review_CHD_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	Mar-22	Amber	
202002558	Sep-21	Public Service Ombudsman (Wales)	202002558	Open	N/A	Nursing	Mental Health & Learning Disabilities	Olivia Barker	Director of Operations	202002558_004	N/A	Commissions and completes its planned review of the Health Board's child psychology services and reports the findings back to the Ombudsman.	Action plans held with Ombudsman Liaison Manager	Mar-22	Mar-22	Amber	
202004188	Oct-21	Public Service Ombudsman (Wales)	202004188	Open	N/A	Unscheduled Care (GGH)	Scheduled Care/ Radiology	Olwen Morgan	Director of Operations	202004188_005	N/A	R5. I recommend that, within 6 months of the date of this report, the Health Board should: Take steps to ensure that all patients with epilepsy are provided with an accessible point of contact, in line with the Epilepsy Guideline, including when there is an unavoidable delay in offering an initial consultant appointment.	Action plans held with Ombudsman Liaison Manager.	Apr-22	Apr-22	Amber	27/10/21- Recommendation to be completed by 18/04/2022.
202004188	Oct-21	Public Service Ombudsman (Wales)	202004188	Open	N/A	Unscheduled Care (GGH)	Scheduled Care/ Radiology	Olwen Morgan	Director of Operations	202004188_006	N/A	R6. I recommend that, within 6 months of the date of this report, the Health Board should: Confirm agreed reporting timescales for radiology reports to be produced, audit a reasonable sample of ED requests for compliance with those timescales to identify the level of compliance, and take action to address any shortcomings.	Action plans held with Ombudsman Liaison Manager.	Apr-22	Apr-22	Amber	27/10/21- Recommendation to be completed by 18/04/2022.
202003339	Jan-22	Public Service Ombudsman (Wales)	202003339	Open	N/A	Nursing	Nursing	Cheryl Fannin	Director of Nursing, Quality and Patient Experience	202003339_001	N/A	Apologises to Mr and Mrs X for the identified failings.	Reflect on the findings of the investigation report and draft an appropriate apology letter.	Feb-22	Feb-22	Amber	
202003339	Jan-22	Public Service Ombudsman (Wales)	202003339	Open	N/A	Nursing	Nursing	Cheryl Fannin	Director of Nursing, Quality and Patient Experience	202003339_002	N/A	Reminds staff that the advice given for supporting carers when a sling is removed should be documented.	Action plans held with Ombudsman Liaison Manager	Apr-22	Apr-22	Amber	
202003339	Jan-22	Public Service Ombudsman (Wales)	202003339	Open	N/A	Nursing	Nursing	Cheryl Fannin	Director of Nursing, Quality and Patient Experience	202003339_003	N/A	Ensures that manual handling plans are in place to include contingency plans for non-availability of slings or failure with the hoist.	Action plans held with Ombudsman Liaison Manager	Apr-22	Apr-22	Amber	
202003339	Jan-22	Public Service Ombudsman (Wales)	202003339	Open	N/A	Nursing	Nursing	Cheryl Fannin	Director of Nursing, Quality and Patient Experience	202003339_004	N/A	Offers manual handling training for Mr and Mrs X	Action plans held with Ombudsman Liaison Manager	Apr-22	Apr-22	Amber	
National Diabetes Quality Programme (NDQP)-Peer Review Report	Apr-20	Royal College of Paediatrics & Child Health (RCPCH)	National Diabetes Quality Programme (NDQP)- Peer Review	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	National Diabetes Quality Programme (NDQP)-Peer Review Report_011a	N/A	There has been progress in the establishment of transition services, however the formalised implementation of planned pathways must be expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition programme suspended due to COVID 19. HB to support all Clinicians across all areas to participate in the Transition programme when re-started.	N/K	01/12/2021 30-June-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. 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 expedited to ensure all young people transfer to adult services appropriately and with the necessary skills and knowledge to promote future positive health outcomes.	Transition is more successful by an employed youth worker. Paper to be developed to evidence best practice.	Aug-21	Aug-21 Mar-22	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.

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)	Matthew Willis	Director of Operations	RCP2019_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 03/11/2021- email sent to County Director, Ceredigion, for agreement that outstanding recommendations from this report be noted as 'Strategic' on the audit tracker. Awaiting response. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 03/11/2021- email sent to County Director, Ceredigion, for agreement that outstanding recommendations from this report be noted as 'Strategic' on the audit tracker. Awaiting response. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 03/11/2021- email sent to County Director, Ceredigion, for agreement that outstanding recommendations from this report be noted as 'Strategic' on the audit tracker. Awaiting response. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 03/11/2021- email sent to County Director, Ceredigion, for agreement that outstanding recommendations from this report be noted as 'Strategic' on the audit tracker. Awaiting response. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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~~ N/K	Red	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
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)	Matthew Willis	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~~ N/K	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. 04/10/2021- Assurance and risk officer to discuss recommendation with Director of Operations on 29/10/2021. 03/11/2021- email sent to County Director, Ceredigion, for agreement that outstanding recommendations from this report be noted as 'Strategic' on the audit tracker. Awaiting response. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.

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)	Matthew Willis	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. 10/08/2021- Following Exec Team a review will be undertaken of Strategic Log items with the relevant Exec Lead. 20/12/2021- Assurance and risk officer contacted new BGH GM to schedule discussion on outstanding recommendations, awaiting response.
Primary care training and the Welsh language	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language	Open (External rec)	N/A	Workforce & OD	Workforce & OD	Annmarie Thomas	Director of Workforce & OD	PCTWL_002	WG taking forward.	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at a All Wales Level.	Mar-20	~~Mar-20~~ N/K	External	Language skills data from Primary Care contractors is not collected. Staff in the four Managed Practices however have to log their Language skills on ESR. Over summer 2019, the Primary Care team administered a questionnaire, on behalf of Welsh Government, with all four Primary Care contractor areas to assess compliance with the six Welsh Language Duties for Primary Care contractors. In response to the Duty to encourage the wearing of a badge, provided by the Local Health Board, by Welsh speakers, to convey that they are able to speak Welsh, 63% of Primary Care contractors who responded to the questionnaire reported that they were meeting this (although this isn't an audit of language skills). 18/09/20: This recommendation is being taken forward at a national level, led by Welsh Government, to enable the collection of Welsh language skills of GPs and Practice staff through the National Workforce Reporting System, as part of the data collection. The intention is that the system will be able to log Welsh language skills next year. Recommendation outside the gift of the Health Board to implement, no change to comments in Jan 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~~ N/K	Red	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. 02/11/2021- review has been undertaken, however no response received from Ops or nursing services due to operational pressures, only partial information collected. No response or further extension provided by WL Commissioner.
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~~ N/K	Red	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. 02/11/2021- review has been undertaken, however no response received from Ops or nursing services due to operational pressures, only partial information collected. No response or further extension provided by WL Commissioner.
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~~ N/K	Red	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. 02/11/2021- review has been undertaken, however no response received from Ops or nursing services due to operational pressures, only partial information collected. No response or further extension provided by WL Commissioner.

Reports Closed on the Audit Tracker since ARAC December 2021

Report name	Lead Executive/Director
Audit Wales Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements *no recommendations listed therefore report added to the audit tracker and closed.*	Board Secretary/ Director of Finance
Delivery Unit: All Wales Assurance Review of Primary Care Child and Adolescent Mental Health Services - The Review of Under 18s March 2019 LPMHSS	Director of Operations
Health and Safety Executive: Improvement notice - Incidents 02-11/07/19 IN6	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Improvement notice - Theatres, Bronglais Hospital 02-11/07/19 IN7	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Improvement notice - Manual Handling 02-11/07/19 IN2	Director of Nursing, Quality and Patient Experience
Health and Safety Executive: Improvement notice - Locations where Health Board employees and Agency workers work (Needlestick injuries) IN8	Director of Nursing, Quality and Patient Experience
Health Inspectorate Wales: Glangwili Hospital (Maternity), 7-9 October 2019	Director of Operations
Health Inspectorate Wales: How are healthcare services meeting the needs of young people? Thematic Review 2019	Director of Operations
Internal Audit: Human Tissue Act Compliance	Medical Director
Internal Audit: IT Backup & Recovery Arrangements	Director of Finance
Internal Audit: Single Tender Actions	Director of Finance
Internal Audit: Waiting Lists Risk Management Final Internal Audit Report	Director of Operations
Internal Audit: Withybush General Hospital Wards 9 & 10 Lessons Learnt	Director of Operations
Internal Audit: Women & Children Health Directorate Governance Review Final Internal Audit Report	Director of Operations
MWWFRS: Letter of Fire Safety Matters. Glangwili General Hospital, Dolgwili Road, Carmarthen, SA31 2AF BFS/KS/SJM/00107739	Director of Operations

Public Service Ombudsman (Wales): 202003187	Director of Operations
Human Tissue Authority: Glangwili General Hospital - 12136 - Routine 27/07/2021	Director of Operations

Reports Opened on the Audit Tracker since ARAC December 2021

Report name	**Lead Executive/Director**	**Final report received at**
Audit Wales Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements	Board Secretary/ Director of Finance	To be received at Audit and Risk Assurance Committee, February 2022
Health Inspectorate Wales: Onsite Inspection of Ward 7, Prince Philip Hospital	Director of Nursing, Quality and Patient Experience	Quality, Safety and Experience Committee, February 2022
Health Inspectorate Wales: Ty Bryn Quality Check, November 2021	Director of Operations	Quality, Safety and Experience Committee, February 2022
Human Tissue Authority: Glangwili General Hospital - 12136 – Follow up 19/10/21 (On –site inspection)	Director of Operations	To be received at Audit and Risk Assurance Committee, February 2022
Internal Audit: IT Backup & Recovery Arrangements	Director of Finance	Audit and Risk Assurance Committee, December 2021
Internal Audit: Financial Planning, Monitoring and Reporting	Director of Finance	Audit and Risk Assurance Committee, December 2021
Internal Audit: Therapies Directorate Review	Executive Director of Therapies and Health Sciences	Audit and Risk Assurance Committee, December 2021
Internal Audit: Deployment of WPAS into MH&LD	Director of Finance	Audit and Risk Assurance Committee, December 2021
Internal Audit: Discharge Processes	Director of Primary Care, Community & Long-Term Care	Audit and Risk Assurance Committee, October 2021
Internal Audit: Glangwili Hospital Women & Children's Development *(re-opened)*	Director of Operations	Audit and Risk Assurance Committee, May 2021
MWWFRS: The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: WITHYBUSH HOSPITAL,	Director of Operations	Health & Safety Committee, January 2022

WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ		
MWWFRS: The Regulatory Reform (Fire Safety) Order 2005 Letter of Fire Safety Matters Premises: Prince Philip Hospital, Dafen Road, Llanelli, SA14 8QF	Director of Operations	To be received at Health & Safety Committee, March 2022
Peer Review – Congenital Heart Disease (CHD) Provider 18/10/2021	Director of Operations	W&C Quality, Safety and Experience Committee, November 2021
Public Service Ombudsman (Wales): 202002558 (Section 23 (public interest))	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee
Public Service Ombudsman (Wales): 202003339	Director of Nursing, Quality and Patient Experience	Improving Experience Sub-Committee