Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 August 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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.

Asesiad / Assessment

The attached report and supporting appendices will aim to provide assurance on the progress in respect of the implementation of recommendations from audits and inspections, since the previous report presented to ARAC in June 2024. Due to the introduction of the new internal escalation framework, going forward, this report will provide ARAC with a high-level summary of report activity from audits, inspectorates and regulators, and report on each Directorate's escalation status, as opposed to the previous process of highlighting "services of concern".

In response to these new arrangements, it is proposed that the Audit Tracker paper is presented to the Committee at every other meeting going forward, to provide assurance on the effectiveness of the new arrangements in respect of driving improvements in the Health Board's progress in implementing recommendations from auditors, inspectorates and regulators, with the Risk Assurance paper to be presented to the Committee at meetings where the Audit Tracker is not an agenda item.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements; and
- **TO AGREE** on the proposal to amend the frequency of reporting of the Audit Tracker to every other meeting as a result of the implementation of the revised performance management arrangements.

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.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	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 DU – Delivery Unit GGH – Glangwili General Hospital GIRFT – Getting It Right First Time 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 IRMER – Ionising Radiation (Medical Exposure) Regulations MH&LD – Mental Health & Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience PHW – Public Health Wales PPE – Post Project Evaluation PPH – Prince Philip Hospital PODCC – People, Organisational Development & Culture Committee PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SDM – Service Delivery Manager UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance/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

Introduction

This report provides the Audit and Risk Assurance Committee (ARAC) with the current progress being made to implement recommendations as raised in various audits and inspections across the Health Board.

All reports from audits, reviews and inspections carried out across the Health Board are logged and tracked on AMaT, with progress updated by relevant service leads regarding the implementation against each recommendation. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates. The criteria for this system is as below:

Status	**Explanation**
Green	Recommendation has been confirmed as completed by the service / directorate lead (*AMAT Status: Fully Complete*)
Amber	Recommendation is currently in progress, and within the agreed **original** timeframe for implementation (*AMAT Status: In Progress*)
Red	Recommendation is in progress, but has exceeded its agreed **original** timeframe for implementation (i.e. overdue) (*AMAT Status: Overdue*)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation (*AMAT Status: Unable to Complete*)

Internal Escalation Framework

Revised performance management arrangements have been implemented since the previous report presented to ARAC in order to help address the challenges which the Health Board is currently facing and its increased escalation status to Targeted Intervention status with Welsh Government (WG).

The existing Directorate Improving Together (DIT) sessions have been strengthened to support an internal escalation framework for Directorates, who are assessed against the following six domains in order to drive improvement in performance:

- Quality;
- Governance;
- Workforce;
- Finance, Strategy and Planning;
- Fragile Services; and
- Performance and Outcomes.

One of the metrics under the Governance domain is Directorates' progress and implementation of recommendations as raised by regulators and inspectorates. Directorates performance is analysed on a monthly basis, and one of the following ratings applied:

Level	Definition
3	No assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
2	Limited assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
1	Reasonable assurance that there are no significant concerns within the Directorate

This in turn informs the wider escalation framework, where Directorates are assessed via the 3As assessment approach, and are awarded an Alert, Advise or Assure status.

3A Status	Definition
Alert	There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
Advise	There are areas of concern where assurance has been taken on actions in place but requires closed monitoring. An early warning of an emerging and potentially serious concern.
Assure	There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Escalation meetings are held for Directorates where an Alert status has been awarded for three or more domains, and are chaired by the Director of Finance and reported to the Targeted Intervention Working group. For those Directorates which are awarded a level 3 for governance, but are not awarded an overall Alert status, meetings are set up between the Director of Corporate Governance and relevant service leads to discuss concerns, and determine next steps for de-escalation.

The Assurance and Risk Team, via a business partnering approach, continue to support Directorates in monitoring and providing reports of their progress against recommendations and attendance at local governance meetings, and the delivery of relevant training sessions and holding one-to-one meetings where necessary.

Now that there are strengthened performance management arrangements in place in which Directorates' progress on the implementation of recommendations is analysed and assessed, going forward, this report will provide ARAC with provide with a high-level summary of report activity from auditors, inspectorates and regulators, and report on each Directorate's escalation status, as opposed to the previous process of highlighting "services of concern". Data is assessed as at the most recent month-end position to align with the escalation framework. Directorate performances can be found later in this report.

Audit Management and Tracking System (AMaT)

Work has continued since the previous meeting to transfer recommendations to the AMaT system for progress updates and ongoing monitoring. The Assurance and Risk Team are working closely with colleagues in the Quality, Assurance and Safety Team (QAST), Clinical Audit Team, and the Effective Clinical Practice Team to improve system capabilities and supporting processes where possible. The transfer of all operational services' reports to AMaT is now complete. All reports for corporate functions have been transferred, with the exception of reports monitored via Sustainable Resources In-Committee in relation to cyber security, due to the sensitive nature of their recommendations. Progress updates for these recommendations are obtained directly from the relevant leads by the Assurance and Risk Team, and monitored from a secured drive. Services are now able to update progress against all their recommendations via one system to alleviate operational pressures, ensure consistency in approach with regards to processes and reporting, and support services with their governance.

For the purposes of this report, all data used is taken from the Audit & Inspection tracker, with service updates and timescales reconciled with AMaT.

Summary of activity since previous report (June 2024)

Since the previous report to ARAC, 8 reports have been closed or superseded, and 23 new reports have been received by the Health Board, as detailed in Appendix 3. The table below highlights the movement on the open reports and recommendations since the previous report to ARAC in June 2024.

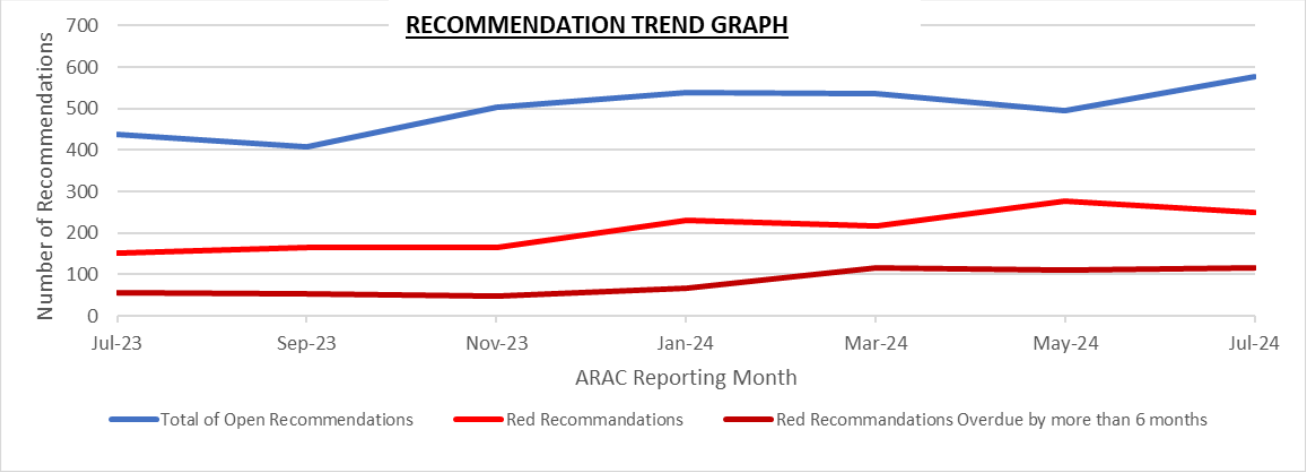
	June 2024	August 2024	Trend
Number of open reports	143	158	↑
Number of overdue reports	60	62	↑
Number of recommendations *	496	577	↑
Number of overdue recommendations *	277	250	↓
Number of recommendations overdue by more than 6 months *	110	116	↑
Number of recommendations classified as 'External' *	51	51	→
Number of recommendations without revised timescales (N/K)**	150	108	↓

**details on these recommendations can be found in Appendix 2. Appendix 2 does not include recommendations from HIW and Llais reports relating to inspections of independent contractors (i.e. GP and dental practices not managed by the Health Board). The practices remain directly accountable for implementing these recommendations.*

*** Appendix 4 details the date at which recommendations became N/K, and the reasons why they are N/K.*

Details on these movements, along with an analysis of each service / directorate's performance, can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

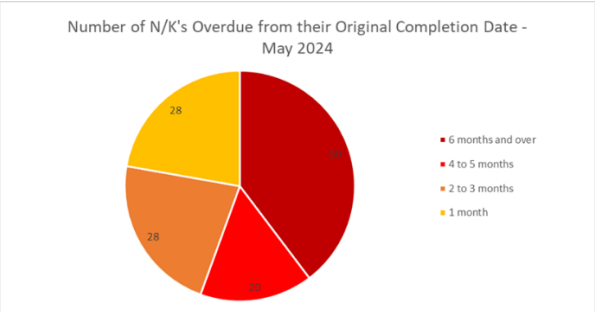
The graph below illustrates the trend in the number of overdue (red) recommendations, as well as the number of recommendations that are overdue by more than 6 months, in relation to the total number of open recommendations over the previous 12 months.

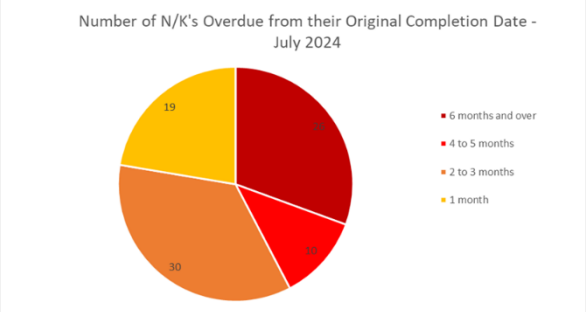


The 108 N/K recommendations are comprised of:

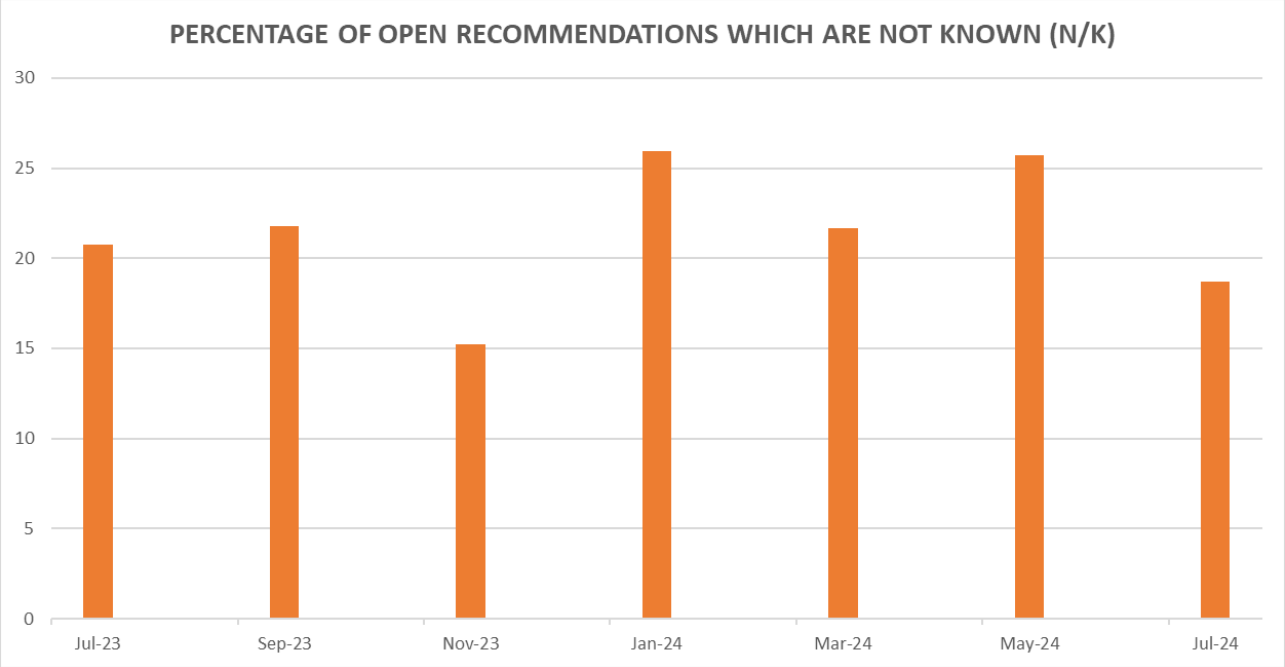
- 74 recommendations which have lapsed to N/K status **since the previous report** ;
- 52 recommendations where revised completion dates have lapsed to N/K status **prior to the previous meeting**, and awaiting revised completion dates from the services; and
- 23 recommendations noted as 'external'.

A breakdown is provided below of the N/K recommendations, which are not considered 'external', split by how long overdue they are from their original completion date.



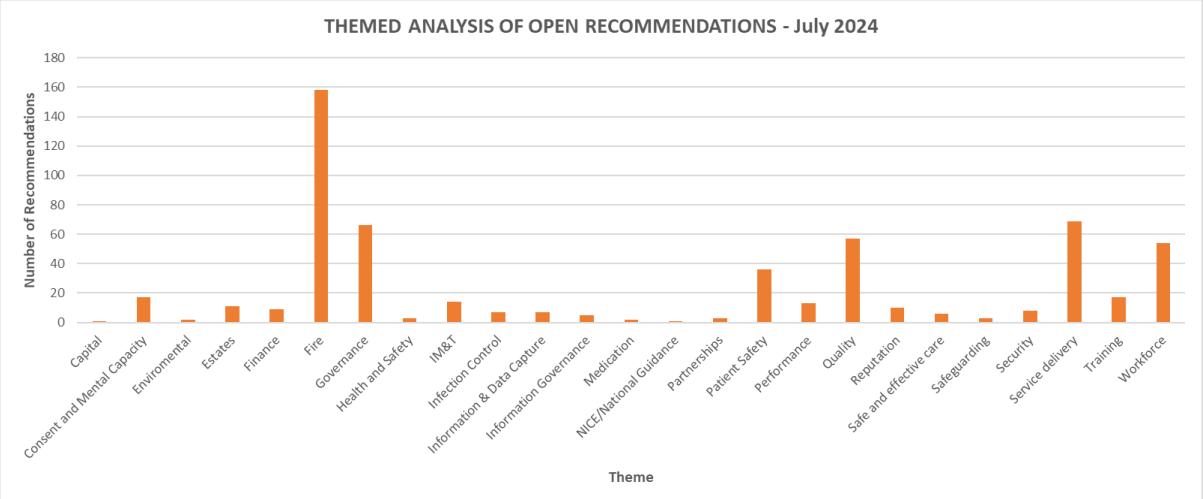


Below is a chart detailing the percentage of open recommendations that do not have revised timescales (N/Ks) from for the previous 12 months.



One factor that may be contributing to the N/Ks is the lack of a revised date field on the AMaT system, however Directorates have been asked to enter a revised date for completion in the progress field. A request has been submitted regarding this revision, and is currently being worked on by the system's development team, who prioritise requests received and action on a quarterly basis (noting that AMaT is a national system). The Assurance and Risk team continue to liaise directly with services, and review the status of reports monitored to obtain progress updates and revised completion dates where applicable. The QAST and Assurance and Risk Team are currently offering AMaT system training to service leads.

The chart below provides a thematic analysis for all open recommendations as at 3 July 2024, noting that the majority of recommendations relate to the themes of fire (27% (*May 24: 22%*)), service delivery (12% (*May 24: 14%*)), governance (11% *(May 24: 11%*)), quality (10% (*May 24: 13%*)) and workforce (9% (*May 24: 9%*)).



Summary of open reports per Inspectorate / Regulator

Detail per regulator is provided in the table below. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

Inspectorate / Regulator	Open reports at ARAC June 24	New reports since June 24	Closed reports since June 24	Open reports at ARAC August 24	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	8	1	0	9	6	11	8
Care Inspectorate Wales	0	2	0	2	0	4	3
HEIW	2	1	0	3	1	6	2
HIW	15	2	1	16	10	51	38
Human Tissue Authority	0	1	0	1	0	0	0
Independent Review	0	0	0	0	0	0	0
IA	30	5	4	31	10	22	7
Llais[3]	4	0	0	4	3	6	6
MWWFRS	53	8	0	61	14	32	0
NHS Wales Cyber Resilience Unit[4]	1	1	1	1	0	0	0
NHS Wales Executive[5]	8	0	0	8	3	11	6
Peer Reviews	10	0	0	10	9	93	41
PSOW - S21	6	1	2	5	2	5	0
PHW	1	0	0	1	1	0	0
Royal Colleges	1	0	0	1	1	2	2
Welsh Risk Pool	2	0	0	2	1	4	3
WLC	1	0	0	1	1	0	0
Welsh Government	1	1	0	2	0	3	0
TOTAL	**143**	**23**	**8**	**158**	**62**	**250**	**116**

1 Reports which have passed their original implementation date.
2 Original implementation date noted for the recommendation has passed, or will not be met.
3 From 1 April 2023 Llais replaced the seven Community Health Councils (CHCs).
4 These recommendations are not included on Appendix 2 due to the sensitive nature of the information.
5 Formerly Delivery Unit.

Audit Tracker Summary Per Service / Directorate

A snapshot of activity split and escalation status by service/directorate as at 3 July 2024 is included from page 8 onwards. The level awarded to each Directorate in relation to the most recent escalation framework data is now included within the detail on the following tables.

The graphs included in the tables overleaf highlight the performance as reported to ARAC over the last 12 months in line with the previous “service of concern” process for context. Going forward, this data will be replaced by trend analysis based on the outcomes of the recently implemented escalation framework process.

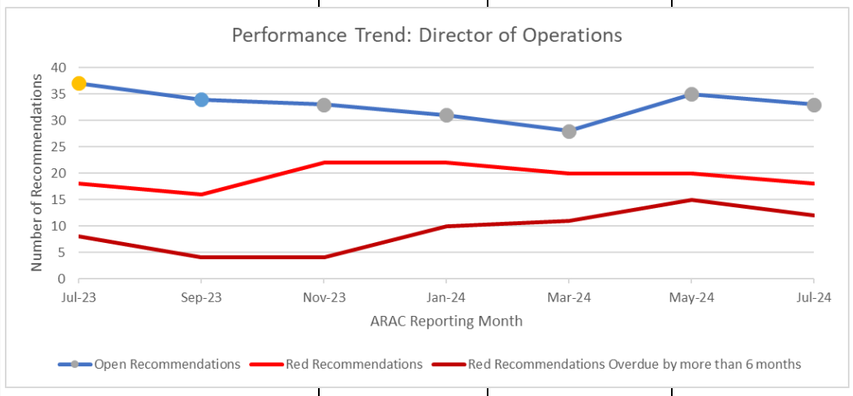
	Service of Concern	Where services have been identified as an area of concern for two consecutive reports
	Concerning trend	Special cause concerning variation = a decline in performance that is unlikely to have happened by chance.
	Usual trend	Common cause variation = a change in performance that is within our usual limits.
	Improving trend	Special cause improving variation = an improvement in performance that is unlikely to have happened by chance.

The following Services/Directorates do not currently have any open reports on the audit tracker:

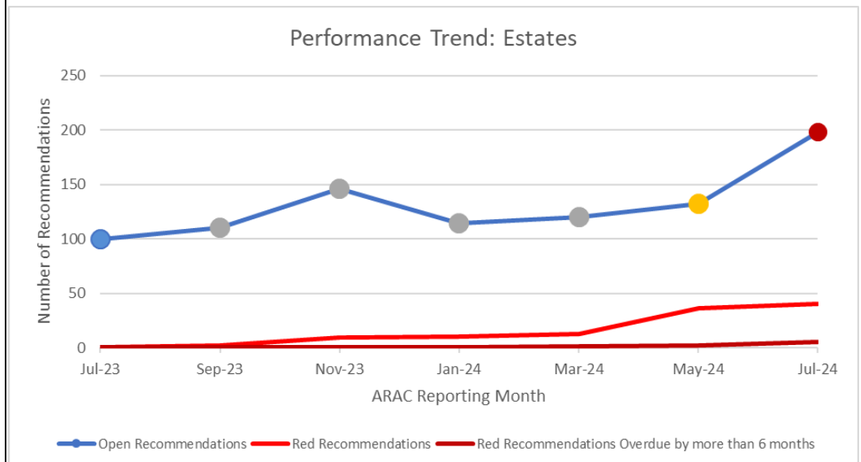
- Cardiology;
- Carmarthenshire;
- CEO Office (Welsh Language);
- Performance;
- Pembrokeshire; and
- Therapies

Level 3 - Services with No Assurance at July 2024

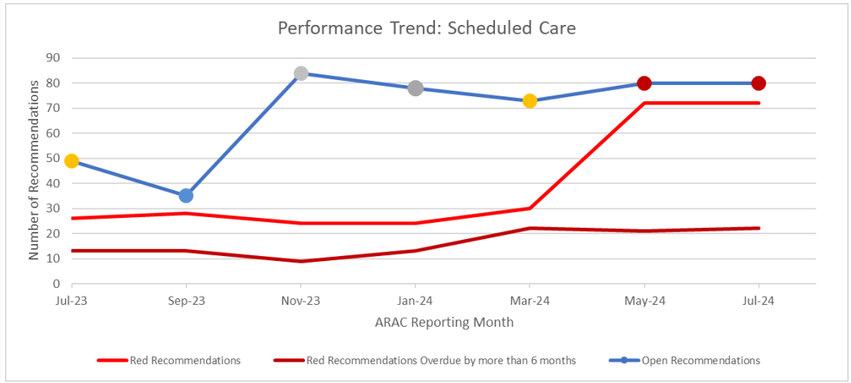
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Director of Operations ***(including Central Operations, Acute Service, and USC: Health Board wide)***	Reports: 7 → Recs: 33 ↑	Reports: 7 ↓ Recs: 18 ↑	Reports: 5 ↓ Recs: 12 ↓	Acute Services Since the previous report to ARAC in June 2024, two IA reports have been transferred to Director of Operations given the system-wide nature of the report – these relate to Transforming Urgent and Emergency Care (TUEC), and TUEC – Discharge Management. The HIW National Review on Welsh Ambulance Service Trust (WAST) remains open with 6 recommendations of 'external' status as they are for WAST consideration. Progress updates have been received from the service for those recommendations which were in the gift of the Health Board to implement and confirmed as completed. These are currently awaiting final confirmation from the Interim Director of Nursing, Quality and Patient Care to close the report. Central Operations Since the last report to ARAC in June 2024, the service has shown a slight improvement, with IA confirming the closure of the "Records Management 2019" report and the number of overdue recommendations decreasing from 12 to 10. Outstanding recommendations on the "Out of Hours Peer Review" remain dependent on the outcomes of the restructure of Acute Services. Changes to the WAST front end Clinical Assessment programme have also impacted on the ability to progress other recommendations included in this report to closure. The report has 10 overdue recommendations, 9 of which are overdue by more than 6 months, and 1 which is noted as having an 'external' status as it is currently outside the gift of the Health Board to progress. Director of Operations The AW "Review of Quality Governance Arrangements" report has 1 'external' recommendation and 1 recommendation overdue by more than 6 months with a revised timescale of September 2024 relating to the consistency of approach to risk management by operational services. The WRP "National Review of Consent to Examination & Treatment Standards in NHS Wales" report has 1 'external' recommendation and 2 overdue recommendations with revised timescales of July and August 2024. 1 of which has become overdue by more than 6 months since the previous report to ARAC in February 2024. The Head of Assurance and Risk attends the monthly Acute Leadership Group meeting to present risks aligned to the service. Whilst there are currently no formal governance meetings in place for Central Operations, the Head of Assurance and Risk is liaising with the Business and Governance Manager within the Directorate to determine what meetings could be instigated so that the Assurance and Risk Team are able to attend and present the position of their risks. An escalation meeting is scheduled on 19 August with Director of Operations to discuss current status.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.
Facilities ***(previously reported as Estates)***	Reports: 71 ↑	Reports: 16 ↑	Reports: 3 ↑	Since the previous report presented to ARAC in June 2024, when Estates were reported as a service with a concerning trend, a deteriorating position is noted, with a rising number of overdue reports and recommendations, including the number of reports and recommendations overdue by more than 6 months.	Ensure that at least 90% of audit/inspection recommendations are

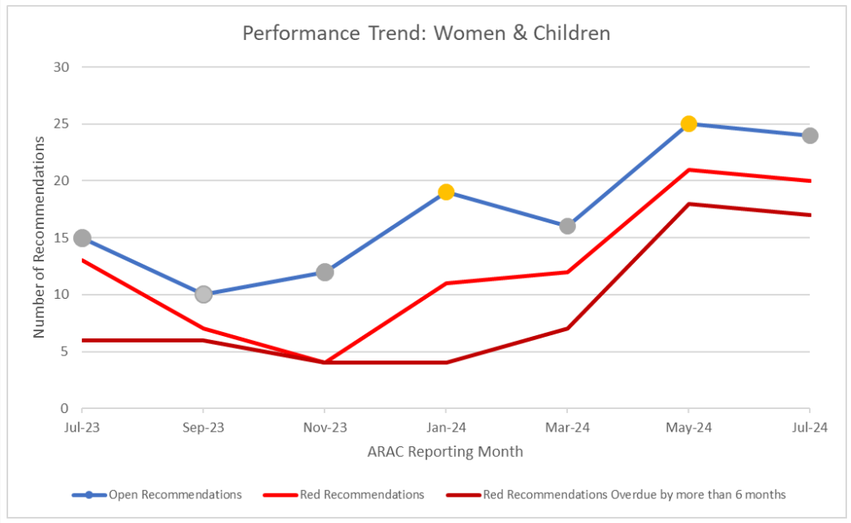


Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
	Recs: 198 ↑	Recs: 40 ↑	Recs: 5 ↑	The number of open reports has increased to 71 (June 2024: 58) due to the receipt of 8 new Letters of Fire Safety Matters (LOFSMs), 1 new IA report, 'Reinforced Autoclaved Aerated Concrete Programme – Withybush', 2 CIW reports, 'Withybush Hospital Creche Report October 2023' and 'Withybush Hospital Creche Follow-Up Report March 2024' and the transfer of 2 HIW reports from the MHLD service (as all outstanding recommendations rely on action from the Estates directorate in order to complete). Of the 40 overdue recommendations (June 2024: 36) 17 are without revised completion dates. It is also noted that the number of overdue recommendations has steadily increased since October 2023. There is also an increased number of reports overdue by more than 6 months (June 2024:0) due to the following 3 reports: 1 Letter of Fire Safety Matters, 'Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital' and the transferred 2 HIW reports from MHLD (HIW St Caradog Ward, Withybush Hospital and HIW Bryngofal Inspection July 2022). The increased number of recommendations overdue by more than 6 months (June 2024:2) is due to the receipt of the CIW report, 'Withybush Hospital Creche October 2023' with 3 recommendations having passed their original completion date of October 2023, all without revised completion dates and noted as, 'Not Started' on AMaT. In addition to the reports assigned to Estates, they are noted as being a supporting service for 2 additional overdue reports aligned to other services: • Nursing, Quality & Patient Experience (1 report): Llais report on "Accident & Emergency Departments in the Hywel Dda Health Board area" which is reliant on completion of works by an external body (Gwili Railway Company) and this is being supported by Estates. • Unscheduled Care, GGH (1 report): HIW report, "Emergency Unit, Glangwili General Hospital" relating to facilities within the unit. The service is reliant on Estates and Facilities to complete the refurbishment to fully implement this recommendation. An update in June 2024 advised that the lockers had been ordered by ED and works would continue by Estates upon delivery*. 25 of the 71 open reports are now complete and awaiting formal approval for closure either from IA or MWWFRS. Progress against MWWFRS reports is overseen by the Health and Safety Committee (HSC) via the Fire Safety Update Report which is provided to every meeting. Whilst there are monthly meetings in place within the Directorate to review recommendations, there are currently no formal governance arrangements in place. **Since the creation of this report, the outstanding recommendation for the HIW report, 'Emergency Unit, Glangwili General Hospital' has now been completed.*	implemented within agreed timescales.



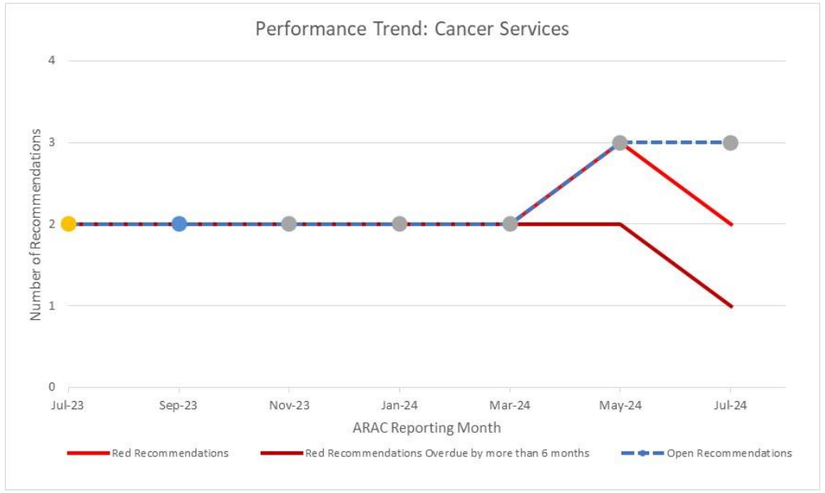
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Planned Care *(including Audiology & Endoscopy)*	Reports: 10 → Recs: 80 →	Reports: 8 ↑ Recs: 72 →	Reports: 6 → Recs: 22 ↑	Since the previous report, the number of overdue recommendations has remained at 72, with the number of recommendations overdue by 6 months or more increasing from 21 to 22. 46 of the 59 recommendations on the Getting It Right First Time (GIRFT) report on Ophthalmology have now lapsed, 19 of which do not have revised timescales. A further 12 recommendations are due to lapse at the end of July. The original timescale agreed for this report was April 2024. There are a range of reasons behind the inability to fully implement these recommendations, including; workforce pressures such as sickness (including key staff) and difficulty recruiting into specialities, unrealistic timescales set when providing initial management responses to reports, a lack of funding, demand and capacity issues, challenges associated with developing new pathways, delays in the rollout of national electronic platforms, and a lack of interest from external providers in the community. A meeting is scheduled for 2 August 2024 to review all GIRFT recommendations and timescales with the General Manager, Service Delivery Managers, the Head of Assurance and Risk, and Assurance and Risk Officer. Whilst there is good engagement with service leads, and bi-monthly meetings in place within the Directorate which the Assurance and Risk Team attend to present the position of the audit and inspection tracker, recommendations remain overdue. Quarterly face to face meetings are being scheduled between the Directorate and the Assurance and Risk team to review recommendations (along with risks and Welsh Health Circulars), the first of which took place in July 2024.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.
Women and Children	Reports: 4 ↓ Recs: 24 ↓	Reports: 3 → Recs: 20 ↓	Reports: 3 → Recs: 17 ↓	Since the previous report to ARAC in June 2024, the service has shown a slight improvement by closing 1 report (IA on “Glangwili Hospital – Women & Children’s Development 2023”), reducing the number of open recommendations from 25 to 24, and the number of overdue recommendations from 21 to 20. The number of recommendations overdue by more than 6 months has decreased from 18 to 17. The number of overdue recommendations remains high, driven primarily by the “GIRFT report on Gynaecology” and has 13 outstanding recommendations, 12 of which are counted as overdue by more than 6 months due to the absence of initial management responses and completion dates upon receipt. 1 recommendation is noted as having an ‘external’ status due to being outside the gift of the Health Board to complete at this time. Timescales between December 2024 and June 2026 have been retrospectively provided for 10 of these recommendations, with the remaining 2 still awaiting timescales (N/K). No further updates have been received on AMaT for the 4 overdue recommendations on the HIW report on "Bronglais Hospital Maternity Unit”. 1 of these recommendations is due to be completed in January 2025, but the remaining 3 do not have revised timescales (N/K) and 1 recommendation has yet to be updated since being added to AMaT in November 2023. Of the 7 outstanding recommendations on the Peer Review follow-up report on “Congenital Heart Defect Provider”, 4 are overdue by more than 6 months, and 1 noted as ‘external’. The remaining 2 recommendations are due to lapse at the end of the July. All recommendations raised in the Llais “West Wales Maternity Services” report are fully complete and approved on AMaT, with the report awaiting formal approval for closure. Whilst there is good engagement with service leads, and monthly meetings in place within the Directorate which the Assurance and Risk Team attend to present the position of the audit and inspection tracker, recommendations remain overdue.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.

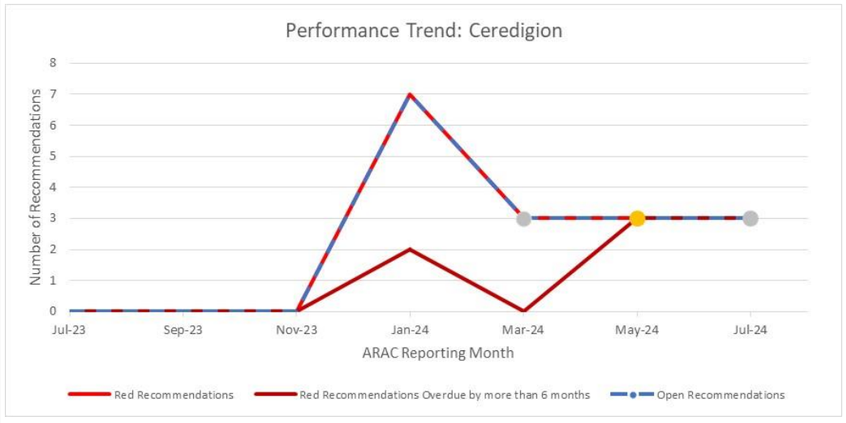




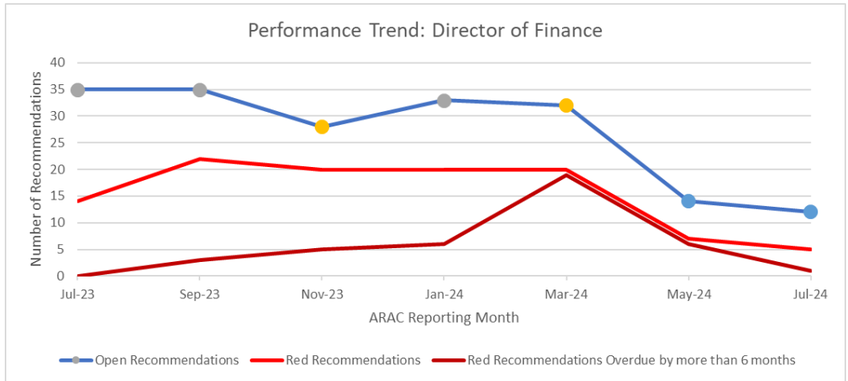
Level 2 - Services with Limited Assurance at July 2024

Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Cancer Services	Reports: 2 → Recs: 3 →	Reports: 2 → Recs: 2 ↓	Reports: 1 → Recs:1 ↓	Since the previous report to ARAC in June 2024, a slightly improved position is reported for Cancer Services, as the number of overdue recommendations has decreased from 3 to 2 and the number of recommendations overdue by more than 6 months from 2 to 1. Despite recent key staff absences and capacity challenges that have delayed the rollout of new pathways for Cancer patients, engagement with the service has been good from a governance perspective, with a full update of recommendations and revised timescales provided by the Cancer Services Delivery Manager. Since the data was extracted for this report, both overdue recommendations have been updated, with one recommendation on the "Colorectal Cancer (Third Cycle) peer review" relating to cover for the single-handed Oncologist in Bronglais Hospital has been noted as complete. The remaining overdue recommendation around the regional approach for Pathology has been assigned an 'external' status as it is currently outside the gift of the Health Board to complete as an update is required from the ARCH regional initiative with Swansea Bay UHB in order to progress. All recommendations on the IA report on "Elective Waiting List Management: Single Cancer Pathway" have now been completed, with evidence uploaded and approved by Internal Audit on AMaT for all but one remaining action related to updating the Terms of Reference for the Cancer Improvement Board. Whilst there a bi-monthly meetings in place within the Directorate, whereby the Assurance and Risk Officer is invited to attend in order to present service leads with an updated position on their risk register, all meetings scheduled for 2024 to date have been stood down as a result of staffing pressures.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.
Ceredigion	Reports: 1 → Recs: 3 →	Reports: 1 → Recs: 3 →	Reports: 1 ↑ Recs: 3 →	No further progress has been obtained on the CHC report on "Palliative and End of Life Care" since the previous report to ARAC in June 2024. 3 recommendations remain outstanding, all of which are now overdue by more than 6 months without revised timescales for completion noted on AMaT and the report is now noted as being overdue by more than 6 months. It is noted that responsibility for the progression of recommendations in this report are system-wide, and discussions are ongoing to determine the appropriate reporting structure to monitor the progress of this report. Monthly governance meetings are in place for the county, with attendance from the Assurance and Risk Team, with "Assurance" now added, alongside "risk", as a standing agenda item at these meetings to increase engagement around the governance of this report, with a monthly report to be delivered by the Assurance and Risk officer.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.

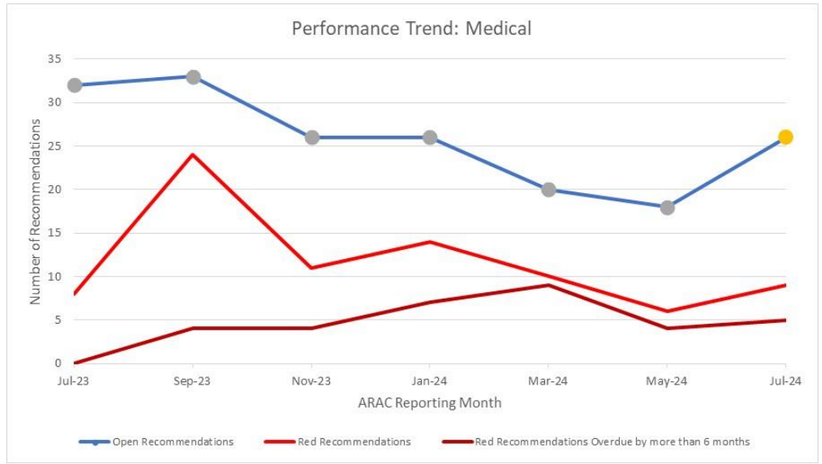


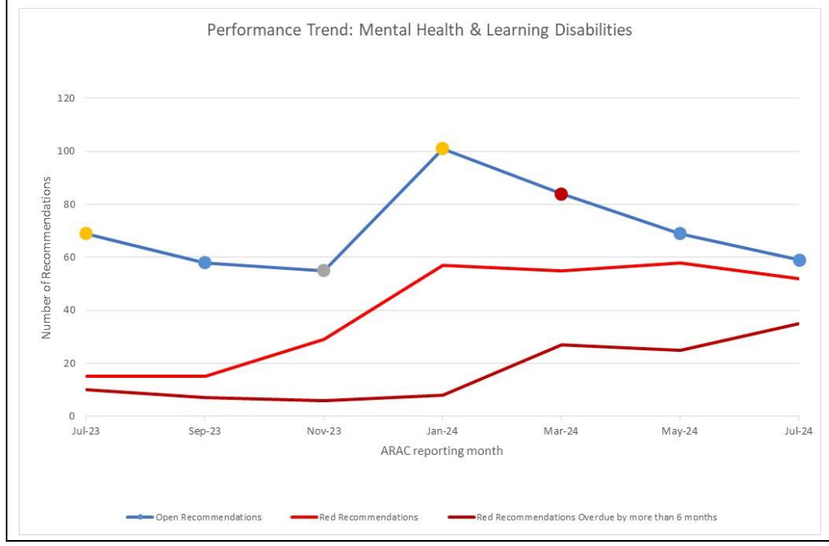


Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Director of Finance *(including Finance, Digital & Performance)*	Reports: 5 ⬇ Recs: 12 ⬇	Reports: 2 ⬇ Recs: 5 ⬇	Reports: 0 ⬇ Recs: 1 ⬇	<u>Digital</u> Since the previous report in June 2024, an improving trend is noted for Digital. Engagement with the service has been good, with a review of all reports recently undertaken with service leads and 2 reports closed by Internal Audit: "Cyber Security" and "Fitness for Digital". A new Cyber Resilience Unit report carried out in March 2024 has now superseded the 2022 report on the tracker. The report, due to be presented at Information Governance Sub Committee in July, has 6 outstanding recommendations and a proposed completion date of June 2026. The number of overdue recommendations for Digital has decreased from 6 to 5, with revised timescales ranging between December 2024 and March 2025, and the number of recommendations overdue by more than 6 months has decreased from 5 to 1. It is noted however that 2 IA reports have lapsed since the previous ARAC meeting in June, hence the increase in overdue reports from 1 to 2. <u>Finance</u> Since the previous report presented to ARAC in June 2024, an improving trend is noted for Finance. Engagement with the service has been good, with updates received on all reports, including those for which Finance is noted as a 'supporting service'. The Assurance and Risk team continue to provide ongoing support by attending the Finance Senior Management Team monthly meetings. The service currently has no overdue recommendations or reports. Since the data was extracted for this report, IA have confirmed closure of the report on "Financial Management" and the remaining recommendation on the IA report on "Regional Integration Fund" has been given an 'external' status as it is not currently within the gift of the Health Board to complete. <u>Performance</u> No open reports currently on the Audit and Inspection Tracker for the service. Papers are regularly submitted to the Director of Finance's Finance, Digital and Performance meeting (attended by senior leadership from the three directorates), and further supplemented by in-depth discussions on the progress made with the implementation of recommendations at the monthly Finance Senior Management Team meeting, with attendance from the Assurance and Risk Team. Arrangements have also commenced in July 2024 with the Digital Senior Leadership team whereby the Assurance and Risk Officer attends bi-monthly meetings to review the Directorate's risk register. Whilst there is an improved position in terms of the Directorate's performance in managing their recommendations, a Level 2 was awarded as part of the Escalation Framework as concerns were raised in relation to management of risks for the Digital directorate, as detailed in the Risk Assurance paper being presented to ARAC in August 2024.	Ensure that at least 90% of Digital's audit/inspection recommendations are implemented within agreed timescales.

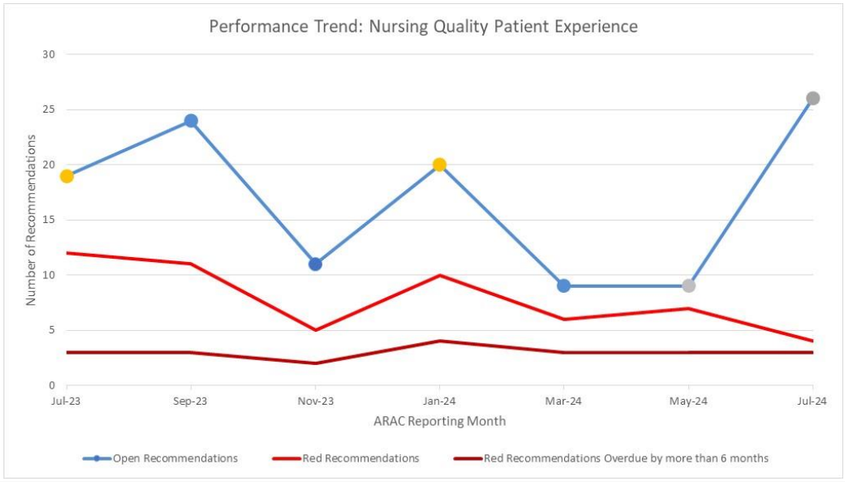


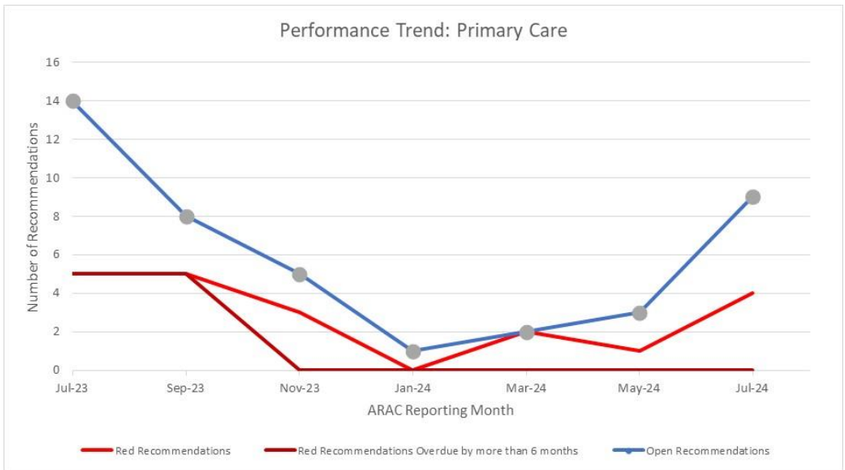
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Medical Directorate	Reports: 7 ↑ Recs: 26 ↑	Reports: 4 → Recs: 9 ↑	Reports: 4 → Recs: 5 ↑	Since the previous report presented to ARAC in June 2024, the number of open recommendations has increased from 18 to 26, with the number of overdue recommendations increasing from 6 to 9. Recommendations overdue by more than 6 months have also increased from 4 to 5. Of the 9 overdue recommendations, 3 do not have a revised timescale (N/K). 7 outstanding recommendations have an 'external' status as they are currently awaiting further input from Public Health Wales, and therefore currently outside the gift of the Health Board to complete. The Assurance and Risk Team continue to support the Medical Directorate via their newly established Business and Governance meetings to obtain further updates on these recommendations. As the July meeting was stood down, the Assurance and Risk business partner met with the Assistant Director to advise that these reports are due to be transferred to the AMaT system, with further updates required.	Ensure that at least 90% of audit / inspection recommendations are implemented within agreed timescales.
Mental Health and Learning Disabilities	Reports: 13 ↓ Recs: 59 ↓	Reports: 4 ↓ Recs: 52 ↓	Reports: 5 ↑ Recs: 35 ↑	There continues to be an overall improvement in the Directorate's performance since the previous report presented to ARAC in June 2024, with a reduction in the number of open recommendations (June 2024: 69) and 5 reports overdue by more than 6 months. In addition, 6 reports are awaiting closure with all recommendations having been completed. Whilst there has been an increase in overdue recommendations by more than 6 months (June 2024: 25) this is predominantly due to the HIW Mental Health Discharge Review report, with 29 of the overdue recommendations, 5 of which do not have revised dates and are required from the service on AMaT, with updates to be reflected to ARAC in October 2024. Following the meeting between the Head of Assurance and Risk, the Director of Mental Health and the Assistant Director of Nursing MH&LD in April 2024 to discuss strengthening current governance processes in place, this has now been actioned with any new reports received being presented to the senior team for sign off before submission, which will support the setting of realistic timescales going forward. There continues to be good engagement, and the Directorate have monthly meetings in place (QSE and BPPAG) which are attended by the Assurance and Risk Team, with standing agenda items in relation to the progress on recommendations. The Assurance and Risk Team continue to work closely with the service and monthly meetings are in place with the Assistant Director of Nursing MH&LD and service leads to provide ongoing support.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.



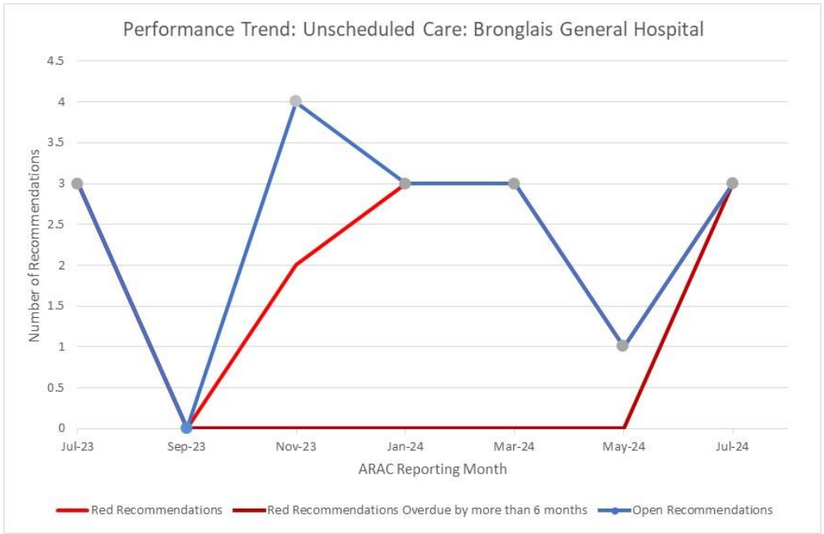


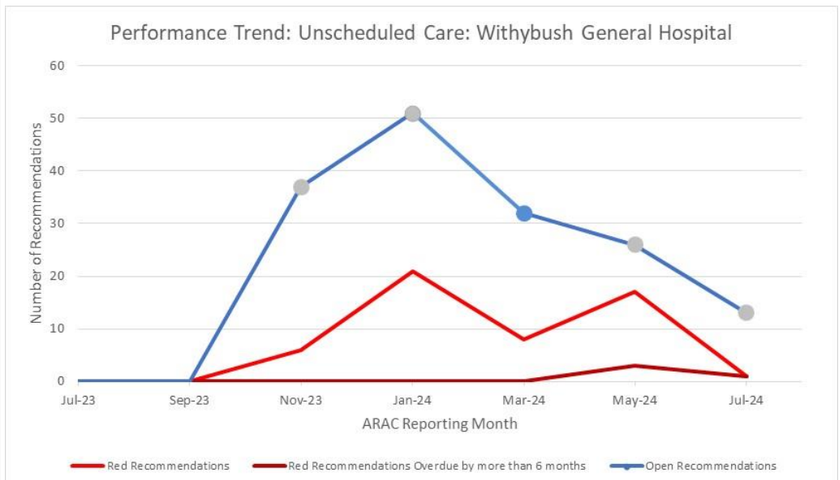
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Director of Nursing: Nursing, Quality and Patient Experience	Reports: 8 ↑ Recs: 26 ↑	Reports: 2 → Recs: 4 ↓	Reports: 2 → Recs: 3 →	Since the previous report to ARAC in June 2024, 2 new reports have been received, IA report, "Health & Care Quality Standards Final Internal Audit Report June 2024" with 3 recommendations for completion by September 2024 and a HIW report, "DNACPR Review" with 17 new recommendations for completion by December 2024. 3 reports are still awaiting formal approval for closure (IA: 2 and PSOW: 1). Of the 2 open reports, which are overdue by more than 6 months, there has been progression since the previous report to ARAC with only 1 recommendation (June 2024: 2) now remaining from the Llais report on "Accident & Emergency Departments in the Hywel Dda Health Board area" which is reliant on completion of works by an external body (Gwili Railway Company), supported by Estates. The IA report on "Falls Prevention and Management" has 1 outstanding recommendation, which was due to be presented to the Clinical Education Governance Group Panel for approval on 25 June 2024. The outcome of this presentation will be presented to ARAC in October 2024. The "WRP Concerns Assessment" report has 1 recommendation overdue by more than 6 months. Progress updates and revised timescales are required from the service on AMaT and will also be reflected to ARAC in October 2024. Monthly governance meetings are in place, with representation from the Assurance and Risk team. It is noted that in addition to the management of recommendations, the Directorate were also escalated to Level 2 in relation to the difficulties in progressing and implementing Welsh Health Circulars assigned (details of which can be found in the Quality Assurance report presented to QSEC in August 2024), and concerns around policies being out of date review (noting that they are currently pending extension).	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.
Primary Care Management *(Long Term Care and Chronic Conditions)*	Reports: 1 → Recs: 1 ↓	Reports: 1 → Recs: 1 ↓	Reports: 0 → Recs: 0 →	Since the previous report presented to ARAC in June 2024, the total number of overdue recommendations for Long Term Care has decreased from 2 to 1 as one outstanding recommendation on the IA report on "Deprivation of Liberty Safeguards" issued in August 2023 has been noted as complete, with evidence to be uploaded to AMaT for approval by IA. The remaining recommendation on this report became overdue as of March 2024 and does not currently have a revised timescale (N/K), though the service have confirmed on AMaT that they will be able to update this further in August 2024. Concerns remain in relation to risk management with the Directorate, and detailed in the Risk Assurance paper being presented to ARAC in August 2024, and were therefore a Level 2 in the Escalation Framework as at June month-end. *The performance trend graph data for Long Term Care is available from December 2023 onwards only. Prior to this, Long Term Care figures were included within the Primary Care service data.*	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales



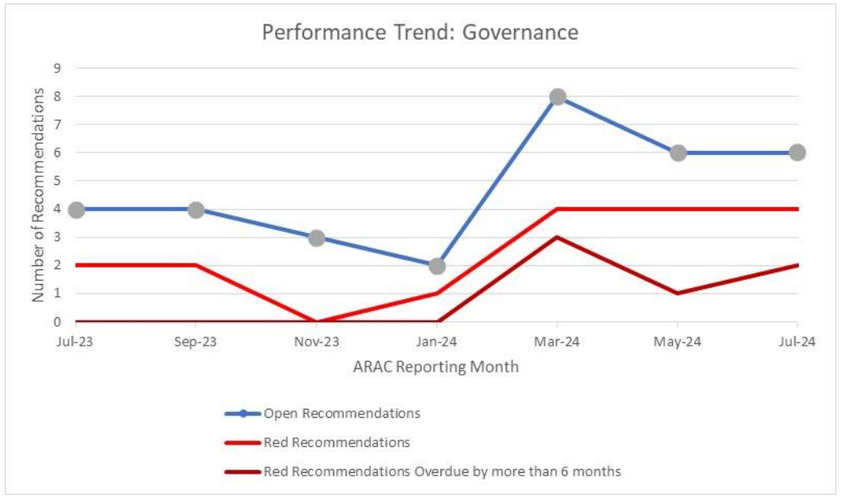
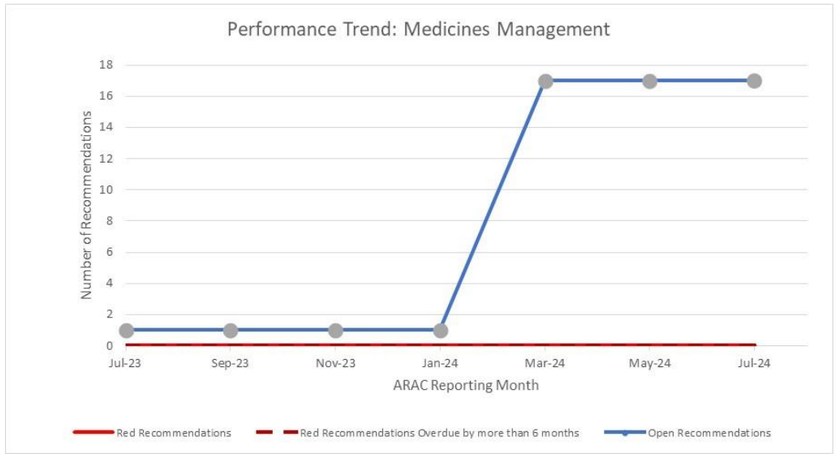


Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Unscheduled Care: Bronglais General Hospital	Reports: 1 → Recs: 3 ↑	Reports: 1 → Recs: 3 ↑	Reports: 1 ↑ Recs: 3 ↑	The IA follow-up report on "Bronglais General Hospital Quality & Safety Governance" issued in February 2024 has 3 overdue recommendations, with revised completion dates of October 2024. 2 of these recommendations were previously reported to ARAC in June 2024 as complete and awaiting approval of evidence by Internal Audit, however upon request of further evidence to be submitted, these recommendations were reopened on the tracker. Support has been provided to the service by Internal Audit and the Assurance and Risk Team to provide clarity on what is required to close these recommendations and IA have confirmed actions can be closed pending review of evidence submitted since the data was extracted for this report. Monthly governance meetings are in place for the site, with attendance from the Assurance and Risk Team. Summary positions are also reported for the site at the monthly Acute Leadership Group meetings.	Ensure that at least 90% of audit/inspection recommendations are implemented within agreed timescales.
Unscheduled Care: Withybush General Hospital	Reports: 3 → Recs: 13 ↓	Reports: 2 → Recs:1 ↓	Reports: 0 → Recs: 1 ↓	Since the previous report presented to ARAC in June 2024, 2 reports have progressed, with all recommendations now completed for the "National Review of Patient Flow – a journey through the stroke pathway" (original completion date of December 2024), and the PSOW "202300406" report (original completion date of June 2024). 1 report (HIW Emergency Department Withybush General Hospital; 27 recommendations were issued with varying timescales from August 2023 to March 2024) has 1 recommendation which is overdue by more than 6 months and relates to roof/guttering replacement which is reliant on Estates to complete. The number of both open and overdue recommendations has decreased, with the number of overdue recommendations significantly decreasing from 17 to 1 since the previous report to ARAC in June 2024. This is due to the completion of all recommendations of the "National Review of Patient Flow" report (11 recommendations) the completion of the remaining recommendation from the PSOW report (1 recommendation) and the completion of 4 recommendations from the HIW Emergency Department, Withybush General Hospital report. There is good engagement with the service, with bi-monthly governance meetings in place for the site, with attendance from the Assurance and Risk Team. Summary positions are also reported for the site at the monthly Acute Leadership Group meetings.	

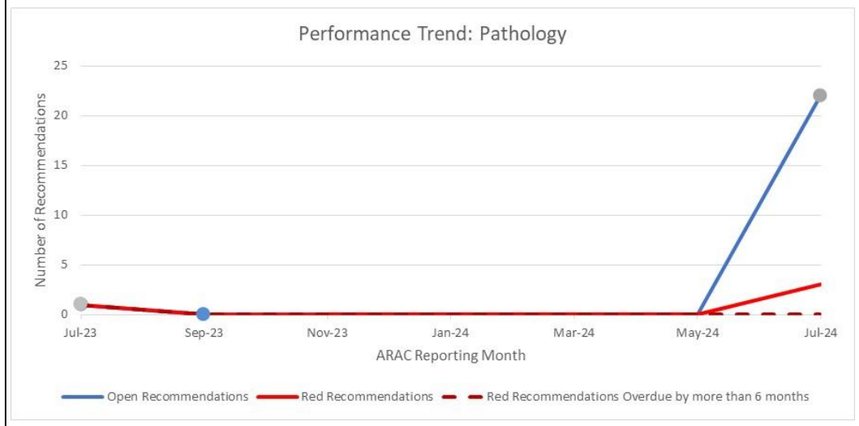


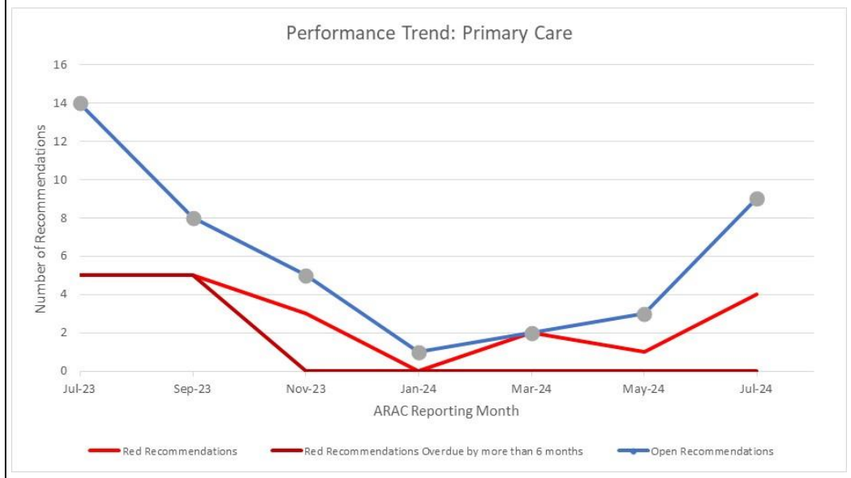


Services With Reasonable Assurance at July 2024

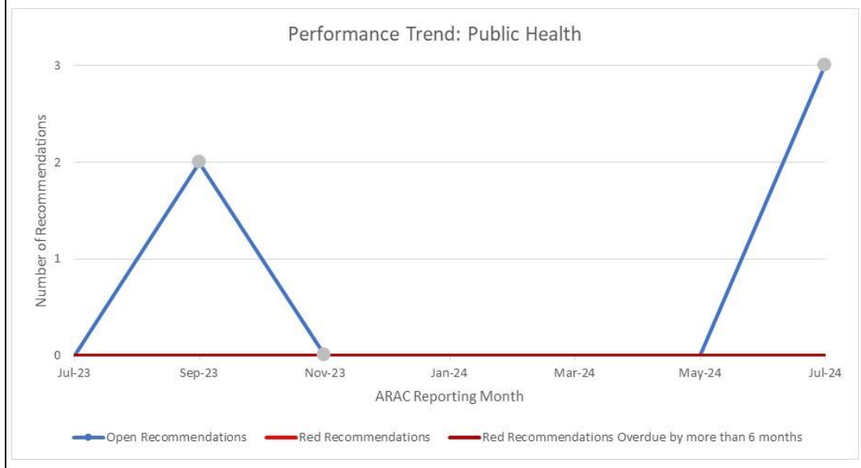
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Corporate Services *(including Governance and CEO Directorate):* 	Reports: 2 → Recs: 6 →	Reports: 1 → Recs: 4 →	Reports: 0 → Recs: 2 ↑	Since the previous report presented to ARAC, 2 recommendations previously noted as being overdue by more than 6 months have now closed. The remaining recommendations as raised in the Structured Assessment Reports for both 2022 and 2023 are outside the gift of the service to complete, as they are assigned to the Director of Operations, Director of Finance and Director of Strategy and Planning to implement. The Governance directorate have monthly Senior Management Team meeting in place, with detail provided by the Assurance and Risk team to provide an update position on progress made with the implementation of recommendations.	N/A
Medicines Management 	Reports: 2 → Recs: 17 →	Reports: 1 → Recs: 0 →	Reports: 1 → Recs: 0 →	Since the previous report presented to ARAC in June 2024, the number of outstanding recommendations for Medicines Management has remained at 17. The WG “Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales” report has 16 separate recommendations comprised of both short- and long-term sub-recommendations with timescales ranging from September 2024 to April 2029, however these may now be subject to change following official guidance received from WG. There is one outstanding recommendation on the AW report on “Medicines Management in Acute Hospitals”, relating to electronic prescribing/discharging, which has been assigned an ‘external’ status as the systems approved on the national framework are awaiting funding. This is reflected in risk *1171 – Risk of avoidable medication related patient harm due to no e-prescribing and electronic medication administration system*, which has a current risk score of 16 as at July 2024. The reports assigned to Medicines Management have recently been transferred to the AMaT and system training with service leads has commenced. The Assurance and Risk team have previously attended the Directorate’s Medicines Management Operational Group (MMOG) to present updates on progress made against recommendations raised, however discussions are currently ongoing so that the team attend the Senior Pharmacy Leadership (SPL) business meetings on a bi-monthly basis going forward.	N/A

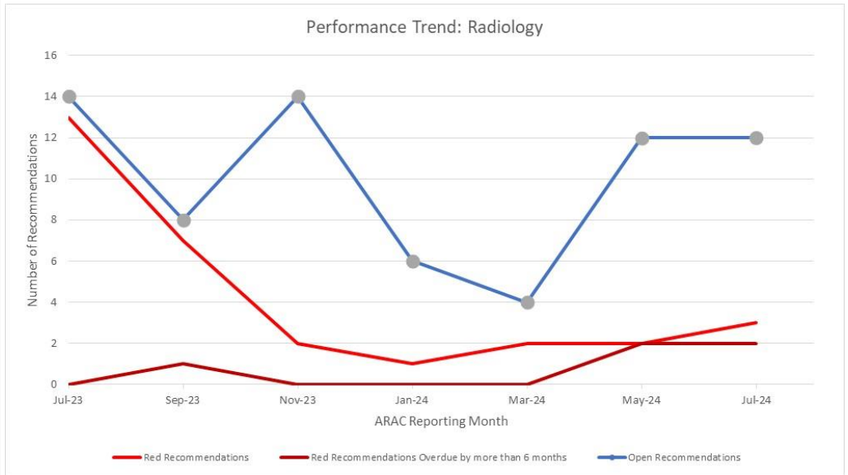
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Pathology	Reports: 2 ↑ Recs: 22 ↑	Reports: 0 N/A Recs: 3 N/A	Reports: 0 N/A Recs: 0 N/A	Since the report to ARAC in June 2024, 2 new reports have been added for Pathology. The HTA (Human Tissue Authority) report, "Glangwili General Hospital Mortuary Inspection April 2024" with 9 recommendations (3 of which are currently overdue, with no revised completion dates), and a report issued by Welsh Government, "Fuller Inquiry Part One" with 17 recommendations. Both reports are due for completion by September 2024. The Directorate have bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.	N/A
Primary Care	Reports: 4 ↑ Recs: 9 ↑	Reports: 3 ↑ Recs: 4 ↑	Reports: 2 ↑ Recs: 0 →	Since the report to ARAC in June 2024, 2 new reports have been added for Primary Care. The HIW report on "Neyland and Johnson Health Centre Inspection January 2024", which has 5 outstanding recommendations, 3 of which are overdue without revised timescales (N/K), and the IA report on "Accelerated Cluster Development Final Internal Audit Report June 2024" which has one recommendation on track for completion in November 2024. There is one 'external' recommendation remaining on the Welsh Language Commissioner report on "Primary care training and the Welsh language", issued March 2019. As at July 2024, there has been no further update received from Welsh Government about the development of a national system to identify and monitor the language skills of Primary Care staff, including those within the independent contractor workforce. Quarterly governance meetings are in place with the Directorate, further supplemented by governance meetings for each service within Primary Care. Arrangements are currently being discussed between the Directorate and the Assurance and Risk team to confirm the most relevant forum for attendance going forward from a risk perspective, with a meeting scheduled for 26 July 2024 to finalise. *The performance trend graph for Primary Care includes Long Term Care reports up until October 2023, after which Long Term Care has been split as a separate service for the purpose of this report.*	Ensure at least 90% of audit/inspection recommendation are implemented within agreed timescales

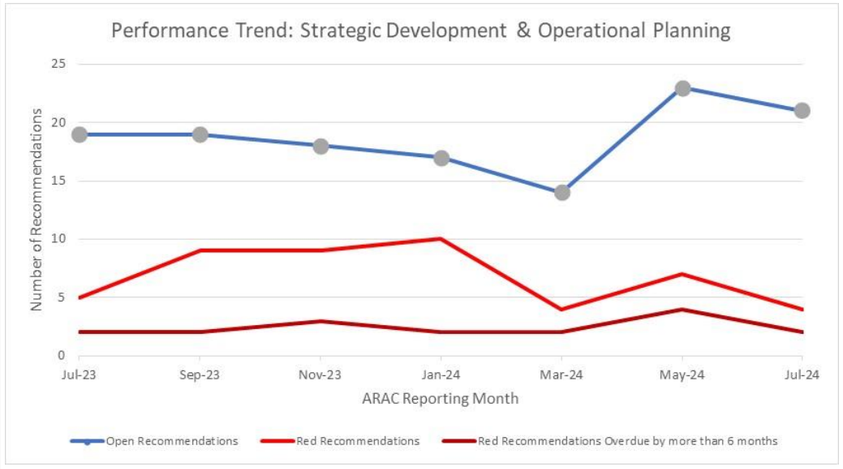
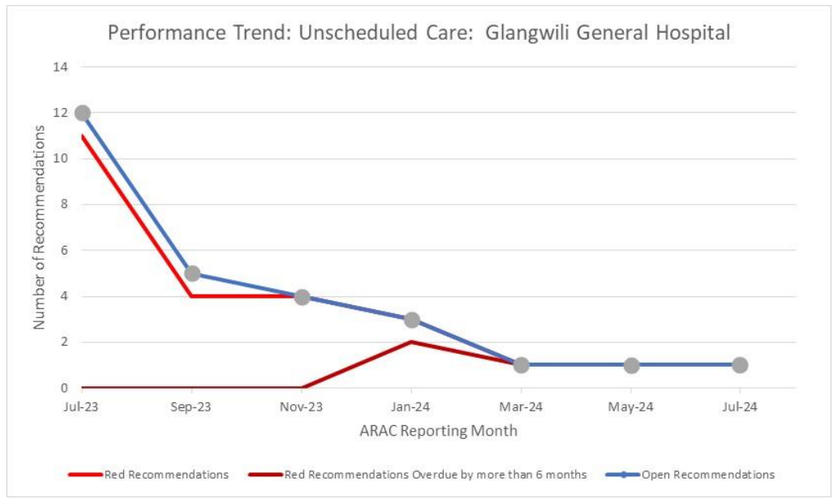




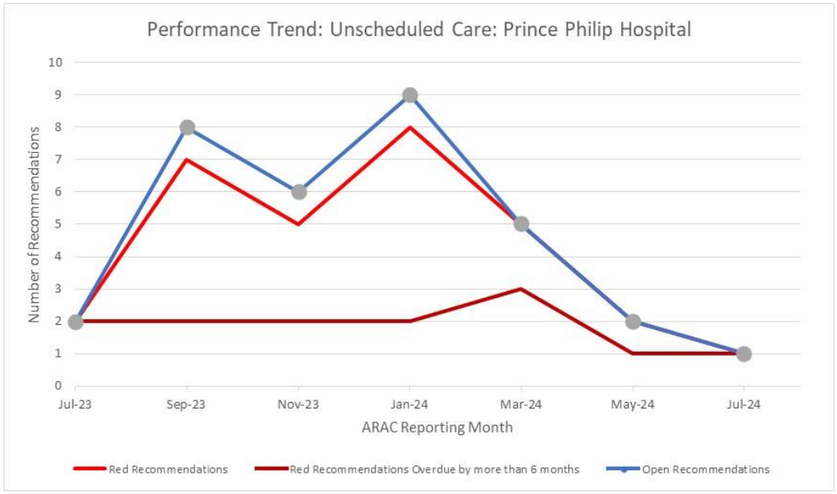
Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Director of Public Health	Reports: 1 ↑ Recs: 3 ↑	Reports: 0 N/A Recs: 0 N/A	Reports: 0 N/A Recs: 0 N/A	Since the report to ARAC in June 2024, 1 new report has been added for Public Health. The IA report on "Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024", has 3 recommendations, with completion dates of July 2024. The Directorate have bi-monthly quality meeting, which has representation from the Assurance and Risk team.	N/A
Radiology	Reports: 3 → Recs: 12 →	Reports: 1 → Recs: 3 ↑	Reports: 1 → Recs: 2 →	Since the previous report to ARAC in June 2024, 1 outstanding recommendation on the HIW IRMER "Diagnostic Imaging x-ray department Withybush Hospital 2024" report has become overdue, with no revised timescale noted on AMaT (N/K). 7 further recommendations on this report are due to lapse in July and August. It is noted that since the data was extracted for this report, further evidence has been uploaded to AMaT to support closure of the majority of recommendations on the HIW IRMER report for GGH issued in February 2022, with one additional recommendation completed, leaving only 1 recommendation outstanding, which is overdue by more than 6 months without a revised timescale (N/K). This recommendation relates to a document management system, for which there is an associated risk on Datix (*Risk 1399 - Non-compliance with IR(ME)R standards and governance requirements and associated patient safety risks*) with a current risk score of 16. The PSOW report issued in February 2024 has one outstanding recommendation which is also due to lapse in July 2024. The PSOW Case Manager will be seeking an update on this report in readiness for the next ARAC meeting. Despite recent challenges resulting from staff absences, there is good engagement with the service with regular updates provided by service leads. The Directorate have bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.	Ensure at least 90% of audit/inspection recommendation are implemented within agreed timescales

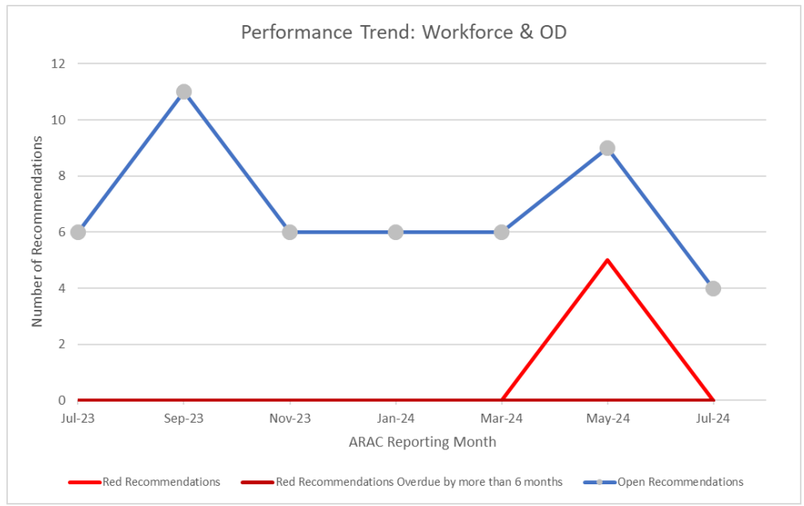




Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
Director of Strategy and Planning 	Reports: 7 ↑ Recs: 21 ↓	Reports: 3 ↓ Recs: 4 ↓	Reports: 2 ↓ Recs: 2 ↓	Since the previous report to ARAC in June 2024, the number of open reports assigned to the Directorate has increased (June 2024: 6) due to 1 new report from IA on "Planning Maturity Matrix Final Internal Audit Report June 2024", with 2 new recommendations. Two reports are awaiting closure, the Peer Review report, "Planning Arrangements in Hywel Dda University Health Board" and the Internal Audit report, "Follow Up: Strategic Programme Governance" with all recommendations now complete. The 4 remaining reports have revised completion dates ranging from July 2024 to June 2025. The Assurance and Risk team attend the Directorate's Senior Management Team, a process which commenced in July 2024.	Ensure at least 90% of audit/inspection recommendation are implemented within agreed timescales
Unscheduled Care: Glangwili General Hospital 	Reports: 1 → Recs: 1 →	Reports: 1 → Recs: 1 →	Reports: 1 → Recs: 1 →	As reported to ARAC in June 2024, 1 recommendation remains outstanding from the HIW report, "Emergency Unit, Glangwili General Hospital" relating to facilities within the unit. The service is reliant on Estates and Facilities to complete the refurbishment to fully implement this recommendation. An update in June 2024 advised that the lockers had been ordered by ED and works would continue by Estates upon delivery. The site has bi-monthly governance meetings in place, with attendance from the Assurance and Risk team along with good engagement from site leads.	Ensure at least 90% of audit/inspection recommendation are implemented within agreed timescales
Unscheduled Care: Prince Philip Hospital	Reports: 1 ↓	Reports: 1 ↓	Reports: 1 →	As reported in June 2024, 1 recommendation relating to the current service model as raised in the Peer Review report "Respiratory Cancer Review, issued June 2016" remains overdue by more than 6 months.	Ensure at least 90% of audit/inspection

Service	Open reports and recommendations – July 2024	Overdue reports and recommendations – July 2024	Overdue reports and recommendations more than 6 months – July 2024	Analysis	Minimum requirement for de-escalation (recommendations)
	Recs: 1 ↓	Recs: 1 ↓	Recs: 1 →	The Director of Operations had requested that evidence be submitted to confirm that the required strategic review as per the original management response had been undertaken, and that an action plan is in place to monitor going forward, after which the recommendation can be noted as completed. The Head of Assurance & Risk is currently in the process of escalating this recommendation to the Director of Operations to seek a resolution to this situation, with an update to be provided in the next report to ARAC. The site has bi-monthly governance meetings in place, with attendance from the Assurance and Risk team.	recommendation are implemented within agreed timescales
Director of Workforce & OD	Reports: 2 → Recs: 4 ↓	Reports: 0 → Recs: 0 ↓	Reports: 0 → Recs: 0 →	No new reports have been added to the tracker since the previous report presented to ARAC in June 2024. All 6 outstanding recommendations previously reported have now been closed as raised in the AW "Open report on the Review of Workforce Planning Arrangements", currently pending formal approval of closure.	N/A





Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	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

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Jan-22	2021/22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Pathology	Lisa Humphrey	Director of Operations	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ ~~Mar-24~~ Jan-26	Red
Jan-22	2021/22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ ~~Mar-24~~ N/K	External
Mar-24	2023/24	Internal Audit	Elective Waiting List Management: Single Cancer Pathway Final Internal Audit Report	Open	Reasonable	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	Medium	R3. The Cancer Improvement Board terms of reference should be reviewed and updated to reflect current arrangements.	The TOR for the Cancer Improvement Board are being updated.	Apr-24	~~Apr-24~~ ~~May-24~~ Jun-24	Red

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R1. Clinical leadership within the OOH service requires expansion to include leadership at system wide level and on- shift. Action: Review leadership roles and recruit to expand both at system level and operational level.	This is accepted as an area requiring attention. Exploration of the capacity of leadership is now the subject of discussion within the senior team along with at the Improving Together sessions recently instituted by executives. Limited numbers of GPs with an interest in OOHs remains a challenge so longer term development opportunity may be needed. The operating relationship with leads in TUEC and UPC opens up further reconciliation needs.	Jun-23	~~Jun-23~~ ~~Aug-23~~ ~~Mar-24~~ ~~Jun-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review options for consolidation of bases.	Bases have been consolidated overnight from five to three since 2020 in the interests of patient safety and better management of expectation. This temporary service change remains under review as the underlying intention remains to operate from five bases. Latterly shift fill has not shown any significant improvement. Key to improving this is to develop the MDT model such that the interested medical parties in the numbers available can be spread across five centres.	Sep-23	~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review rural models in operation in Cumbria with a view to implementation in the West.	The TUEC Director has made arrangements to pilot a model which is based on the Airedale service which is soon to commence in the Carmarthenshire area and will offer support to the residential care sector. In addition the OOHs team will seek to understand the arrangements specific OOHs impacts as a result of the Airedale model's operation in Cumbria.	Jun-23	~~Jun-23~~ ~~Dec-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts. Action: Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ ~~Jun-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: OOH and UPCC to work collaboratively on development of a workforce plan for increasing the MDT	Collaborative working with WAST and other teams within HDUHB has commenced with a view to developing the model.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: UPCC to utilise the UPC Framework to expand scope of practice of practitioners	OOHs Clinical Lead sits on national group discussing UCP framework – continued development of this is in place.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red

Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R10. The service relies mainly on sessional GPs to provide shift cover. Consideration needs to be given as to how to attract new GPs to the role. There is an opportunity to work collaboratively with UPCC to create salaried, rotational posts. In addition on-boarding of GPs willing to work in OOH has been hampered due to this being managed by Medical recruitment. Action: Workforce plans need to be developed for OOH and UPCC increasing the number of salaried/ rotational posts.	Development of a broader workforce plan which incorporates PC/ UPCC	Dec-23	~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review utilisation of HCSW in base and in cars, link with CTM to understand how they deploy their HCSW.	Promoting further use of HCSW in OOHs is active. As part of Internal Service Review all JDs being discussed as 1:1 and emphasis being made to using skills. CTUHB will be approach on this arrangement also	Sep-23	~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation of HCSW in bases in the West could support a rural model of care.	Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared with opportunities and needs.	Jun-23	~~Jun-23~~ ~~Dec-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation and training of HCSW in community hospitals could support medicines administration, link with Pharmacy and Social Services.	Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared to opportunities and needs Engagement to facilitate better understanding of the need and to establish what opportunities might exist whilst remaining a compliant approach to care.	Dec-23	~~Dec-23~~ ~~Mar-24~~ Sep-24	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Consider training for staff in VoD and management of catheters.	Requires wider engagement with DN /ART to assess frequencies and demand profiling to inform workforce modelling.	Sep-23	~~Sep-23~~ ~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Consider a workshop bringing together UPCC, Clusters and OOH to work on an integrated plan	Being led by TUEC Programme Director.	Sep-23	~~Sep-23~~ N/K	Red

Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Review use of dedicated slots for UPC offered in GMS, consider whether any slots can be utilised by OOH.	To discuss with PC, Cluster and UPC leads	Sep-23	~~Sep-23~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: develop policies that support clinicians to undertake tasks related to remote prescribing.	Remote prescribing being received with excessive caution on the part of OOH clinicians. DMD supporting the development of a compromise.	Sep-23	~~Sep-23~~ N/K	External
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: Review policy for booking F2F slots to allow remote clinicians to book slots	Some negative feedback received from clinicians and DMD supporting a compromise.	Sep-23	~~Sep-23~~ ~~Dec-23~~ ~~Mar-24~~ Mar-25	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R16. Clinicians raised concerns about the appropriateness of calls sent across from 111, which could have been closed by 111. Action: Consider a table top review of calls sent across by 111 deemed inappropriate	Data gathering has continued with the recent restoration of Adastra and its concentrator. Analysis of call profiles to be undertaken and interpretations to be compared.	Sep-23	~~Sep-23~~ Nov-24	Red
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R17. Clinicians were concerned about calls being held on the 111 advice queue from early afternoon and then being passed to OOH at 6:30pm on weekdays. Action: Gather data to determine the extent of this issue and raise via Joint Operational group.	Similar data profile noted above to be gathered to assess validity of claim	Sep-23	~~Sep-23~~ Nov-24	Red

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Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R2b. The Health Board needs to provide assurance that case reviews are carried out to see what can be learned from individual cases as the Health Board seeks to implement and monitor its strategy.	Implement recommendations from the Palliative and EOL Strategy to establish a monthly Health Board wide peer review.	Sep-23	N/K	Red
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R3b. The Health Board needs to consider whether the initial discussions with patients, carers and loved ones are as comprehensive as they can be in terms of decision-making and communication.	To ensure all patients and relatives are reached, the Health Board is contributing to the digitalisation of an All Wales Advance and future care plans.	Sep-23	N/K	Red
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R3e. The Health Board needs to consider whether the initial discussions with patients, carers and loved ones are as comprehensive as they can be in terms of decision-making and communication.	Following Welsh Government guidelines, the Palliative care & EOL service to contribute to the implementation of the All Wales Advance and Future Care Planning when it is finalised.	Sep-23	N/K	Red
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R4b. The Health Board needs to ensure that the needs of an effective palliative care model are consistently met by local GP/Out of Hours services	To ensure access to nursing support is available across Hywel Dda 24/7. In addition to the Nursing support Specialist Palliative Consultants are available Out of Hours (OOH) as well as the provision of a separate telephone advice line for Patients and their families and Health Care Professionals requiring OOH GP support.	Sep-23	N/K	Red

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Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Medium	R4a. All network management tools should be correctly configured so as to be able to identify and categorise alerts by importance/severity, and to assist with capacity management.	The Asset Management workstream will be integrating the Solarwinds Network Management tool with FreshService. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur.	Feb-23	~~Feb-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~May-24~~ ~~Jul-24~~ Dec-24	Red
Nov-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Low	R5. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	~~May-24~~ Jan-25	Red
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	High	R1. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	~~May-24~~ Mar-25	Red
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Medium	R2. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	~~May-24~~ Mar-25	Red
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	High	R3. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	~~Mar-24~~ ~~Sep-24~~ Mar-25	Red
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	High	R1. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Dec-25	Dec-25	Amber
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	Medium	R2. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Jun-26	Jun-26	Amber
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	High	R3. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Jun-26	Jun-26	Amber
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	High	R4. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Jun-25	Jun-25	Amber
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	High	R5. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Dec-24	Dec-24	Amber
Mar-24	2023/24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Open		Digital	Digital	Gavin Jones	Director of Finance	High	R6. Not included on tracker due to sensitivity of report	Not included on tracker due to sensitivity of report	Jun-26	Jun-26	Amber

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Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	~~Dec-23~~ Nov-24	External
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	~~Jul-22~~ Nov-24	External
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ Sep-24	Red
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R1. Complete the review of the Transfusion Policy.	Confirm that the Transfusion Policy has been reviewed, updated and approved by the Transfusion Committee.	Aug-23	~~Aug-23~~ ~~Oct-23~~ ~~Mar-24~~ ~~Jun-24~~ Jul-24	Red

Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R6. Develop a database of patient information leaflets used within the consent process.	Convert the EIDO audit spreadsheet into a database.	Jun-23	~~Sep-23~~ ~~Dec-23~~ ~~Feb-24~~ N/K	External
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R8. Undertake a peer review of the organisation's consent process using the All Wales peer review tool. In addition to monitoring the organisation's consent process it will enable compliance with requirement No. 6 of WRP RMA2020-01 Consent to Treatment –monitoring compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of provision of procedure specific patient information leaflets.	Consult with the Deputy Medical Director regarding appropriate timing. Discuss process for audit with relevant clinical leads. Plan and schedule the audit.	Dec-23	~~Mar-24~~ ~~Jun-24~~ ~~Jul-24~~ Aug-24	Red
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care (TUEC) Final Internal Audit Report	Open	Reasonable	Director of Operations	Ceredigion	Peter Skitt	Director of Operations	Medium	R1. Consider the merits of developing a Health Board-wide delivery plan to drive operational activity and ensure consistency between the three Counties.	The Health Board is currently in the process of submitting both the Annual Plan and Six Goals Programme Plan for Welsh Government, setting clearly the TUEC Programme actions with agreed timescales, milestones and responsible officers. It is our intention that the detail for each action should be referenced in the Operational Delivery Plans, this will allow each County system to be regularly monitored against their baseline.	Apr-24	~~Apr-24~~ N/K	Red
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care (TUEC) Final Internal Audit Report	Open	Reasonable	Director of Operations	Ceredigion	Peter Skitt	Director of Operations	Medium	R2. Assign specific and time-bound targets to the identified metrics to enable meaningful assessment of progress and success in achieving the strategic aims of the programme.	The Transforming Urgent and Emergency Care Programme is one of continuous improvement, rather than of defined end points against the agreed metrics. Furthermore, due to the complexities of the Urgent and Emergency Care system it is extremely difficult to be able to align specific actions to delivering improvements in specific areas. As such, the Health Board have signed off the collection of Conveyance, Conversion and Complexity metrics to highlight at a high level the success and benefits of the programme as a whole. However, the Health Board do recognise the importance of being able to track success and failure, and to have valid and reliable data to determine funding decisions. We are currently working with Operational Teams across each of our Counties to be able to improve the position by aligning local Operational Plans, actions and expected improvement trajectories to Annual Planning processes (please see 1.1). Additionally, the TUEC programme is currently working with the Informatics Directorate to ensure that we have the correct format of data required to monitor key metrics for the TUEC programme. For example, we hope to have a TUEC dashboard going forward with monthly views, historical and predictive trend lines. This will enable more accurate monitoring of data which are key for holding to account meetings such as Improving Together and the governance meetings associated with the TUEC Programme.	Jul-24	Jul-24	Amber

Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care (TUEC) Final Internal Audit Report	Open	Reasonable	Director of Operations	Ceredigion	Peter Skitt	Director of Operations	Medium	R3. Align the metrics to the projects and actions that influence them so there is a direct link between performance and the root cause.	The Transforming Urgent and Emergency Care Programme is one of continuous improvement, rather than of defined end points against the agreed metrics. Furthermore, due to the complexities of the Urgent and Emergency Care system it is extremely difficult to be able to align specific actions to delivering improvements in specific areas. As such, the Health Board have signed off the collection of Conveyance, Conversion and Complexity metrics to highlight at a high level the success and benefits of the programme as a whole. However, the Health Board do recognise the importance of being able to track success and failure, and to have valid and reliable data to determine funding decisions. We are currently working with Operational Teams across each of our Counties to be able to improve the position by aligning local Operational Plans, actions and expected improvement trajectories to Annual Planning processes (please see 1.1). Additionally, the TUEC programme is currently working with the Informatics Directorate to ensure that we have the correct format of data required to monitor key metrics for the TUEC programme. For example, we hope to have a TUEC dashboard going forward with monthly views, historical and predictive trend lines. This will enable more accurate monitoring of data which are key for holding to account meetings such as Improving Together and the governance meetings associated with the TUEC Programme.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	Medium	R1. The Discharge and Transfer of Care Adults Policy should be promptly reviewed and updated in line with national guidance.	The Discharge Strategy Group will review and update The Discharge and Transfer of Care Adults Policy in line with recent WG National Discharge Guidance, incorporating links to the Reluctant Discharge Policy and Care Home of Choice policy.	Jun-24	~~Jun-24~~ Sep-24	Red
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	High	R2. A review of discharge health and care service provisions across the three counties should be undertaken and aligned into a single, consistent model.	A review of the current discharge processes in line with the principles of optimal hospital flow will be undertaken by the TUEC Programme, QIST and the Discharge Strategy Group to identify areas of variation and to establish a single consistent model for discharge processes, recognising that each county and local authority will have some natural variation.	Jul-24	~~Jul-24~~ Sep-24	Amber
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	High	R2. A review of discharge health and care service provisions across the three counties should be undertaken and aligned into a single, consistent model.	Review all existing discharge patient information and develop a single Discharge Patient Information Leaflet to be implemented across all acute and community sites.	Sep-24	~~Sep-24~~ Dec-24	Amber
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	Medium	R3. A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Develop clear 'action' cards for all staff involved with discharge processes to ensure clarity of roles and responsibilities	Sep-24	Sep-24	Amber
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	Medium	R3. A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Undertake a review of the current discharge liaison services across the acute and community hospital sites to mitigate variation and establish core principles for service delivery	May-24	~~May-24~~ Sep-24	Red
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	High	R5. Ward staff should ensure the Frontier system is promptly and accurately updated to reflect the patients' status as maintained on the whiteboards.	Operational Management Teams to meet with QIST Practitioners to agree local communication / engagement plans ensuring all ward staff are aware of the importance of ensuring that the Frontier system is updated in a timely manner to ensure accuracy of data being collected.	Jun-24	~~Jun-24~~ Sep-24	Red

Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Director of Operations	Acute Services	Ceri Griffiths	Director of Operations	Medium	R6. An audit of the Frontier system should be undertaken to establish whether the data is complete and accurately reflects patients status on the ward. Where issues are identified, consideration should be given to establishing the circumstances and implementing actions to address any issues, such as additional training.	Regular (bi-monthly) spot audits to be implemented by Senior Nurse Managers in clinical areas using Frontier to review compliance and accuracy with capturing data including EDD, D2RA Pathway and R2G.	Jun-24	~~Jun-24~~ Sep-24	Red
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R1. Once the new operations structure is in place the Health Board should protect against silo working by ensuring governance processes support cross working across the three integrated systems and between the clinical care groups	Agree. Creation of the proposed Clinical Care Group model will facilitate the bringing together of the senior leadership triumvirates across key areas of operational service delivery into an integrated operational management meeting, that also aligns with and supports the Health Board's revised Executive Team Governance Arrangements. As an example, the creation of the Community and Integrated Medicine Clinical Care Group is intended to ensure a more consistent approach is taken across the three integrated systems, led by a triumvirate at Care Group level.	Dec-24	Dec-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open	N/A	Director of Operations	Finance	TBC	Director of Operations		R2. The Finance, Digital and Perfomance Directorate should enhance its governance arrangments by: 2.1 Mapping the governance structure for the directorate as a whole to ensure arrangements are supporting good flows of information and assurance	Agree. While the arrangements are understood internally, this does rely on the stability of the directorate's staffing arrangements. Consequently, the governance structure will be mapped to ensure arrangements are supporting good flows of information and assurance.	Sep-24	Sep-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open	N/A	Director of Operations	Finance	TBC	Director of Operations		R2. The Finance, Digital and Perfomance Directorate should enhance its governance arrangments by: 2.2 The Finance Team should develop a standard reporting template to support flows of information and assurance within the team	Agree. The Finance Team will adopt the standard reporting template currently utilised for reporting by the digital team.	Sep-24	Sep-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.1 Design an appropriate governance structure, showing how meetings interact and how flows of assurance and escalation work	Agree. The Health Board's Governance Team will support the Director of Operations in mapping the operational governance and meeting arrangements to reflect the new operational structure and revised Executive Team Governance Arrangements.	Dec-24	Dec-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.2 Review the Operational Planning, Governance and Performance Group, to consider whether it is fit for purpose, has appropriate membership and where it fits in the context of the new governance structure	Agree. A review of the existing OPGP is in progress to confirm its role and relationship with the new Executive Team Governance Arrangements as an enabling/support group.	Dec-24	Dec-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.3 For business meetings held within directorates, develop a standard terms of reference, agenda and reporting template which aligns with the Improving Together Framework.	Agree. A standard terms of reference, agenda and reporting template, aligned with the Improving Together Framework, will be introduced.	Dec-24	Dec-24	Amber

May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.4 Once recommendation 3.3 is operational, the Health Board should ensure teams are compliant with standard arrangements for both operational business meetings and quality safety and experience meetings through compliance testing	Agree. The Health Board utilises Internal Audit for a rolling review of Directorate Governance Arrangements; these audits will be prioritised and compliance with the standardised arrangements introduced to business meetings will be built into the scope of those audits	Mar-25	Mar-25	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.5 Review and update the Scheme of Delegation as the new operations structure is rolled out	Agree. The Interim Chief Executive has been reviewing Executive Portfolios and the Scheme of Delegation will be amended at its annual review to reflect any changes made. Once the Clinical Care Groups are established, any required changes will be made to the Scheme of Delegation as part of its on-going review.	Mar-25	Mar-25	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open	N/A	Director of Operations	Finance	TBC	Director of Operations		R3. To ensure the new operations structure supports good governance the Health Board should: 3.6 Review the Directorate Improving Together Sessions to ensure sessions are targeted at the appropriate tier within the new operations structure	Agree. The Improving Together Process will be reviewed to reflect the new operational structure	Nov-25	Nov-25	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R4. To improve risk management arrangements the Health Board should ensure directorates: 4.1 Incorporate the risk management review process into routine business meetings held by operational teams, building on good practice seen within the Carmarthenshire County Team	Agree. Please see 3.3 this will form part of the standardised approach.	Dec-24	Dec-24	Amber
May-24	2024/25	Audit Wales	Review of Operational Governance – Hywel Dda University Health Board	Open		Director of Operations	Finance	TBC	Director of Operations		R4. To improve risk management arrangements the Health Board should ensure directorates: 4.2 Review risk management training within their teams and where appropriate request refresher training from the corporate risk and assurance team	Agree.	Mar-25	Mar-25	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Feb-20	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/0011471 9- KS/890/04	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	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-25	~~Dec-24~~ Apr-25	Amber
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	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.	Jul-24	~~Jul-22~~ ~~Feb-23~~ ~~Nov-23~~ ~~Jan-24~~ Jul-24	Amber
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	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.	Jun-25	~~Aug-24~~ Jun-25	Amber

Sep-21	2021/22	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Estates	Estates	Liz Carroll	Director of Operations	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC.	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~Jan-23~~ ~~May-23~~ ~~Aug-23~~ ~~Dec-23~~ Sep-24	Red
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber

Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	Mar-24	~~Nov-22~~ ~~Oct-23~~ ~~Mar-24~~ Jun-24	Red
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	Mar-24	~~Nov-22~~ ~~Oct-23~~ ~~Mar-24~~ Jun-24	Red

Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout the block. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber

Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Blue Block. For example: - • Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber

Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1.A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber

Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R6. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R8. An assessment should be undertaken to ensure all Internal and external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Dec-25	Dec-25	Amber
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber

Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber

Oct-22	2022/23	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Estates	Estates	Kay Isaacs	Director of Operations	N/A	Appropriate and safe curtains are to be placed in patient bedrooms	Estates to review the environment in bedrooms and identity work plan to replace curtains.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ ~~Sep-23~~ ~~Dec-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~Jun-24~~ Sep-24	Red
Jan-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 24 - Diabetes Research Clinic, West Wales General Hospital, Dolgwili, Carmarthen. SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. Provide a staff/general fire routine notice stating in concise terms, the action to be taken upon discovering a fire or on hearing the fire alarm. A copy of the notice should be exhibited in the vicinity of each fire alarm actuation point.	Full action plan held by Estates.	Nov-24	Nov-24	Amber
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Templates 8 & 9,(Wards 3 & 4, Wards 6 & 5), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00141802	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •R35 Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. 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 requirement. (Estates ref 3.5).	Full action plan held by Estates.	Mar-24	~~Mar-24~~ ~~May-24~~ Sep-24	Red
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01	Full action plan held by Estates.	Apr-24	~~Apr-24~~ Jun-24	Red
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Charging of battery devices must not be done within the means of escape, remove all charging items into a suitable room with a fire door. The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Apr-25	Apr-25	Amber

Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The storage and use of electrical equipment/devices within the means of escape is not permitted, remove all electrical devices into a suitable room with a fire door. • Fridge (behind the nurse station WD1) • Photocopier. (next to the nurse station WD3 & 4) • Laptop charging units (noted mounted in various ward corridors / department corridors).The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Apr-25	Apr-25	Amber
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. During the inspection breaches in compartmentation were identified within the endoscopy storeroom which houses the photocopier and a large air conditioning unit. The breaches in compartmentation would not support the existing evacuation strategy.In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. Compliance with this or an equivalent standard will normally satisfy the requirement. I am happy for this to item to be address in the Phase 2 enforcement works Scheme.	Full action plan held by Estates.	Apr-25	Apr-25	Amber
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. A fire door should be installed providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance in the following location: • Between the sluice room and electrical room within Ward 4 Fire resisting doors need to be fitted with • A self-closing device • Intumescent strips and smoke seals. • Three brass/steel hinges. 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 requirement	Full action plan held by Estates.	Apr-25	Apr-25	Amber
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. Reduce the risk within this area to as low as practicable by: Either reconfigure the area by moving the kitchen into the staff room or make up the corridor so it provides adequate fire resistance to allow the relevant person to effect a safe exit.	Full action plan held by Estates.	Apr-25	Apr-25	Amber

Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, (Out Patients, Cardio & Respiratory) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. 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. Compliance with these standards will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	~~Mar-24~~ Sept-24	Red
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The opening in the wall in the following location: •From R45 into Service Duct should be in-filled with non-combustible materials, to provide 60 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Aug-24	Aug-24	Amber
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The opening in the ceiling located in: •R12 •R13 •R48 should be in filled to achieve the same fire resistance as the rest of the ceiling. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Jun-24	Jun-24	Amber
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. 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. Compliance with these standards will normally satisfy the requirement	Full action plan held by Estates.	Jun-24	Jun-24	Amber
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The storage and use of electrical equipment/devices within the means of escape is not permitted, remove all electrical devices into a suitable room with a fire door. •Fridge (Cadog Ward) The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Mar-24	~~Mar-24~~ ~~May-24~~ N/K	Red

Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R1. The UHB should ensure that all sites have appropriate surveys in accordance with the five-year recommended cycle. These surveys should be undertaken by individuals who are appropriately skilled to ensure that the estimated cost of remedial works is appropriate to inform the EFPMS.	Accepted – Noting financial pressures, the UHB will risk assess each site to evaluate survey requirements prior to approaching the market.	Apr-24	~~Apr-24~~ Jun-24	Red
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R3. The Property Asset Strategy should be enhanced to include items such as performance measures, RAAC issues and to further align with the Welsh Health Building Note 00- 08 2018 (cross-referencing other key documents as required).	Accepted – Management will ensure a review and alignment of existing documents to Estatecode requirements.	Apr-24	~~Apr-24~~ Jun-24	Red
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R5. A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity based on the current configuration of the estate - pre any redevelopment. Following this, a clear financial model for the revenue support needed in the estate should be developed.	Accepted - Management will undertake a review of its workforce based of the current estate configuration.	Jul-24	Jul-24	Amber
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Future estate workforce reviews will be aligned with the 'A Healthier Mid and West Wales Transforming our Hospitals Programme Business Case' or associated interim service plans,to ensure capability, capacity, and future requirements of the service are met.	Accepted - Management will look to review its workforce based on the future configuration of the estate.	Jul-24	Jul-24	Amber
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following Server cupboards to be cleared of all storage and kept locked shut when not in use. •R02	Full action plan held by Estates.	Mar-24	~~Mar-24~~ Jun-24	Red
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The existing windows located in (Dental corridor – first floor) should be re-glazed with the appropriate fire resisting glazing to a minimum period of fire resistance in accordance with the manufacturer's instructions. The glazing should conform to a relevant standard. Table A4 Approved Document B Volume 2 Buildings other than dwelling houses.	Not a Fire boundary. This was an old compartment line	Mar-24	~~Mar-24~~ ~~Apr-24~~ ~~May-24~~ Sep-24	Red
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. A number of doors should be replaced with fire doors providing the relevant fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. (e.g., Laser correction room – Ground floor, Dental practice – rooms containing cylinders and storage rooms containing high levels of combustible materials). Fire resisting doors need to be fitted with: - • A self-closing device. • Intumescent strips and smoke seals. • Three Brass/steel hinges. Fire doors should confirm 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 timber-based fire door assemblies code of practise.	Adjust self-closing devices and fit smoke seals. Hazard rooms to be reviewed by MG	Mar-24	~~Mar-24~~ Jul-24	Red
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Action plan held by Estates team.	Apr-24	~~Apr-24~~ Jun-24	Red

Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Establish procedures to be followed in case of fire and nominate people to put those procedures into effect.		Apr-24	~~Apr-24~~ Jun-24	Red
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Ensure that sufficient numbers of employees are provided with adequate training to enable them to understand and interpret the fire alarm panel.		Apr-24	~~Apr-24~~ Jun-24	Red
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. All drapes and curtains withing the Radio Studio should be of inherently flame-retardant material or be treated in accordance with a relevant standard. E.g.BS 5867-1:2004 Textiles and textile products – curtains and drapes general requirements and BS 5867-2:2008 Specification for fabrics for curtains or drapes flammability requirements. Compliance with this or an equivalent standard will normally satisfy the requirement.	To be addressed by Hotel Services.	Apr-24	~~Apr-24~~ Jun-24	Red
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. 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. Compliance with these standards will normally satisfy the requirement		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following stairwells are to be cleared of all storage and combustibles: •R 16 & R 44: GF Teifi ward		Apr-24	~~Apr-24~~ Jun-24	Red
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Day Room R08 (Teifi) •Office R36 (Picton) •Bathroom R21 (Picton) •Clinical Room R06 (Picton) Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. 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 requirement		Aug-24	Aug-24	Amber

Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following Fire doors fitted with automatic hold open devices do not close satisfactory upon actuation of the fire alarm. • Dayroom R09 (Derwen) Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors 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 requirement		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01		Jun-24	Jun-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. Extend the existing fire detection and warning system by providing automatic smoke detection in the following areas: • R21 (Preseli) • R18 (Derwen) All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017.		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided; • Indicating exit stairs in Corridor R45 (Derwen) • In both stairwells at eye level. Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • D006 A/B Stem corridor GF. • Store Room R34 Stem corridor GF 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 requirement		Aug-24	Aug-24	Amber

Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R11. During the inspection the self-closing devices on the doors located at; •6 x Doors leading on to stairwells from GF, FF & SF. Were found to be missing and should therefore be installed and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R12. Ceiling tiles in the following areas were found to be damaged, they should be repaired or replaced to provide or reinstated a 30/60 minutes standard of fire resistance. •Store/server room R44 (Picton) The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.		Aug-24	Aug-24	Amber
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 14, (Pathology, Mortuary), Prince Phillip Hospital, Dafen, Llanelli, SA15 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The intumescent strips and cold smoke seals on a number of sampled doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Action plan held with Estates team.	Jun-24	Jun-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified: •R39 Switch Room (Block 6) •R27 Store Room (Block 5) The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Apr-24	~~Apr-24~~ Jun-24	Red

Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.		Jun-24	Jun-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Switch rooms to be cleared of all storage and kept locked shut when not in use.		Apr-24	~~Apr-24~~ Jun-24	Red
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. •R21 Anaesthetic Store (Block 6) Oxygen Cylinders should be stored in accordance with HTM 02 - 01		May-24	~~May-24~~ Aug-24	Red
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following 30-minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •Z003A (Block 6) •Z010 B (Block 5) Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		Jul-24	Jul-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. During the inspection the self-closing devices on the doors located at; •Z004A/B (Block 5) Were found to be ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		Jul-24	Jul-24	Amber

Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •Z007A/B (Block 6) The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		Jun-24	Jun-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Action plan held by Estates team.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.	Action plan held by Estates team.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. During the inspection breaches in compartmentation were identified: •Switch Room T17 The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Action plan held by Estates team.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. 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. Compliance with these standards will normally satisfy the requirement.	Action plan held by Estates team.	Sep-24	Sep-24	Amber

Mar-24	2023/24	Internal Audit	RAAC Internal Major Incident Final Internal Audit Report	Open	Reasonable	Estates	Estates	Rob Elliott	Director of Operations	High	R1. Update the Health Board Major Incident Plan to require that arrangements for recording decisions in a command-and-control incident response be appropriate to the nature and scale of the incident. If it is deemed that decision logs are not necessary, any alternative means (including command-and-control group minutes) must ensure that key decisions are easily identifiable and captured clearly and concisely in order to demonstrate transparency and accountability.	The major incident plan is currently going through its annual review process and a revision relating to decision making will be included as part of this. Scalability will be highlighted and options for appropriate recording of decisions will be detailed ranging from the highlighting of decisions as part of action notes/minutes completed by admin support up to formal decision logs completed by trained Loggists (as appropriate for the scale and nature of the incident). The revised plan will go through the EPRR Group initially then on to the Health & Safety Committee and then Board for ratification. The major incident plan is then stored on the Health Board intranet site for ease of access.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. Duty to take general Fire Precautions - Ignition sources (corridor on 2nd floor). An assessment should be undertake to make the ceiling lighting unit safe	Full action plan held by Estates.	May-24	~~May-24~~ Jun-24	Red
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Emergency routes and exits - Escape routes throughout the premises An assessment should be undertaken to ensure that all escape routes throughout the premises are clear from debris, for example: - Underneath stairs	Full action plan held by Estates.	May-24	~~May-24~~ N/K	Red
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. Maintenance (monthly testing of extinguishers) 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: - Monthly testing of all firefighting equipment It is recommended the records are kept in a logbook.	Full action plan held by Estates.	May-24	~~May-24~~ Jun-24	Red
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. Maintenance (Fire Procedures and/or fire drills (6 monthly drills)). Established procedures to be followed in case of fire and nominated people to put those procedures in place. Regular fire drills to take place with members of the public and staff, moitored and recorded in the relevant documentation.	Full action plan held by Estates.	Jun-24	Jun-24	Red
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 GF, EBME, Physiotherapy, & CT Scanner, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • 0023A/B • 0005A/B (Hole in frame for wiring) • 0026A/B (Gap) • 0014A/B (Gap) • 0021A/B (Gap) 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 requirement		Jun-25	Jun-25	Amber

Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 FF, Library, Secretaries offices & Chapel, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. During the inspection breaches in compartmentation were identified: •Switch room R22 The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Jun-25	Jun-25	Amber
Apr-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 5 FF, Library, Secretaries offices & Chapel, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •D0125 (Frame) •D003 •D007A/B (Gap) •D009A/B (Gap) 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 requirement		Jun-25	Jun-25	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Compliance with cleaning audit frequencies (as stipulated in the Standards) and cleaning audit results should be formally reported via written updates to the County Infection Prevention Groups. Matter Arising 1: Governance, Monitoring & Reporting (Design)	Cleaning audit report to be developed for IPSSG & county infection groups.	Sep-24	Sep-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Compliance with the Standards should be monitored and formally reported via written updates to the IPSSG, with assurances and issues appropriately escalated through the Health Board's governance structure. Matter Arising 1: Governance, Monitoring & Reporting (Design)	Cleaning audit report to be developed for IPSSG & county infection groups.	Sep-24	Sep-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Facilities management to engage with those responsible for these groups to ensure that minutes and action logs clearly evidence the discussions and scrutiny taking place at these meetings. Matter Arising 1: Governance, Monitoring & Reporting (Design)	Facilities Lead will raise this formally with the chair of each meeting / committee to formally request that this becomes s standard agenda item with written reports, action plans and appropriate minutes recorded.	Sep-24	Sep-24	Amber

Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R5. Review and update the Environmental Cleaning Policy to ensure that it reflects changes to cleaning practices including the move from Cleaning 4 Credits to the new Synbiotix system. Matter Arising 2: Environmental Cleaning Policy (Design)	Noting the delay in the new All Wales NSOC (National Standards of Cleanliness) The HB will press ahead with updating policy in advance of clarity in the All-Wales position. (This is likely to require a refresh in circa 12 months when this update is made available to health Boards	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Review and update training manuals to ensure they reflect current practice and requirements, and standardise training manuals in use across the Health Board to ensure consistency. In light of poor cleaning audit scores, consider the merits of: • routine refresher training to ensure staff are competent and compliant with requirements. • reintroducing dedicated training supervisors who would have the necessary expertise and skills to administer training. A central record of training should be maintained to facilitate training compliance monitoring. Matter Arising 3: Training (Design)	All cleaning training manuals have already been rewritten on a consistent basis. Ratify through EHG (Environmental Hygiene Group)	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Review and update training manuals to ensure they reflect current practice and requirements, and standardise training manuals in use across the Health Board to ensure consistency. In light of poor cleaning audit scores, consider the merits of: • routine refresher training to ensure staff are competent and compliant with requirements. • reintroducing dedicated training supervisors who would have the necessary expertise and skills to administer training. A central record of training should be maintained to facilitate training compliance monitoring. Matter Arising 3: Training (Design)	Refresher training will be completed.	Apr-25	Apr-25	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Review and update training manuals to ensure they reflect current practice and requirements, and standardise training manuals in use across the Health Board to ensure consistency. In light of poor cleaning audit scores, consider the merits of: • routine refresher training to ensure staff are competent and compliant with requirements. • reintroducing dedicated training supervisors who would have the necessary expertise and skills to administer training. A central record of training should be maintained to facilitate training compliance monitoring. Matter Arising 3: Training (Design)	Facilities Quality assurance Manger to implement central training database	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R7. Health Board-wide implementation of successful practices identified following the pilot study. Matter Arising 4: Implementation of Revised Working Arrangements (Design)	The phased roll out will prioritise areas with the highest infection rates and anticipated to take 12-18 months to complete, subject to organisational change processes.	Oct-25	Oct-25	Amber

Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R8. In line with the Policy requirements Service Level Agreements and cleaning schedules should be established for each ward/clinical area. The format of cleaning schedules should be standardised across the Health Board to include cleaning tasks and frequency of completion. Management should determine whether schedules should be completed as confirmation of tasks undertaken and retained as evidence, ensure a standardised approach is adopted across the Health Board and reflect requirements in the Policy. Matter Arising 5: Service Level Agreements & Cleaning Schedules (Design & Operation)	SLA's are already in draft format and will be formalised and agreed with acute site Heads of Nursing. This will develop as the new HB cleaning strategy is rolled out across the HB over the next 12 months.	Sep-24	Sep-24	Amber
Apr-24	2024/25	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Ensure all wards/clinical areas are included on Synbiotix and appropriately risk assessed. In line with Standards and Policy, very high-risk areas should be audited weekly moving to monthly once consistently high standards of cleanliness are achieved. If necessary due to resource constraints, consider adopting a risk-based approach to prioritise very high-risk areas with the lowest scores for more frequent auditing. Estates and nursing staff should participate in audits for very high-risk areas even if only on a periodical basis to ensure a multi-disciplinary approach to auditing. Matter Arising 6: Cleaning Audits (Design & Operation)	Capacity with our supervisors currently does not allow us to complete weekly monitoring. This is in the new cleaning strategy currently being rolled out.	Apr-25	Apr-25	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The Health Board should evaluate and source possible funding options (if full, partial, or no additional funding is realised) as a matter of priority. Matter Arising 1: Financial - Budget Position (Design)	Agreed. An additional funding request has been submitted and scrutinised by Welsh Government. The UHB had responded with additional information requested. The UHB awaits confirmation of a decision. In the (anticipated unlikely) event that additional Welsh Government funding is not approved in full a decision will need to be taken on halting the project and engaging with MWWFRS on the current enforcement notice in place.	Jun-24	Jun-24	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Low	R5. The derogation schedule should be enhanced to accurately depict the timelines for when each derogation was proposed, internally approved and sign off by the MWWFRS. Matter Arising 3: Approvals – Derogations (Operation)	Agreed. Derogation schedule will be updated accordingly.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R6. Management should continue to work with the Supply Chain Partner to ensure that subcontractors are promptly paid for certified work. Matter Arising 4: Financial – Project Bank Account (Operation)	Agreed. The timely payment of subcontractors will continue to be monitored and raised with the SCP.	Jun-24	Jun-24	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Low	R7. Efforts should be increased to obtain opt-out forms from subcontractors that chose not to participate in the Project Bank Account. Matter Arising 4: Financial – Project Bank Account (Operation)	Agreed. The SCP will be asked again to provide the opt-out forms for appropriate subcontractors.	Jul-24	Jul-24	Amber

Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R10. Assurance should be sought that any delays attributed to the Supply Chain Partner (or it's appointed design team) in relation to the underground ducts that impact the overall programme (and any associated cost impact) will not be the responsibility of the UHB. Matter Arising 5: Programme Management – Amendments (Operation)	Agreed. The UHB's advisers will be instructed to seek assurances from the SCP surrounding any potential delays to the underground ducts.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R11. An evaluation of performance to date should be undertaken to inform future phases of the fire enforcement works. Matter Arising 6: Performance Management – Performance Information (Design)	Agreed. An initial meeting had been held to discuss lessons learned and the arrangements for future phases to inform phase 2 works. This will be completed and reported to the Project Group. This is a joint task and finish group with NWSSP.	Aug-24	Aug-24	Amber
Apr-24	2024/25	Internal Audit	Glangwili General Hospital - Fire Precautions Phase 1 Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R12. Performance management information regarding the prompt rectification of snags, defects, etc., should be consistently provided, highlighting trends monthly. This reporting should include details on completed items, outstanding issues, and other relevant updates Matter Arising 7: Supervisor Role – Performance Information (Design)	Agreed. The supervisor will be requested to provide the required additional performance information as part of their June 2024 report. Note reports received form MWWFRS had been hugely supportive of the quality of workmanship report within this phase 1 fire programme.	Jun-24	Jun-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R2. Ensure Care Inspectorate Wales is informed of any significant changes to the service	To develop standard operating procedure for reporting of significant changes and events to Care Inspectorate Wales which meets the requirement of Regulation 31	Jul-24	Jul-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R3. Ensure the statement of purpose is regularly reviewed and reflects a current and accurate reflection of the service provided	To complete the online self assessment of service statement through the CIW portal	Jul-24	Jul-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R4. Ensure all staff working at the nursery receive regular supervisions and appraisals	To undertake appraisals for all staff within the creche and ensure that the Health Board target of 85% as a minimum is achieve.	Jul-24	Jul-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R8. Ensure that positive behaviour management strategies are developed	To review the positive behaviour management policy and ensure it reflect current best practice.	Jun-24	Jun-24	Amber

Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R8. Ensure that positive behaviour management strategies are developed	To ensure all staff have received and are following the updated positive behaviour policy (once approved)	Jul-24	Jul-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R9. Create an operational plan which is regularly reviewed to reflect the current running of the setting	To create an operational plan which reflects current running of the creche and ensure that the operational plan meets the organisational corporate standards for control documents.	Jun-24	Jun-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R11. Create policies and procedures that include 'prevent duty' and online safety	Awaiting management response	Oct-23	N/K	Red
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R12. Ensure parents are fully informed about changes to the setting, children's progress, routines and practices.	To undertake weekly spot checks to ensure daily reports to parents are completed. They will continue weekly until there is evidence that practice is routine.	Jun-24	Jun-24	Amber
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R14. Enhance and develop areas of continuous provision that promote curiosity and creativity	Awaiting management response	Oct-23	N/K	Red
Oct-23	2023/24	Care Inspectorate Wales	Withybush Hospital Creche October 2023	Open		Estates	Estates	Rob Elliott	Director of Operations		R15. This service does not provide an 'Active Offer' of the Welsh language and does not demonstrate a significant effort to promoting the use of the Welsh language and culture	Awaiting management response	Oct-23	N/K	Red
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R2. The provider must ensure all staff working at the setting receive regular supervisions and appraisals	To undertake appraisals for all staff within the creche and ensure that the Health Board target of 85% as a minimum is achieve.	Jul-24	Jul-24	Amber
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R5. The provider must ensure they complete the Self-Assessment of Service Statement	To complete the online self assessment of service statement through the CIW portal	Jul-24	Jul-24	Amber
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R6. The provider must ensure they inform Care Inspectorate Wales of any significant changes to the service	To develop standard operating procedure for reporting of significant changes and events to Care Inspectorate Wales which meets the requirement of Regulation 31	Jul-24	Jul-24	Amber

Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R7. Ensure that positive behaviour management strategies are developed	To review the positive behaviour management policy and ensure it reflect current best practice.	Jun-24	Jun-24	Amber
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R7. Ensure that positive behaviour management strategies are developed	To ensure all staff have received and are following the updated positive behaviour policy (once approved)	Jul-24	Jul-24	Amber
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R9. Ensure parents are fully informed about changes to the setting, children's progress, routines and practices.	To undertake weekly spot checks to ensure daily reports to parents are completed. They will continue weekly until there is evidence that practice is routine.	Jun-24	Jun-24	Amber
Mar-24	2023/24	Care Inspectorate Wales	Withybush Hospital Creche Follow-Up Report March 2024	Open		Estates	Estates	Rob Elliott	Director of Operations		R10. Ensure all staff undertaking school runs have received paediatric first aid training	To undertake a check of staff training records to identify where training is required and put in place a training plan	May-24	~~May-24~~ N/K	Red
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R2. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Door in Sub-compartment wall leading to R30 Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. 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 requirement.		Sep-24	Sep-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R3. The following rooms are to be cleared of all storage and kept locked shut when not in use. •Tech Room R39		Aug-24	Aug-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R4. The Smoke Detectors were found to be hanging from the ceiling in the following locations : •Reporting Room R16 •Tech Room R39 •BMC R31 They are required to be re-attached securely to the ceiling. All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017.		Jul-24	Jul-24	Amber

May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R5. Remove existing lock fastenings from door(s) indicated/located •Staff Rest room R49 If the door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally . satisfy the requirement.		Aug-24	Aug-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R6. Emergency routes and exits must lead as directly as possible to a place of safety. All routes to emergency exits including passages, gangways, corridors, lobbies and stairways forming part of the means of escape shall be kept clear and unobstructed. •Corridor R35 This is to allow persons to evacuate the premises as quickly and safely as possible.		Aug-24	Aug-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R7. Provide an internally illuminated exit sign incorporating a directional arrow .•BS40 Processing Signs should be designed and installed in accordance BS 5499- 4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.		Aug-24	Aug-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R8. The following 30 minute fire resisting doors were found to be damaged. These doors must be repaired/replaced. •D002A/B •Door to corridor R55 Fire doors should conform to a relevant standard e.g.Appendix B (including Appendix C Table B1) of Approvd 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 requirement		Sep-24	Sep-24	Amber

May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations		R9. The intumescent strips and cold smoke seals on the following fire resisting doors were found tb be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •BMC R31 •Staff Rest Room R49 •D194 (to Office R26) The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies - Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		Sep-24	Sep-24	Amber
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.		May-24	N/K	Red
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Switch Room is to be cleared of all storage and kept locked shut when not in use.		May-24	N/K	Red
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01		May-24	N/K	Red
May-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Emergency escape routes must be indicated by adequate escape signage. A notice `FIRE EXIT KEEP CLEAR' is to be provided at about eye level to the external side of final exit doors. Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.		May-24	N/K	Red
May-24	2024/25	Internal Audit	Reinforced Autoclaved Aerated Concrete Programme – Withybush General Hospital	Open	Substantial	Estates	Estates	Rob Elliott	Director of Operations	Low	R1. Highlight reports should be provided to the task and finish groups associated with the activities of the Supervisor, with any pertinent issues highlighted.	Agreed – Update reports will be provided to the Task and Finish Group.	Jul-24	Jul-24	Amber

May-24	2024/25	Internal Audit	Reinforced Autoclaved Aerated Concrete Programme – Withybush General Hospital	Open	Substantial	Estates	Estates	Rob Elliott	Director of Operations	Medium	R2. The UHB should establish a risk reporting arrangement for the remaining elements of the RAAC programme that clearly interlinks with the UHBs established risk management processes.	Agreed – Construction risk registers will be in place for the remaining elements of the works. A capital highlight report (including risks, time, cost etc) will be supplied to the Task and Finish Group.	Jul-24	Jul-24	Amber
May-24	2024/25	Internal Audit	Reinforced Autoclaved Aerated Concrete Programme – Withybush General Hospital	Open	Substantial	Estates	Estates	Rob Elliott	Director of Operations	Medium	R3. The programme reporting arrangements should follow the established standardised approach to reporting within the Capital Sub-Committee papers.	Agreed – An updated highlight report will be prepared by Estates and included for submission within the Capital SubCommittee Governance Update paper	Aug-24	Aug-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures valuated in the fire risk assessment must be implemented		May-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01		May-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Emergency escape routes must be indicated by adequate escape signage. Directional signage should be provided at; •Rear escape route through the garden area. Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.		May-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Ensure emergency lighting system is working correctly (which is to be independent of all other systems), to illuminate •Rear escape route through the garden area.		May-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Ceiling tiles in the following areas were found to be damaged, •Room 50 Sluice Ceiling tiles should be repaired or replaced to provide or reinstated a 30 minutes standard of fire resistance . The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses		May-24	N/K	Red

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. During the inspection the self-closing devices on the doors located at; •Staff kitchen Were found to be missing and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies - Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		May-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The following 30 minute fire resisting doors were found to be damaged/defective . These doors must be repaired/replaced. •Cross corridor next to R68 (Gaps) •D006A/B (Gaps & Strips/Seals} •Cross Corridor next to R25 (Keyhole & Damage} •Door to R59 (Strips/Seals} •Cross Corridor doors R58 (Strips/Seals} 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 requirement.		Jun-24	N/K	Red
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented .		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The opening in the ceiling in the following location: 0135 IT Server Room should be in-filled with non-combustible materials, to provide 60 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. . Compliance with this or an equivalent standard will normally satisfy the requirement.	Action plan held by Estates team.	Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Confirm that the following hatches located: •In the corridors, above bedrooms, are fire resisting. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Extend the .existing fire detection and warning system by providing automatic smoke detection in the following areas: •Tea room - LSU •Service ducts All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following 30-minute fire resisting doors were found to be damaged/defective.These doors must be repaired/replaced. •3037 •Store R30 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 requirement		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missi ng. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •First floor Office 007 •LSU Meeting room 006 •LSU Dining room 0066 •Cross-Corridor doors PICU next to dining room The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies - Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The ceiling hatch and surrounding ceiling in LSU Food Prep were found to be damaged, they should be repaired or replaced to provide or reinstated a 30 minutes standard of fire resistance. The fire resistance should conform to a r.elevant standard e.g. Appendix A (including Table A1 A2} of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen,Jobs Well Road,Carmarthen SA31 3HB	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. The Responsible Person must ensure that his employees are provided with adequate safety training, and that the training is repeated periodically at appropriate intervals. The percentage for training completion was lower than average for staff on PICU and LSU Ward		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position. Doors that are required to be self-closing may be held in the open position by the installation of automatic door releases, providing: - (a) The door release mechanism conforms to British Standard 5839: Part 3, and fails safe, i.e. in the event of a fault or loss of power, the release mechanism is triggered automatically; (b) All doors fitted with automatic door releases are linked to an automatic fire warning system which complies with British Standard 5839: Part 1. (c) All automatic door releases in the premises are triggered by any one of the following: - (i) the actuation of any automatic fire detector; (ii) the actuation of any manual fire alarm call point; (iii) any fault in the fire warning system; and (iv) any loss of power to the fire warning system. (d) The doors are capable of being closed manually; (e) The release mechanisms are tested at least once each week in conjunction with the fire alarm test to ensure; (i) the mechanisms are working effectively; and (ii) the doors close effectively onto their frames. (f) The automatic door release is fitted as close as possible to the selfclosing device to reduce the possibility of the door becoming distorted; (g) The fire warning system and the release mechanisms are subject to a competent and effective maintenance contract.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Continue to action the significant findings of your Fire Risk Assessments within the agreed timescales		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. All passages, corridors and staircases forming part of an escape route are to be kept free of any obstructions or combustible materials. Particular attention is to be paid to the following areas: • Level 2 plant area – storage in the means of escape • Level 1 day surgery - storage in the means of escape • Storage under the staircase at the back of A&E		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. It is essential all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time. Evidence of this training must be made available to fire safety inspecting officers when they audit your premises.It is good practise to have a live evacuation training session to ensure the evacuation procedure is suitable and sufficient.		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position. Doors that are required to be self-closing may be held in the open position by the installation of automatic door releases, providing: - (a) The door release mechanism conforms to British Standard 5839: Part 3, and fails safe, i.e. in the event of a fault or loss of power, the release mechanism is triggered automatically; (b) All doors fitted with automatic door releases are linked to an automatic fire warning system which complies with British Standard 5839: Part 1. (c) All automatic door releases in the premises are triggered by any one of the following: - (i) the actuation of any automatic fire detector; (ii) the actuation of any manual fire alarm call point; (iii) any fault in the fire warning system; and (iv) any loss of power to the fire warning system. (d) The doors are capable of being closed manually; (e) The release mechanisms are tested at least once each week in conjunction with the fire alarm test to ensure; (i) the mechanisms are working effectively; and (ii) the doors close effectively onto their frames. (f) The automatic door release is fitted as close as possible to the selfclosing device to reduce the possibility of the door becoming distorted; (g) The fire warning system and the release mechanisms are subject to a competent and effective maintenance contract.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Items preventing the fire doors from closing effectively into their rebates, in the laundry corridor are to be re-located to a more suitable location. Particular attention is to be paid to the electrical switch room.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The underside of the mezzanine floor and staircase are to be underdrawn to provide a minimum of 30-minutes standard of fire resistance		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Continue to action the significant findings of your Fire Risk Assessments within the agreed timescales.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. It was identified during the inspection that the managers fire door was being held open by staff, due to issues with not being able to hear the Cardiac Alarm activating on the Level 3 Dyfi Ward. Your Fire Risk assessment should be reviewed, updated and communicated to the appropriate members of staff, to ensure the door is shut in the event of a fire.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The general housekeeping in the following areas is considered unacceptable. Combustible items store within close proximity of ignition sources are to be re located to a more suitable location: • Fuse board areas Level 2 • Electrical room MRI fuse board • Old linen room next to Meurig Ward		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The Meurig Ward is currently unavailable for utilisation for horizontal evacuation, due to current building works. Your existing evacuation plan for the Angharad children's ward to evacuate into the Meurig Ward is to be reviewed, updated and communicated to all staff.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. Oxygen cylinders are to be stored within a 30-minute fire resisting compartment.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. The existing fire detection and warning system is to be extended to provide adequate cover in the following areas: • Level 4 Cleaners Cupboard • Level 0 store cupboard in hotel services The extensions are to comply with the current edition of British Standard 5839: Part 1 - Fire Detection and Alarm Systems in Buildings.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. Confirmation is required that the old detector head in the paint store, in the Boiler Room, is linked and working with the current BS5839: Part 1 fire detection and warning system within the premises.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R11. The Manual Call Point located in the external carpenter's workshop is obstructed. This is not acceptable. The call point should be readily available for use, at all material times.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R12. All passages, corridors and staircases forming part of an escape route are to be kept free of any obstructions or combustible materials.Whilst there are storage issues throughout the block, particular attention is to be paid to the following areas: • Angharad ward stairwell – chair and notice board in the escape route • Waste bins in lift lobby on Level 4 • Level 3 escape routes, including the storage of hoists • Storage of combustible materials above lockers in the laundry area		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R13. Replace the lock(s) on the following door(s) with a fastening that can be opened easily and immediately, from the inside, during an emergency, without the use of a key: • Pharmacy – back office		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R14. The emergency lighting unit in the location detailed below, is to be relocated to the other side of the fire doors: • Outpatients to MRI		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R15. It is essential all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time. Evidence of this training must be made available to fire safety inspecting officers when they audit your premises.It is good practise to have a live evacuation training session to ensure the evacuation procedure is suitable and sufficient.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position. Doors that are required to be self-closing may be held in the open position by the installation of automatic door releases, providing: - (a) The door release mechanism conforms to British Standard 5839: Part 3, and fails safe, i.e. in the event of a fault or loss of power, the release mechanism is triggered automatically; (b) All doors fitted with automatic door releases are linked to an automatic fire warning system which complies with British Standard 5839: Part 1. (c) All automatic door releases in the premises are triggered by any one of the following: - (i) the actuation of any automatic fire detector; (ii) the actuation of any manual fire alarm call point; (iii) any fault in the fire warning system; and (iv) any loss of power to the fire warning system. (d) The doors are capable of being closed manually; (e) The release mechanisms are tested at least once each week in conjunction with the fire alarm test to ensure; (i) the mechanisms are working effectively; and (ii) the doors close effectively onto their frames. (f) The automatic door release is fitted as close as possible to the selfclosing device to reduce the possibility of the door becoming distorted; (g) The fire warning system and the release mechanisms are subject to a competent and effective maintenance contract.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Confirmation is required that the fusible link to the shutter of the old ventilation duct, within the level 7 plant room is still fully operable. If the shutter is not working it is either to be restored to full working order, or the gap sealed to provide a minimum of 30 minutes fire resisting separation.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Continue to action the significant findings of your Fire Risk Assessments within the agreed timescales.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Oxygen cylinders are to be stored within a 30-minute fire resisting compartment.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The existing fire detection and warning system is to be extended to provide adequate cover in the following areas: • ITU roof plant – heat detection • Electrical fuse board risers – smoke detection The extensions are to comply with the current edition of British Standard 5839: Part 1 - Fire Detection and Alarm Systems in Buildings.		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. During the inspection, a number of fire extinguishers were found to have defective or missing tamper tags. The effected extinguishers are to be examined by a competent person, to ensure they are still fit for purpose and re-tagged accordingly.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. All passages, corridors and staircases forming part of an escape route are to be kept free of any obstructions or combustible materials. Whilst there are storage issues throughout the block, particular attention is to be paid to the theatre areas on level 7 and lab west on level 3		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The surfaces of all external routes of escape are to be maintained in good condition with regular clearance of excessive undergrowth or overhanging shrubbery. Particular attention is to be paid to the following area: • Final exit out of green level 2 lift lobby.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Replace the lock(s) on the following door(s) with a fastening that can be opened easily and immediately, by a single action, from the inside, during an emergency. The locks must be openable without the use of a key: • HSDU entry door, as identified during		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. The emergency lighting system is to be extended to provide adequate illumination throughout the following areas: • Microbiology lab final exit. The extension is to comply with the appropriate current edition of British Standard 5266, Part 1		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R11. The emergency light in the area detailed below is to be restored to full working order: • Unit serving the final exit in HSDU		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R12. It is essential all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time. Evidence of this training must be made available to fire safety inspecting officers when they audit your premises.It is good practise to have a live evacuation training session to ensure the evacuation procedure is suitable and sufficient.		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. It is important to ensure that self-closing fire resisting doors are not propped or wedged in the open position. Doors that are required to be self-closing may be held in the open position by the installation of automatic door releases, providing: - (a) The door release mechanism conforms to British Standard 5839: Part 3, and fails safe, i.e. in the event of a fault or loss of power, the release mechanism is triggered automatically; (b) All doors fitted with automatic door releases are linked to an automatic fire warning system which complies with British Standard 5839: Part 1. (c) All automatic door releases in the premises are triggered by any one of the following: - (i) the actuation of any automatic fire detector; (ii) the actuation of any manual fire alarm call point; (iii) any fault in the fire warning system; and (iv) any loss of power to the fire warning system. (d) The doors are capable of being closed manually; (e) The release mechanisms are tested at least once each week in conjunction with the fire alarm test to ensure; (i) the mechanisms are working effectively; and (ii) the doors close effectively onto their frames. (f) The automatic door release is fitted as close as possible to the selfclosing device to reduce the possibility of the door becoming distorted; (g) The fire warning system and the release mechanisms are subject to a competent and effective maintenance contract.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The gap at the head of the fire door serving the Air Plant room, is to be sealed to provide a minimum standard of 30 minutes fire resistance.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The unauthorised locks on fire doors in the Banwy annex are currently preventing self-closing devices from working effectively. These locks are to be removed with immediate effect.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Continue to action the significant findings of your Fire Risk Assessments within the agreed timescales.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. It was identified during the inspection that a large section of the ceiling between Level 3 and the Level 4 attic space is not fire rated. It was explained to me that the attic space has been 'zoned off' to reduce the risk of extended fire spread from the ward into the attic space. Your fire risk assessment is to be reviewed and updated to include this information		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Oxygen cylinders are to be stored within a 30-minute fire resisting compartment		Dec-24	Dec-24	Amber

Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The existing fire detection and warning system is to be extended to provide adequate cover in the following areas: • Former changing room (Rhiannon west annex) • Disposal hold by upper link bridge (Rhiannon ward lobby) • ECG room • Corridor serving cardiology The extensions are to comply with the current edition of British Standard 5839: Part 1 - Fire Detection and Alarm Systems in Buildings		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. All passages, corridors and staircases forming part of an escape route are to be kept free of any obstructions or combustible materials. Particular attention is to be paid to the following areas: • Rhiannon ward stairwell – chair in the escape stairs • All escape routes • Medical chairs and equipment being charged in escape routes on Level 2		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Notices detailing the action to be taken in case of fire are to be displayed in staff areas, adjacent to fire alarm call points and to fire points. The notices are to conform to British Standard 5499: Part 1 i.e. be predominantly blue in colour with white lettering.		Dec-24	Dec-24	Amber
Jun-24	2024/25	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. It is essential all staff, including agency and temporary staff, are fully trained in evacuation procedures for the premises. You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of residents to safety within the determined safe evacuation time. Evidence of this training must be made available to fire safety inspecting officers when they audit your premises.It is good practise to have a live evacuation training session to ensure the evacuation procedure is suitable and sufficient.		Dec-24	Dec-24	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Apr-23	2022/23	Internal Audit	Regional Integration Fund	Open	Reasonable	Finance	Finance	Director of Finance	Director of Finance	High	R1. The UHB as "Host" for the RIF Finances, work with the Regional Partnership Board to ensure an agreed Memorandum of Understanding is in place explicitly setting out the Health Board and other key partners roles and responsibilities for the governance and accountability arrangements of RIF for the next financial year.	We will ensure that we work with the RPB to finalise the MoU which clearly sets out the key roles and responsibilities for the governance and accountability arrangements for RIF for the next financial year.	Jun-23	~~Jul-23~~ ~~Sep-23~~ N/K	External

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Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Central Operations	Gareth Rees	Director of Operations	High	R2. While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgenc	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Dec-23	~~Dec-23~~ Sep-24	Red
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Performance	Tracy Price	Director of Finance	High	R3. While performance arrangements exist at an operational level, there is scope to bring these together into a holistic review of performance. Alongside the rollout of its Improving Together Framework, the Health Board should revisit its performance management arrangements to ensure that there is a joined up approach at an operational level.	Our Improving Together framework has been developed over the last 18 months and deployed within a number of pilot areas. Following this progress, the approach was agreed with the Executive Team in December 2022 for it be used for Directorate level performance management arrangements. The Framework aligns teams to our strategic objectives and what matters to us as a health board. It focusses on key improvement measures identified by the directorate and team and regular coaching style discussions around how we are performing and whether additional improvements need to be made. These discussions are supported by "Our Performance" and "Our Safety" dashboards which provide triangulated data sets from across quality and safety, performance, risk and finance. The Directorate level sessions are holistic, covering performance, safety, quality workforce, finance and planning. The Director of Operations will chair these sessions monthly and will be supported by the Executive Directors of Finance (with executive responsibility for Performance), Director of Strategic Development and Operational Planning, Director of Workforce and OD and Director of Nursing. Additional executive colleagues will be invited to attend if required. The sessions will focus on any concerns that teams wish to escalate, which may originate from the data in the dashboard and progress around KPIs for each team. These sessions have been scheduled to commence on the 30th and 31st January 2023.	Dec-22	Sep-24	Red
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Finance	Andrew Spratt	Director of Finance	High	R6. The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	The 2023/24 planning cycle is underway which will, with Board approval, reflect the challenges that have been experienced during 2022/23. Opportunities have been clearly articulated, and the planning cycle will be the vehicle for teams across the Health Board to deliver sustainable plans in the areas highlighted as opportunities, as well as undertaking their delegated financial responsibilities to review and deliver all efficiency and benchmarking opportunities. With the unprecedented demand challenges that have been experienced, the financial overspends have resulted in a significant deterioration to our deficit. The recovery plan will need to be cognisant of the impact which these demand challenges are having across our system.	Mar-24	~~Mar-24~~ Jun-24	Red

Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Nursing	Director of Corporate Governance	Director of Corporate Governance	N/A	R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes. However, those we interviewed were unclear what happens to the notes afterwards. The Health Board should: b) report back on walkabout themes, twice a year, for example, through the Quality Assurance Report received by the Quality, Safety and Experience Committee (Medium Priority).	Consideration will be given to providing a Patient Safety Walk Round update to Board members at a future Board Seminar. To be forward work planned through the Director of Corporate Governance/Board Secretary.	Jul-24	Jul-24	Amber
Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Finance	Director of Corporate Governance	Director of Corporate Governance	N/A	R3. Performance Management Arrangement Assurance Given the Health Board is under Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended.	We will commission an annual review of the effectiveness of the Improving Together Framework from Internal Audit. We will ask for the first review to be undertaken during Q1 2024/25.	Jun-24	Jun-24	Amber
Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Strategic Development and Operational Planning	Director of Corporate Governance	Director of Corporate Governance	N/A	R4. Aligning planning and strategic objectives The Health Board has taken steps to better articulate its planning objectives in its 2023-24 Annual Plan, by streamlining the planning objectives and setting them against eight strategic planning goals and four domains. However, the domains and strategic planning goals do not explicitly align to the Health Board's six overarching strategic objectives, as detailed in its Board Assurance Framework (BAF) and Integrated Performance Assurance Report (IPAR) dashboards. As part of the next planning cycle, the Health Board should more explicitly set out how each of its planning objectives link to its strategic objectives.	A process and action plan has been detailed as part of the Planning Cycle for the development of the 2024/25 Plan. This process and action plan (as detailed in the annex), sets out the process for reviewing the Strategic Objectives, the Planning Objectives and the removal of the four planning domains to simplify the process. Steps are also included to ensure the appropriate alignment of Planning Objectives to the appropriate Committees of the Board for assurance purposes, and the revision of the BAF.	Mar-24	~~Mar-24~~ Oct-24	Red

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Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Long Term Care	Mental Health & Learning Disabilities	Jill Paterson	Director of Primary Care, Community and Long Term Care	Low	R1. Progress updates on the development of the referral spreadsheet and web-based referral form should be provided regularly to management.	The Digital Project Support request submitted to the IT team was agreed in October 2023. The implementation of this project will commence once resources have been confirmed and allocated.	Mar-24	~~Mar-24~~ N/K	Red

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	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~~ N/K	Red
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as “attend anywhere” – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties. The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	~~Mar-24~~ N/K	Red
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	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~~ ~~Dec-23~~ Dec-24	Red
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R1. The outbreak has not yet concluded and the high level of latent TB infection in the population implies further risk. This risk is heightened because the active disease in this population is predominantly pulmonary and therefore more infectious. Although the level of active TB infection is low in West Wales, delayed presentation in unrecognised cases may lead to further outbreaks and deaths. The level of awareness amongst the public and their health care professionals must be therefore increased and maintained. This also applies to trainee health professionals.	To manage the risk of the outbreak and raise awareness amongst the public and Healthcare Professionals, to reduce the risks of any future outbreaks.	Jun-23	~~Jun-23~~ N/K	External

Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R2. Any future outbreaks should be overseen by PHW from the outset with a TB -specific standard operating procedure for the conduct and recording of outbreak management. The current SOP and OCT policy needs to be updated in this respect. The latter needs to be developed alongside modern data analysis and WGS typing so that outbreaks are identified and contained. Comprehensive contact networks of all cases should be recorded electronically and plotted with social network analyses undertaken to ensure links between cases are uncovered quickly and easily.	To work with PHW to create a Standard Operating Procedure and updated OCT policy. Development of a revised methodology for managing contact networks and analyses to ensure links between cases are uncovered quickly and easily.	Jul-23	~~Jul-23~~ N/K	External
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R3. Funding should be identifiable ahead of time for outbreaks of infectious diseases so that such outbreaks can be managed in a timely and effective manner without the need for time-wasting discussion.	To develop an agreed service modeland contingency plans for resourcing any future outbreak	Jul-23	~~Jul-23~~ N/K	External
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R5. At a national level, the Cohort Review Programme needs to be supported with adequate funding for each contributing health board.	To agree a plan with WG, other HB's & External Partners to agree an adequate funding model	N/K	N/K	External
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R6. Welsh Government should support both the Cohort Review Programme and the proposal for a National Service Specification that includes the development of a TB pathway to tackle delayed diagnosis (e.g. investigating cough lasting longer than three weeks).	To work with WG and PHW to agree a way forward for the cohort Review Programme and the National Service Specification	N/K	N/K	External
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R7. Wales does not seem to be properly prepared for the challenges of new migrants, refugees, and the occurrence of future drug resistance. These factors should be included in a future TB plan supported and funded by Welsh Government.	To work with WG and at an All Wales level to agree a TB Plan which addresses the shortfalls highlighted for new migrants, refugees and the occurrence of future drug resistance.	N/K	N/K	External

Dec-22	2022/23	Internal Audit	Individual Patient Funding Requests	Open	Reasonable	Medical	Medical	Head of Effective Clinical Practice & QI	Medical Director	High	R1. The IPFR Team, Finance and Pharmacy should collectively agree and establish a suitable mechanism for capturing and monitoring IPFR spend to ensure that approved costs and treatment duration are not exceeded. Noting that the IPFR budget sits outside of the IPFR Team, responsibility and arrangements for monitoring cumulative IPFR spend should be agreed. If this is outside of Finance (as budget holder), sufficient information needs to be provided Clarify ownership and accountability for the IPFR budget, including responsibility for monitoring spend.	To agree a mechanism with Finance (budget holder) and pharmacy to ensure spend is monitored and not exceeding the approved treatment duration. Agree a reporting process for monitoring cumulative IPFR spend against defined budgets and within standing budgetary control requirements.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Nov-23~~ ~~Mar-24~~ Jul-24	Red
Apr-23	2023/24	Health Education and Improvement Wales (HEIW)	Surgical Specialties Glangwili General Hospital	Open	N/A	Medical	Unscheduled Care (GGH)	Head of Medical Education & Professional Standards	Medical Director	N/A	R10. That HEIW will increase the risk rating assigned to these concerns and arrange a further visit for 6 months. An interim catch-up meeting will be scheduled for three months in order to assess progress.	No formal management response presented in PODCC June 2023. Date of visit has yet to be confirmed.	N/K	~~Apr-24~~ N/K	External
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R1. Improve engagement and support for the International Medical Graduates within the Health board. Include information regarding the appraisal requirements on the MARs system, at induction, training sessions and in newsletters	HEIW team - consider allocating an Appraisal Lead to oversee their first appraisals. we only have 2 appraisal leads and the IMGs are numerous, this may overload our Leads. This will be considered following appraiser and appraisal lead recruitment	Dec-23	~~Dec-23~~ ~~Apr-24~~ Aug-24	Red
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R2, Identify a new Independent Member	Awaiting new IP to be announced.	Sep-23	~~Sep-23~~ ~~Dec-23~~ ~~May-24~~ N/K	Red
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R5. Identify Appraisal Leads for Withybush and Glangwili	MH&LD to be split between the site appraisal leads. Appraisal lead to be identified for Withybush and additional appraisal lead to cover Glangwili to reduce the numbers of appraisers being led by Mr Gadgil (currently covering both Prince Philip and Glangwili).	Apr-24	~~Apr-24~~ Aug-24	Red
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R6. Consider holding an internal quality assurance event.	HW & DS to attend a Swansea Bay event due to take place 04/09/2023. Once completed; Hywel Dda event to be planned.	Aug-24	~~Aug-24~~ Nov-24	Amber
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R7. Current appraisal leads to quality assure the first 2-3 summaries for all new appraisers.	Existing appraisal leads quality assure the summaries of those they lead but this is currently not consistent across the Health Board. Examples of good practice to be shared with appraisal leads along with AL to Appraiser Feedback template.	Aug-24	Aug-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	Medium	R1. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15-month period of the last review with a view of attaining the 90% compliance target.	Proposal to allocate clinicians with allocated quarters in which job plan reviews should be carried out each year. Job plan sommunications and non-compliance process will then mirror that of the appraisal process, which has proved effective.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	Medium	R1. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15-month period of the last review with a view of attaining the 90% compliance target.	Job plan needs to be completed in the quarter prior to appraisal, Professional standards lead to arrange for SDMs to be informed of Dr's appraisal quarter	Jul-24	Jul-24	Amber

Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	Medium	R1. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15-month period of the last review with a view of attaining the 90% compliance target.	Letter to be circulated from Medical Director to all SDMs and Consultants to inform them that an update job plan will be required prior to appraisal.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	Medium	R1. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15-month period of the last review with a view of attaining the 90% compliance target.	Service Delivery Managers and Clinical Leads to set up rolling programme of annual job planning compliance.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	High	R2. Service Delivery Managers should: - explicitly set out service outcomes in all consultant job plans to allow for personal outcomes to be accurately aligned to the directorate and/or specialty needs; - ensure SPA are outlined and linked to clear objectives within all consultant job plan; and - agree in discussion with the consultant their personal objectives.	Discussion with LNC regarding the expectation on SPA's in job planning.	Aug-24	Aug-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	High	R2. Service Delivery Managers should: - explicitly set out service outcomes in all consultant job plans to allow for personal outcomes to be accurately aligned to the directorate and/or specialty needs; - ensure SPA are outlined and linked to clear objectives within all consultant job plan; and - agree in discussion with the consultant their personal objectives.	Monitoring arrangements to be developed using the Directorate Improving Together process for Operational Teams, working with the Performance Team to ensure that there is a regular review of: - Accurate service outcomes - Clearly outlined SPA's that are linked to clear objectives - Agreement and discussion of personal objectives during the job planning process	Sep-24	Sep-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	High	R2. Service Delivery Managers should: - explicitly set out service outcomes in all consultant job plans to allow for personal outcomes to be accurately aligned to the directorate and/or specialty needs; - ensure SPA are outlined and linked to clear objectives within all consultant job plan; and - agree in discussion with the consultant their personal objectives.	Amend the Allocate system SPA activity drop down list to ensure more detailed information is recorded and can be confirmed on acceptance of job planning.	Jul-24	Jul-24	Amber
Apr-24	2024/25	Internal Audit	Follow-up: Consultant Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	High	R3. To ensure the contractual detail of all job plans (recorded on Allocate) and ESR are correctly aligned: - service management should review all consultant job plan to ensure session totals accurately reconcile to ESR. Where variances are identified, a change form should be promptly submitted to NWSSP Payroll Services; - the Medical HR Team should continue to develop and rollout a regular audit programme to ensure consultant sessions and additional pay elements (obtained for the new report) are accurate and correct; and - a review of the seven sessional total discrepancies identified during follow up testing should be investigated and rectified as necessary, whilst the remaining four instances of over/under payments identified in our previous audit should be promptly resolved	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.1 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Original baseline to be reviewed with discussions to commence with managers and individual consultants to understand difference between ESR and allocate. Monitoring arrangements to be developed using the Directorate Improving Together process for Operational Teams, working with the Performance Team to ensure that there is a regular review of the baseline assessment. Change forms should be submitted to NWSSP and be supported with an up-to-date signed job plan. Introduction of Allocate E-roster for Medics will support with the monitoring going forward, however, introduction of this will be during 2024/2025.	Oct-24	Oct-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R1. The Health Board must ensure that the departmental induction adequately prepares trainees for their roles in the department.	Review current departmental induction arrangements to ensure that sufficient information is provided to prepare the trainees.	Aug-24	Aug-24	Amber

Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R2. The Health Board must ensure that Educational and Named Clinical Supervisors and trainees have timely and effective interactions to ensure support for education and curriculum delivery	A programme of meetings is to be scheduled in to Educational and Clinical Supervisor calendars so that the appointments are organised well in advance. Dates to be communicated with trainees when they start in the department.	Aug-24	Aug-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R3. The Health Board must ensure that there are effective handovers.	Establish clinical lead for cross-cover induction	Mar-24	Aug-24	Red
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R3. The Health Board must ensure that there are effective handovers.	Continue PDSA cycles to monitor adherence to SOP	May-24	~~May 24~~ Aug-24	Red
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R4. The Health Board must ensure that trainees are able to access training opportunities including theatre time.	Timetable detailing clinical activity to be provided to the trainees so that they know what is available, when and who to contact to attend.	Aug-24	Aug-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R5. The Health Board must ensure that the rota continues to be delivered in its current format with twilight shifts and additional weekend cover, which will require further permanent roles to achieve that.	This will need financial support for long term rota change and this will need to be approved at Executive Level.	Jun-24	Jun-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R6. The Health Board must ensure there are effective means for staff to speak up safely if exposed to inappropriate behaviours, including misogyny. There also need to be effective mechanisms to address it.	Educational film to be created which sets out scenarios which include unprofessional behaviours and will include misogyny. The film will include a signposting section and will provide information on speaking up safely.	Aug-24	Aug-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R6. The Health Board must ensure there are effective means for staff to speak up safely if exposed to inappropriate behaviours, including misogyny. There also need to be effective mechanisms to address it.	Ensure that the Speaking up Safely page on the intranet is included as part of the new doctor induction	Aug-24	Aug-24	Amber
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R7. The Health Board must ensure there this adequate support for trainers to enable them to effectively deliver their roles.	Appropriate time to be allocated in job plans in accordance with job plan activity tariffs.	Mar-24	Mar-25	Red
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R7. The Health Board must ensure there this adequate support for trainers to enable them to effectively deliver their roles.	Ensure that doctors have an up to date job plan.	Mar-24	Mar-25	Red
Mar-24	2023/24	Health Education and Improvement Wales (HEIW)	Trauma and Orthopaedics Glangwili Hospital March 2024	Open	N/A	Medical	Scheduled Care	Head of Medical Education and Professional Standards	Medical Director	N/A	R8. The Health Board should consider how to amalgamate patients onto fewer wards.	The Glangwili Hospital Management Team is currently leading a review of the overall bed model for the site, which includes provision of appropriate bed capacity for Orthopaedic Trauma patients along with other specialities requirements. A target date for implementation is currently being assessed.	Mar-24	Mar-25	Red

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Jun-15	2015/16	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Chris Brown	Director of Primary Care, Community & Long Term Care	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	~~N/K~~ Mar-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.1 Reducing time spent by pharmacy professionals on non-clinical activities a) The Welsh Government will commission a review of opportunities to improve the efficiency of hospital medicines supply and logistics arrangements and release pharmacist and pharmacy technician time for clinical care	N/A - for consideration by Welsh Government.	Sep-24	Sep-24	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS a) Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Mapping in progress to ascertain where current investment is and what the demands currently are in those areas and understand where there are opportunities that are not being covered yet.	Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS b) Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Currently informal and based on funding. To follow from stocktaking action above (R1.2a).	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS c) Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists are designated to support clinical divisions/directorates based on the results of the resource mapping exercise	To follow on from stocktaking action in R1.2a	Apr-25	Apr-25	Amber

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS d) Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Informal triaging undertaken by pharmacy teams, prioritisation tool under development by clinical lead pharmacists and chief technicians. Planning for digital prioritisation method with the introduction of ePMA	Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams a) Where a clinical pharmacy service is provided to a clinical division(s)/ directorate(s) or clinical area, health boards and Velindre University NHS Trust should establish: i) a formal agreement defining the nature and extent of the service and the specific role(s) of any advanced practice and consultant pharmacists involved in the provision of the service, as set out in their job plan(s) ii) the agreement should set out clearly the arrangements for managerial, clinical, and professional accountability	Services based on historic levels. SLA to be developed detailing levels of service to be provided to areas and accountability arrangements. Currently no SLAs in place for clinical services.	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams b) Health boards and Velindre University NHS Trust should determine the demand profile for pharmacy services in all clinical areas and ensure working patterns of pharmacy teams are aligned to patient and service needs. This should include times when pharmacy services may not currently be being provided and should ensure provision wherever it is needed, seven days a week	Following stocktake action (R1.2a), need to develop demand plan, Subsequent resource map needed to understand demand profile and capacity gap.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams c) Health boards and Velindre University NHS Trust should ensure the requirements for clinical and non-clinical pharmacy services are considered in all new service developments and in any clinical service redesign.		Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.4 Realising the potential of pharmacist prescribing a) Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists in clinical roles are or are training to be, prescribers	No consultant or advanced practice pharmacists in post. 67% of pharmacists in hospitals in the HB are Independent prescribers	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.4 Realising the potential of pharmacist prescribing b) The Chief Pharmacists' Peer Group should establish a multidisciplinary short life working group to agree how recommendations 12 and 13 of the RPS's review relating to pharmacist prescribing should be implemented		Apr-25	Apr-25	Amber

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.5 Improving pharmacy support to meet the NHS stated priorities a) Health boards should ensure all Urgent and Emergency Care settings receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams within all Emergency Departments and Same Day Emergency Care units as a priority	Current clinical pharmacy services provide support to these areas. Recruitment into SDEC units has been challenging, need review in where this fits into current service provision and where training needs lie. Pharmacists working within Emergency Departments may not be prescribers or are not actively prescribing within the role.	Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.5 Improving pharmacy support to meet the NHS stated priorities c) Health boards should review and where necessary amend, the working patterns and contractual hours of pharmacy teams to ensure they are aligned with service demand in Emergency Departments and Same Day Emergency Care units	Pharmacist and pharmacy technician input into ED patients across the health board. SDEC recruitment in progress to reinvigorate service.	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.5 Improving pharmacy support to meet the NHS stated priorities d) Health boards should ensure planned care services receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams, prioritising pharmacist prescriber roles in pre-admission and pre-habilitation services	Pharmacists currently available to give advice to pre-admission services. Discussions underway in sites to understand the demand. Should also be highlighted in stocktake action	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.6 Pharmacy's role in optimising patient flow b) Health boards and Velindre University NHS Trust should establish and fully implement their patient medicines self-administration policies to enable patients to manage their own medicines whilst they are in hospital	Self administration policy has been used in some sites, lack of suitable patient lockers and size of policy is a barrier. Being reviewed alongside nursing.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.6 Pharmacy's role in optimising patient flow c) The Welsh Government will commission updated messaging encouraging patients to bring their regular medicines to hospital, supported by national communications activitiea		Apr-25	Apr-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1.6 Pharmacy's role in optimising patient flow e) Pharmacy teams should ensure that all patients requiring post-discharge support with their medicines are referred to the most appropriate community services (e.g. a medicines review by GP or GP practice pharmacist, or a community-based/domiciliary medicines service)		Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.1 Improving pharmacy workforce planning a) Health boards and Velindre University NHS Trust should ensure their organisational workforce plans take account of the benefits of integration of pharmacy professionals in multi-disciplinary teams	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs	Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.1 Improving pharmacy workforce planning b) Health boards and Velindre University NHS Trust chief pharmacists should ensure the organisation has a pharmacy workforce plan to support and expand advanced and consultant pharmacist practice and to identify more clinical roles for pharmacy technicians	Work currently ongoing to develop workforce plan. Beginning planning for development and training of consultant and advanced practice pharmacists. Expand the role of pharmacy technicians using enhanced training courses.	Apr-25	Apr-25	Amber

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care a) HEIW will work with health boards and Velindre University NHS Trust to develop standardised post registration career frameworks aligned to post-registration curricula, for all pharmacists and pharmacy technicians employed by the NHS in Wales		Apr-29	Apr-29	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care b) As part of the career frameworks, NHS organisations will develop standardised national nomenclature for job titles for NHS employed clinical pharmacists aligned to the RPS curricula for post registration practice		Apr-29	Apr-29	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care d) Health boards and Velindre University NHS Trust should ensure the career progression of all NHS employed pharmacists and pharmacy technicians requires individuals to demonstrate they meet the required minimum standard for practising at the level of practise required by the job description (and the standardised nomenclature for job titles) including through credentialling by a professional body where available	Credentialling of pharmacists supported. Pharmacy technician career development pathway underway some enhanced roles (administration) and training (clinical skills diploma).	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care e) National template job descriptions, updated Agenda for Change job profiles, and national template job plans (encompassing the four pillars of advanced practice) should be developed for all pharmacists		Apr-25	Apr-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care f) Health boards and Velindre University NHS Trust should ensure all NHS employed pharmacists have a job plan appropriate for each stage of an individual pharmacist's career	Job plans need creating/reviewing	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care g) Job plans for advanced practice and consultant pharmacists should include time for providing outreach services and integrated working across sectors to support community-based practitioners and patients in the community	Same as above and no consultant/advanced practice pharmacist posts in health board	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care h) HEIW, working with the Association of Pharmacy Technicians UK (APTUK), will develop comprehensive post-registration curricula for pharmacy technicians employed by the NHS in Wales		Apr-29	Apr-29	External

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care i) Once such curricula have been developed, further work should be undertaken to develop a standardised national nomenclature for job titles for NHS employed pharmacy technicians. The nomenclature for job titles should be aligned to those curricula; and national template job descriptions, updated Agenda for Change job profiles, and national template job plans for pharmacy technicians. Health boards and Velindre University NHS Trust should then adopt the standardised national nomenclature for pharmacy technician job titles; and ensure all NHS employed pharmacy technicians have a job plan which is appropriate for each stage of an individual pharmacy technician's career		Apr-31	Apr-31	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.3 Supporting professional development at all stages in careers a) HEIW should work with the Schools of Pharmacy at Cardiff and Swansea Universities to describe examples of pharmacy undergraduate placements within hospital multidisciplinary teams which meet their educational requirements. This should include maintaining and publishing a list of entrustable professional activities for pharmacy undergraduates including appropriate clinical pharmacy activities in hospitals		Sep-24	Sep-24	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.3 Supporting professional development at all stages in careers b) Health boards and Velindre University NHS Trust should develop plans to ensure adequate numbers of pharmacy undergraduate, foundation and post-registration foundation placements are available aligned to the planned number of trainees in Wales including placements with pharmacist prescribers and within multidisciplinary teams	Some sites already offering placements to undergraduate students, all sites offering places for foundation and post foundation trainees. To develop a plan on how more can be supported and gain support from other healthcare professionals as part of an MDT approach.	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.3 Supporting professional development at all stages in careers c) Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising education commensurate with the stage of individuals' careers	Workforce require job plans	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.3 Supporting professional development at all stages in careers d) HEIW should undertake a review of the continuing professional development offer for hospital pharmacy teams to ensure it is meeting their development needs and provides a sufficiently flexible approach for participants		Apr-25	Apr-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.4 Understanding and continually improving the quality of pharmaceutical care a) The Chief Pharmacists' Peer Group should commission a refresh and refocus of the Pharmacy Research Strategy in Wales aligned to the recommendations of the independent review		Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.4 Understanding and continually improving the quality of pharmaceutical care b) The Welsh Government working with health boards, HEIs, and Health and Care Research Wales (HCRW) should develop a network of research mentors for pharmacy professionals		Apr-29	Apr-29	External

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.4 Understanding and continually improving the quality of pharmaceutical care c) Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising research and development commensurate with the stage of individuals' careers	Consultant pharmacists have this identified, wider workforce require job plans.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R2.4 Understanding and continually improving the quality of pharmaceutical care d) The Chief Pharmacists' Peer Group should establish a programme of work with HEIW to establish a continuous rolling programme for formally appraising pharmacy and medicines management workforce needs aligned to new technologies and NHS priorities		Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services d) Health boards and Velindre University NHS Trust should ensure pharmacy services are included within their strategic planning cycle	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs. Need to increase opportunities to collaborate and be routinely included in strategic planning cycle.	Sep-24	Sep-24	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services e) The Welsh Government will work with the NHS Executive, health boards and Velindre University NHS Trust to develop and implement key performance indicators including those derived from digital systems, which demonstrate the effectiveness of pharmacy services, on improving the quality of care		Apr-29	Apr-29	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.2 Pharmacy system leadership a) Each health board's Director of Pharmacy should be responsible for producing a plan for pharmacy and medicines management within the health board setting but how pharmacy teams are responding to relevant Welsh Government and NHS Executive priorities	Directorate structure been created to have an agile way to respond to any relevant WG and NHS Executive priorities	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.2 Pharmacy system leadership b) Health boards and Velindre University NHS Trust should review pharmacy senior leadership and management arrangements including job titles to ensure they meet the new GPhC regulatory requirements and the needs of increasing clinical roles	New GPhC requirements not yet ratified. Pharmacy leadership structure aligns to Clinical Boards which does create a lack of site-based leadership.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.3 Talent management and developing future leaders within pharmacy. a) Working with HEIW and Academi Wales, the Welsh Government will ensure aspiring leaders in pharmacy have access to a range of multidisciplinary and public sector wide opportunities for leadership development such as HEIW's Executive Talent Pool and Academi Wales' Leadership Development Programmes		Apr-25	Apr-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.3 Talent management and developing future leaders within pharmacy. b) Health boards and Velindre University NHS Trust must implement the actions identified in the HEIW "Senior Leadership Development in Pharmacy" report	See action plan in appendix 4.	Apr-29	Apr-29	Amber

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.3 Talent management and developing future leaders within pharmacy. c) HEIW should work with Health boards and Velindre University NHS Trust to promote awareness of the tools in the "Gwella" leadership platform to promote leadership development at all stages of pharmacy professionals' careers and personal development	Some senior staff have undertaken leadership/management training. Historically the Managers passport. There is a HEIW leadership course available and a LEAP training run by the health board.	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.3 Talent management and developing future leaders within pharmacy. d) HEIW will review the outcomes of participation in the Centre for Pharmacy Postgraduate Education's (CPPE's) programme, "The Chief Pharmaceutical Officer's Pharmacy leaders' development", with a view to establishing a rolling programme to develop future NHS Wales Directors of Pharmacy		Apr-25	Apr-25	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.4. Clinical leadership a) HEIW will lead the development of a consultant pharmacist strategy and implementation plan, and health boards and Velindre University NHS Trust should establish a succession plan for advanced practice and consultant pharmacist roles within their respective workforce plans		Apr-29	Apr-29	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.4 Clinical leadership b) The Welsh Government will work with health boards, Velindre University NHS Trust and HEIW to establish clinical governance arrangements for all pharmacist and other non-medical prescribers, which will include the implementation of the agreed NHS Wales Non-Medical Prescribing (NMP) standards, signposting to guidance and facilitating prescribers to expand their scope of practice		Apr-29	Apr-29	External
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3.4 Clinical leadership c) The Chief Pharmacists' Peer Group should review the arrangements for sharing and adopting examples of best practice between health boards. There should a specific focus on standardising clinical pharmacy services in urgent and emergency care and pre-admission/pre-habilitation care, within the first 12 months of this plan being published		Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Digital	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4.1 Better use of data and technology to prioritise pharmaceutical care b) Health boards and Velindre University NHS Trust should prioritise the development of digital and technological skills within pharmacy workforce training and establish clinical informatics pharmacy professional roles within their organisations	Digital lead pharmacist in post - Undergraduate project underway to establish current workforce digital skills	Apr-25	Apr-25	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4.1 Better use of data and technology to prioritise pharmaceutical care c) Working with the DMTP, the Chief Pharmacists' Peer Group should establish a short life working group to agree how ePMA systems and the development of the Shared Medicines Record can be used to provide optimal support for prioritisation and pharmaceutical care planning including outreach services in enhanced community care (virtual wards)		Sep-24	Sep-24	Amber

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. a) Health boards and Velindre University NHS Trust should have plans in place to support the wider use of pharmacogenomic testing including the role of pharmacy professionals in advance of the development of a Wales-wide pharmacogenomic panel	Need to develop health board wide strategy for pharmacogenomics.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. b) Health boards and Velindre University NHS Trust should work with HEIW to provide opportunities to develop awareness of innovative technologies (e.g. Artificial Intelligence and pharmacogenomics) which impact on therapeutic decision making amongst pharmacy teams. This should include but not be limited to, encouraging more pharmacy professionals to access the Swansea and Bangor University postgraduate programmes in genomic medicine	University modules offered to staff, being undertaken this year.	Apr-29	Apr-29	Amber
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making. c) Health boards and Velindre University NHS Trust should develop advanced practice and consultant pharmacist roles for pharmacogenomics to lead the development and implementation of pharmacogenomics plans across the NHS	All Wales JD developed and banded by CAV and VCC in collaboration with AWMGS. To be hosted in CAV (awaiting credentialing).	Apr-31	Apr-31	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements.	Dec-23	~~Apr-24~~ Jun-24	Red
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Update reports on progress of the clinical audit programme to be provided to MHLD QSE in order to provide oversight on outcomes.	Mar-24	~~Mar-24~~ Jun-24	Red
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms.	Mar-24	~~Mar-24~~ Sep-24	Red
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Continue to promote on a regular basis a regular approach to leadership visibility and engagement visits across clinical areas as early as possible	Jun-23	Jun-24	Red
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Engagement and culture change to be included while developing the Directorate Staff Engagement and Organisational and Development Plan	Mar-24	~~Mar-24~~ Sept-24	Red

Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R6. There are significant vacancies within the Directorate which are affecting the ability of the service to meet demand in a timely fashion. Although the Directorate has developed an embryonic workforce management group, there needs to be a more formal approach. The Directorate should develop a formal and targeted approach to address recruitment hotspots and ensure sustainability.	Work has been undertaken by each service within the Directorate to identify significant vacancies. These findings are to inform the development of an overarching Directorate Recruitment and Retention Plan, which will be aligned to wider Health Board strategic objectives and wider national priorities. The development of the Recruitment and Retention Plan will be completed and overseen by the MHLD Workforce Group, which is attended by Heads of Service and Professional Leads monthly.	Dec-23	Jul-24	Red
Feb-23	2022/23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Produce a report for QS&EG with any required pathway improvement/equality recommendations.	Aug-23	~~Jan-24~~ ~~Feb-24~~ ~~Mar-24~~ Dec-24	Red
Feb-23	2022/23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R4. The Health Board should review accommodation within the Emergency Department to provide an environment where a mental health assessment can be provided to ensure privacy, low stimuli and safety for patients and staff.	Review undertaken. Appropriate areas in place Bronglais, Withybush and Prince Phillip. Layout change in Glangwili ED has led to identified area no longer available for mental health assessment. On-going discussions needed with ED management across HDUHB to resolve and ensure the provisions of appropriate assessment areas.	Mar-24	~~Mar-24~~ N/K	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Further Actions a) Development of standards for physical health screening to be incorporated into Service Specifications. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ Sept-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Further Actions b) Further development of Care Partner to capture physical health screening in line with above standards through electronic forms. Please see overarching Clinical Audit Action (Recommendation 34)	Nov-23	~~Apr-24~~ Jul-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R4. The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Further Action d) All teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Dec-23~~ Sept-24	Red

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R6. The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Further Action e) Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ Nov-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Further Actions: f) Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53). Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Further Actions: g) And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ Oct-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R8. The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	Further Action: h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Oct-23	~~Apr-24~~ Dec-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R9. The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	There are a range of current practices in place in relation to the documentation of inpatient MDT meetings which are supported by admin roles. Further Actions as per recommendation 6.	Sep-23	~~Jan-24~~ Nov-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R11. The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Further Actions as per Recommendation 7.	Sep-23	~~Feb-24~~ Oct-24	Red

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R12. The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	Further Actions as per recommendation 7.	Sep-23	~~Feb-24~~ Oct-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R13. The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Further work to strengthen assurances around consistency and effectiveness of this process will be undertaken through the below actions. Please see overarching Clinical Audit Action (Recommendation 34) ~~Further Actions as per Recommendation 7~~	Sep-23	Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R14. The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Further Action as per Recommendation 6 and 7.	Sep-23	~~Feb-24~~ Oct-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R15. The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	Further Action j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	~~Dec-23~~ Nov-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R16. The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.	Please see response to recommendation 15.	Dec-23	Nov-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R17. The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	Further Action as per Recommendation 15.	Dec-23	Nov-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	Further Actions l) Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Sep-23	~~Jan-24~~ ~~Apr-24~~ Sep-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R19. The health board must provide assurances on the electronic patient clinical records systems in place, within its mental health services, to allow for essential information to be shared electronically between inpatient and community services.	Further Action m) Development of process to enable timely access of clinical records for temporary staff eg temporary staff log ins that are issued locally.	Nov-23	N/K	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R20. The health board must implement actions to mitigate against risks associated with staff from different teams being able to accessing patient information in a timely manner.	Access to Care Partner is overseen by the MH/LD Directorate. Access to information is immediate to all teams in all locations when it has been added to Care Partner. Further Action as per Recommendation 19.	Nov-23	N/K	Red

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R21. The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010.	Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R22. The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb 24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R23. The health board must ensure that discharge summaries are completed and sent out to a patient's GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb 24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R24. The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb 24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Sep-23	~~Dec 23~~ Jul-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Nov-23	~~Nov 23~~ Dec-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions q) Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Dec-23	~~Dec 23~~ Jul-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R26. The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	Further Action s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Sep-23	~~Dec 23~~ N/K	Red

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R27. The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	Further Action t) Resolve CRHT access to space within all emergency departments.	Jul-23	~~Mar-24~~ N/K	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R28. The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Please see responses to recommendation 6 and 7. Further Actions as per Recommendation 6 and 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R29. The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Further Action (q) as per Recommendation 25 - (Action q on Amat)	Dec-23	Jul-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R31. The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Further Action (q) as per Recommendation 25	Dec-23	Jul-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R32. The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Further Action u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Nov-23	~~Nov-23~~ Sep-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R33. The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	Further Action v) Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	Mar-24	~~Mar-24~~ Sep-24	Red

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of compliance with 72 hour follow up	Dec-23	~~Dec-23~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	~~Dec-23~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Mar-24	~~Mar-24~~ Jun-24	Red
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R38. The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Further Action dd) Review options for enabling Social Workers who provide a service on behalf of the health board to have direct access to DATIX, establish a process to implement this which includes routine access to DATIX for all new Social Workers joining mental health teams and processes to amend access when moving or leaving the team. Identity existing Social Workers to set up system access and training to enable full use of DATIX and feedback mechanisms within the system.	Jul-23	N/K	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R1. While temporary measures have been put in place since June 2021 there remains significant gaps in the delivery of specialist epilepsy reviews for all individuals who were part of the service provided by Professor Kerr and potential new referrals. This does lead to some urgency to install the short-term plan as below to work towards achieving the “Bronze” level standard (5) in the first instance. (Immediate concern). The pathway which was in existence pre June 2021 needs to be reviewed and as feasible adopted. It would be helpful to review if the pathway that was in existence could be reimplemented while broader changes/modifications are considered for local need. The previously existent pathway is apparently similar to those in place and currently in use in Powys and Swansea Bay Health boards and thus could be implemented swiftly. Consideration needs to be given as to why there were challenges for its continued delivery in HDUHB.	To seek short term employment of a “like for like” medical expert in this field and demonstrate that all reasonable attempts have been made by the commissioners including considering re-engaging the previous medic’s services in a suitable capacity or attempting to engage suitable locum medical consultant with experience of working with PWID and epilepsy.	Mar-24	~~Mar-24~~ N/K	Red

Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R2. The expectation would be for the new service to oversee the complex clinical pathway required for the current patient population. The expectation is that the service clinicians would have clear clinical roles and job descriptions put together to help support complex individuals currently without a dedicated service. The clinicians need to take forward the service towards a sustainable and safe working model to satisfy in the first instance a three-star service over the coming year with reference to Step Together. This would require identifying medical leadership role from psychiatry and /or neurology to help redesign service needs and to also provide confidence to existing PwID and their families given their recent emotional trauma. This medical leadership role is envisaged to have a stronger engagement with senior management such as Mr Carruthers and Ms Carroll.	To update the pathway ensuring that it to reflects the current practice and following consultation to submit to Written Control Documentation Group for approval and subsequently implement across all CTLDs	Feb-24	Sep-24	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R4. Risk screening matrix for emergencies would be developed by the team in keeping with the NICE 2022 guidance, Step Together and NHS England Right Care Toolkit. The immediate focus would be on safety to ensure people in the service and those coming into the service are safe. Suggested actions include contacting SUDEP Action and asking for the permission for use of the SUDEP and seizure safety checklist for all people in the service. This would also act as a surrogate measure for risk change. (Short term plan (6 months))	To contact Public Health Wales to establish the position of all LHB's across Wales	Dec-23	N/K	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R4. Risk screening matrix for emergencies would be developed by the team in keeping with the NICE 2022 guidance, Step Together and NHS England Right Care Toolkit. The immediate focus would be on safety to ensure people in the service and those coming into the service are safe. Suggested actions include contacting SUDEP Action and asking for the permission for use of the SUDEP and seizure safety checklist for all people in the service. This would also act as a surrogate measure for risk change. (Short term plan (6 months))	To consider the responses from across Wales and develop a risk screening matrix for implementation in HDUHB.	Jun-24	Jun-24	Amber
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R6. The current epilepsy nurse job description needs to be reviewed by Ms Paula Hopes or a suitable specialist epilepsy nurse recommended by Epilepsy Specialist Nurse Association (ESNA). The expectation would be to provide a brief report outlining the strengths and weaknesses of the current position holders, competencies as matched to the job description and workload. For any identified areas of the position holder's development, mentoring from an experience specialist epilepsy nurse could be procured from ESNA. This could be part of the professional development of the individual. (Short term plan (6 months))	To review the current epilepsy nurse role description.	Mar-24	~~Mar-24~~ N/K	Red

Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R7. To put in place emergency guidelines and protocols for all those eligible for rescue guidance such as Midazolam. There also needs to be a protocol in place for rapid review and oversight of those who are admitted to an emergency department. Gaining the expertise of an epilepsy specialist nurse via ESNA on this matter could be helpful. The current situation appears to have arisen due to difference in learning disability staff viewpoints and existing organisational culture. Being mindful of this, applied solutions need to ensure that staff stakeholders are included, confident, involved and supportive of these changes. This might require training, education and outlining of resources such as time in current job roles. Best practice guidelines such as Step Together and NHS England Right Care toolkit could help. This would provide resilience and sustainability for delivery of a high quality epilepsy care pathway. (Short term plan (6 months))	To seek guidance from Epilepsy Wales and ESNA on emergency guidelines and protocols including rescue medication guidance	Jan-24	~~Jan-24~~ N/K	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R8. As part of understanding of the challenges within the service, a multistakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To liaise with research and development colleagues to establish the stakeholder's current understanding and expectations of the service.	Mar-24	~~Mar-24~~ N/K	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R8. As part of understanding of the challenges within the service, a multistakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To take forward agreed actions following meeting with carers of patients which were under the specialist service at the time of closure: 1. To review the care provided to 2 patients represented at the meeting 2. To review the complaints received at the time service was closed. 3. To send an easy read memo updating on the next steps following the receipt of the report.	Mar-24	~~Mar-24~~ N/K	Red
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. Consider a suitable model of care for delivering the epilepsy and ID clinical care. Ideally recruiting a specialist ID consultant with competency in epilepsy is desirable. However, there is significant challenges of such specialists being available. In such a situation: a. Consider the existing work force and supporting those psychiatrists working in the current ID service interested in physical health care in developing epilepsy skills and competencies. This should naturally be done as part of service re-design and include suitable job planning (based on work activity) and resource for any potential interested person. There needs to be good peer group and Continued Professional Development arrangements made. b. Offer similar opportunities to neurologists or GPs interested in this clinical area as in point a. above. (Medium term plan (6 months to a year))	To consider options for cover by a specialist LD consultant with interest in epilespy.	Mar-24	~~Mar-24~~ N/K	Red

Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. Consider a suitable model of care for delivering the epilepsy and ID clinical care. Ideally recruiting a specialist ID consultant with competency in epilepsy is desirable. However, there is significant challenges of such specialists being available. In such a situation: a. Consider the existing work force and supporting those psychiatrists working in the current ID service interested in physical health care in developing epilepsy skills and competencies. This should naturally be done as part of service re-design and include suitable job planning (based on work activity) and resource for any potential interested person. There needs to be good peer group and Continued Professional Development arrangements made. b. Offer similar opportunities to neurologists or GPs interested in this clinical area as in point a. above. (Medium term plan (6 months to a year))	To review and develop a local epilepsy LD care pathway using QI methodology	Apr-24	~~Apr-24~~ N/K	Red
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The ADHD service would benefit from continuing to progress their plan to review service pathways and embed capacity and demand management processes to improve equity, consistency, and efficiency.	Undertake demand and capacity training provided by the NHS Executive	Apr-24	Jun-24	Red
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Review current transition arrangements for older YP people waiting diagnostic assessments of ASD and ADHD	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Develop an all age Transition policy/pathway for Neurodivergent Children & Young People.	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure the availability of accessible and appropriate accommodation for diagnostic assessment of CYP with sensory sensitivities and physical impairments.	Undertake a service review of current estates of both services and develop an option proposal/SBAR	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.	Paediatric Psychology will review/update Service Specification	Jun-24	Jun-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.	Review/update S-CAMHS Service Specification	Jun-24	Jun-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Benchmark Paediatric Psychology in line with other Health Boards in Wales	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Identify gaps in availability of psychological interventions in HDUHB in line with Matrics Plant	Oct-24	Oct-24	Amber

Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Undertake and prepare an options appraisal paper based on the above actions (1,2,3)	Dec-24	Dec-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify and implement opportunities for improved psychological interventions & patient outcomes across Paediatrics and S-CAMHS	Jul-24	Jul-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify further resource required to further enhance interventions and outcomes to inform option appraisal from Action 4 of R3	Jul-24	Jul-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Benchmark Paediatric Psychology with that in other Health Boards in Wales	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Internal review within paediatrics to identify appropriate development of psychological provision within paediatrics, leadership structures and pathways in line with governance arrangements of the wider health board	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Paediatric Service to co-produce an annual training plan to include advice and direction from Professional lead and shared training opportunities with SCHAMS	May-24	~~May-24~~ N/K	Red
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Identifying gaps in funding and provision for development in paediatric psychology	Jul-24	Jul-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.	Undertake a service review of current estates of both services and develop an option proposal/SBAR	Nov-24	Nov-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	Review CoP to identify any areas for improvement of compliance and report into CTP monitoring group	Jul-24	Jul-24	Amber
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	Initiate a rolling quality review process for CTPs	Apr-24	~~Apr-24~~ Jun-24	Red
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R8. The HB should embed demand and capacity principles into the management of all services. The HB may wish to access further demand and capacity training from the NHS Wales Executive or other training providers.	Both services will undertake demand and capacity training provided by the NHS Executive	Mar-24	Jun-24	Red
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure that patient feedback, involvement and outcome measures are used across all directorates in service evaluation and planning.	Paediatric Link with VBHC team to develop both a PREM/PROM informed by national outcome measures in order to utilise patient feedback and outcomes to inform future development of the services. .	Jun-24	Jun-24	Amber
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	N/A	R2. The health board must ensure that work is undertaken to improve the appearance and safety of the outdoor areas for patients to use	Estates have attended site and have addressed a number of these concerns. There is a new grounds and gardens contract in place (commencing in early 24) with regular site visits planned to keep the level of grounds maintenance to an acceptable standard.	Feb-24	N/K	Red

Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates to undertake a review of the area and take further action to address the ventilation defects to prevent further mould	Jan-24	~~Jan-24~~ N/K	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates improvements and decoration is currently underway on St Caradog Ward. Temporary signage to be put in place	Dec-23	N/K	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed using anti ligature handrail products to be undertaken	Jan-24	~~Jan-24~~ N/K	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates will review thermostat covers and ensure suitable covers are replaced in patient rooms on St Non ward	Jan-24	~~Jan-24~~ N/K	Red

Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R13. The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mar-24	~~Mar-24~~ Sep-24	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R16. The health board must ensure that records detail consent and capacity to consent are assessed during first 3 months of treatment in accordance with para 25.18 of the Welsh Codes of Practice	Task and finish group to be established to include MCA and MHA leads to review feedback and practice issues raised in relation to capacity and capacity to consent to determine an improvement plan.	Feb-24	Jul-24	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R17. The health board must ensure that where appropriate specific decisions about patient care and treatment are undertaken, as set out in the framework for the Mental Capacity Act in accordance with para 13.7 of the Codes of Practice for Wales, these are recorded in patients notes	Task and finish group to be established to include MCA and MHA leads to review feedback and practice issues raised in relation to capacity and capacity to consent to determine an improvement plan.	Feb-24	Jul-24	Red
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R19. The health board should review and discuss these implications with staff from all areas and try and establish a service level agreement between the Accident and Emergency department and St Non's and St Caradog to try and minimise the staffing issues and distress caused to patients who experience significant delays.	The Interim Senior Nurse for Liaison has already started working with Head of Nursing at Withybush Hospital to develop pathways for Mental Health Inpatients accessing the Accident and Emergency Department. This includes protocols where MHLD inpatient medics have prior contact with the DGH to discuss the patient's presentation and accident and emergency contacting the ward to escort the patient to the department when a practitioner is available to see them, this avoids long waiting times in waiting rooms. A Substantive Senior Nurse for Liaison has been recruited and is due to commence in post in January 2024. They will lead on formally developing and agreeing protocols and procedures with DGHs.	Apr-24	~~Apr-24~~ Oct-24	Red

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	~~Apr-23~~ ~~Jun-23~~ ~~Aug-23~~ ~~Mar-24~~ ~~May-24~~ June-24	Red
Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	~~Apr-23~~ ~~Jun-23~~ N/K	External
Nov-22	2022/23	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Central Operations	Louise O'Connor	Director of Nursing, Quality and Patient Experience	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	GGH is working with Gwili railway to provide an additional 140 spaces for staff to release space in the hospital site.	Jun-23	~~Jun-23~~ ~~Aug-23~~ ~~Oct-23~~ ~~Jan-24~~ ~~Feb-24~~ ~~Apr-24~~ Jul-24	Red
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R1. HDUHB should ensure that all relevant documentation related to a record is uploaded to the Datix Cymru system and a standard naming convention is used to allow for ease of reference for all staff.	Clarity re access to privileged information and audit trail to be discussed at network.	Mar-24	~~Mar-24~~ N/K	Red

Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R4. HDUHB Should consider documenting the process to ensure early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	Redress and Complaints Staff to attend national training.	Dec-24	Dec-24	Amber
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R5. HDUHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice.	SOP is being drafted and will be reviewed by the Listening and Learning Sub-Committee in December.	Dec-23	~~Dec-23~~ ~~Mar-24~~ N/K	Red
Jun-24	2024/25	Internal Audit	Health & Care Quality Standards Final Internal Audit Report June 2024	Open	Reasonable	Nursing	Nursing	Sharon Daniel	Director of Nursing, Quality and Patient Experience	Medium	R1. The Internal Quality & Engagement Act Implementation Group should reconvene to confirm and oversee the further actions required to achieve full implementation of the Act, ensuring ongoing assurance reporting to QSEC.	Recommendation noted. Workshop to be convened to develop next steps to ensure that duty of quality responsibilities are clear and the duty becomes business as usual in all areas. Update to be provided to the Quality, Safety and Experience Committee through the routine Quality Assurance Report.	Sep-24	Sep-24	Amber
Jun-24	2024/25	Internal Audit	Health & Care Quality Standards Final Internal Audit Report June 2024	Open	Reasonable	Nursing	Nursing	Sharon Daniel	Director of Nursing, Quality and Patient Experience	Medium	R2. The next steps required in implementing and embedding the Duty of Quality and standards at throughout the Health Board (i.e. at operational/Directorate level) should be formalised in an action plan with progress reported via existing governance structures.	Recommendation noted. Workshop to be convened to develop next steps to ensure that duty of quality responsibilities are clear and the duty becomes business as usual in all areas.	Sep-24	Sep-24	Amber
Jun-24	2024/25	Internal Audit	Health & Care Quality Standards Final Internal Audit Report June 2024	Open	Reasonable	Nursing	Nursing	Sharon Daniel	Director of Nursing, Quality and Patient Experience	Low	R3. Consider undertaking a training needs analysis and monitoring completion of DoQ e-learning.	Recommendation noted. Workshop to be convened to develop next steps to ensure that duty of quality responsibilities are clear and the duty becomes business as usual in all areas. Update to be provided to the Quality, Safety and Experience Committee through the routine Quality Assurance Report.	Sep-24	Sep-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R1. (MD5) Health boards and trusts must ensure that following DNACPR discussions, clinicians clearly document the details and decision rationale on the DNACPR form and within clinical records (where necessary).	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R2. (MD10) In the absence of patient capacity to engage in and understand a DNACPR decision, health boards and trusts must ensure that clinicians complete all relevant parts of section 1 of the DNACPR form. Additionally, a mental capacity assessment and the decisions around the best interests of a patient should be appropriately recorded and filed in the clinical records.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R3(MD12) Health boards and trusts must ensure that clinicians clearly and succinctly record a patient's clinical summary within section 2, and the reasons why CPR would be inappropriate, in line with the all-Wales Policy.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R4. (MD13) Health boards and trusts must ensure that section 6 of the DNACPR form is completed in a timely manner by the Senior Responsible Clinicians in line with the all-Wales Policy.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R5. (MD14) Health boards and trusts must ensure that communication of a DNACPR decision is improved across to the relevant clinical teams involved in the care of patients, and these within section 8 of the DNACPR form, such as their GP, care home and out of hours providers where appropriate	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber

Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R6. (MD16) Health boards and trusts must consider their audit processes for the DNACPR form in line with the all-Wales Policy, to ensure when this is conducted, the process is robust, and that learning is shared across their organisation.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R7. (MD17) Health boards and trusts must consider the staff and public's experience and comments highlighted throughout this report and determine how these could influence improvement with the quality of the DNACPR decision making process, and the overall patient experience.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R8. (SD1) Health boards and trusts should ensure that clinicians completing the date section 'for review' within a DNACPR form, must clearly document all the required information including the date and their professional registration numbers, to ensure that clinicians are identifiable if required.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R9.(SD2) Health boards and trusts should ensure that clinicians are providing or signposting patients and those close to them with sufficient information resources, in an appropriate format, to help them understand and consider the CPR process, and what DNACPR means.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R10. (SD3) The Advance and Future Care Planning Group (Wales) should consider how to further increase public awareness within health boards and trusts regarding the existing resources and the meaning and process for DNACPR decision making, to ensure people can appropriately engage in conversations about their preferences during the end of their lives.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R11. (SD4)Health boards and trusts should explore how clinicians can consider holding DNACPR discussions as early as appropriate with patients and those close to them, to allow them time to understand the decision, reflect on discussions and to generate follow-up discussions if appropriate.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R12. (SD6) In line with the all-Wales Policy, health boards and trusts should ensure that clinicians fully engage in appropriate discussions with patients and family, to ensure an individual's life is respected and valued, and to make clear that a DNACPR decision does not prejudice any other aspect of care.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R13. (SD7) Health boards and trusts should consider how staff can be supported with appropriate time to undertake training, and access the information resources available, to support them with considering people's spiritual needs, values, and beliefs, when making DNACPR decisions	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R14. (SD8) The all-Wales Advance and Future Care Planning Group should consider whether the current DNACPR and/or Advance and Future Care Plan policy and relevant documents can cater for individuals' spiritual needs, values, and beliefs, so this information can be more readily accessible and can be considered by all clinicians involved in a person's care.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber

Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R15. (SD9)Health boards and trusts should consider its staff awareness of the support, resources and training available to them about inclusive and accessible DNACPR discussions, and how to improve the promotion of its availability.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R16. (SD11) Health boards and trusts should undertake a training needs analysis relating to the Mental Capacity Act and completion of mental capacity assessments. This should be considered widely across the organisation and not exclusively for those completing a DNACPR decision form.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber
Dec-23	2023/24	HIW	DNACPR Review	Open	N/A	Nursing	Nursing	David Wastell	Director of Nursing, Quality and Patient Experience	N/A	R17. (SD15) Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions, for instance within Welsh Clinical Portal, to help achieve prompt and robust communication of these decisions throughout Wales. This would benefit patients and those close to them, communication nationally across different health board teams in secondary care, and community and primary care, and in care homes, and emergency services.	To establish a Quality Improvement project through the Health Boards EQUIiP (cohort 6), to consider the areas within the recommendations of the HIW report and implement improvements for these areas, strengthening DNACPR arrangements within the Health Board	Dec-24	Dec-24	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R1. Whilst there is a documented schedule of audits that include checking swipe card access records against authorised staff lists, audits are not carried out against the CCTV.	Staff to be trained to review CCTV	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Carry out a gap analysis to establish what training records have been completed by porters	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Create an action plan for porters to complete outstanding training programmes	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Discuss with L&D whether it would be possible to create a porter training course in ESR	Jul-24	Jul-24	Amber

Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Create an action plan for mortuary locum/bank staff to complete outstanding competences	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Review mortuary competence documentation - ensure they contain education worksheets and direct observation of performance (to assess knowledge and skills).	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Review SOPs to ensure they are sufficiently detailed	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R4. Whilst staff know how to identify incidents and report them internally; a review of the incident log by the inspection team identified several incidents that were not reported to the HTA. These incidents included HTA reportable (HTARI) categories which fall under 'serious security breach', 'accidental damage to a body' and 'major equipment failure'.	Review, and update as required, MIMOR605 HTA reportable incidents - porters. Circulate to porters	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R4. Whilst staff know how to identify incidents and report them internally; a review of the incident log by the inspection team identified several incidents that were not reported to the HTA. These incidents included HTA reportable (HTARI) categories which fall under 'serious security breach', 'accidental damage to a body' and 'major equipment failure'.	Carry out a gap analysis to check which mortuary staff have completed TPMOR607 and out an action plan in place to get any outstanding training completed	Jul-24	Jul-24	Amber

Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R4. Whilst staff know how to identify incidents and report them internally; a review of the incident log by the inspection team identified several incidents that were not reported to the HTA. These incidents included HTA reportable (HTARI) categories which fall under 'serious security breach', 'accidental damage to a body' and 'major equipment failure'.	Provide training for non-pathology staff with respect to HTARIs (e.g.,. maternity staff, porters)	Jul-24	Jul-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R8. Some SOPs are not detailed enough to ensure uniformity between staff following procedures. For example: - The SOP for PM procedure does not state the current practice for evisceration where the pathologist conducts an external examination of the deceased prior to instructing the APT to proceed with evisceration. - The SOP that details the same/similar name procedure does not include the placing of a same/similar name wristband on the deceased and practices on this vary between staff.	Carry out a gap analysis to identify SOPs lacking in detail	Sep-24	Sep-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R8. Some SOPs are not detailed enough to ensure uniformity between staff following procedures. For example: - The SOP for PM procedure does not state the current practice for evisceration where the pathologist conducts an external examination of the deceased prior to instructing the APT to proceed with evisceration. - The SOP that details the same/similar name procedure does not include the placing of a same/similar name wristband on the deceased and practices on this vary between staff.	Create an action plan to update SOPs (ensure these are standardised across site where possible to ensure uniformity of practice across the Health Board)	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R1. Ensure that non-mortuary staff and contractors, including maintenance staff employed by the Health Boards external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.	SOP on Lone Working Contractors to be reviewed and make reference to Mortuary working if possible.	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R2. The Health Board must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance is undertaken, does not happen.	Cold box Bariatric storage – review capacity & size of these units	Mar-24	~~Mar-24~~ N/K	Red
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R3. The Health Board must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The health board should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	Mortuary Staff, Hywel Dda University Health Board – DBS Checks in place on initial employment but not re-evaluated on a routine basis. HB DBS Policy for Facilities and external contractors to be checked by HR & Workforce Simon Chiffi to assist with this regarding Facilities staff & Wendy Davies, HR & Workforce.	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R3. The Health Board must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The health board should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	Email all Service Providers about Staff DBS Checks including Contracted Funeral Directors who store deceased on behalf of HB	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R3. The Health Board must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The health board should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	DBS Checks – Bring to Operational QSESC	Sep-24	Sep-24	Amber

Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R4. The Health Board must assure itself that its mortuary managers are suitably qualified and have relevant anatomical pathology technologist experience. The mortuary manager should have a clear line of accountability within the Health Boards management structure and must be adequately managed and supported	Regional Mortuary Manager – Qualified APT HD Operational Mortuary Manager – not a Qualified APT.	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R5. The role of mortuary manager should be protected as a full-time dedicated role, in recognition of the fact that this is a complex regulated service, based across multiple sites that requires the appropriate level of management attention	Regional Mortuary Manager – Full time HD Operational Mortuary Manager – Full time	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R6. The Health Board must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary	Access to Mortuary – list all SOP's/Audit Schedules and Escalation Procedures to be developed.	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R7. The Health Board must audit implementation of any resulting new policy, with respect to security arrangements, and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	Access to Mortuary – list all SOP's/Audit Schedule and Escalation Procedures to be developed.	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R8. The Health Board should treat security as a corporate not a local departmental responsibility	review Mortuary Security, CCTV and Access Systems across all Mortuary sites in order to become compliant	Apr-24	Apr-24	Red
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R9. The Health Board must ensure that footage from the CCTV is reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern	CCTV Audit- discussions ongoing.	Sep-24	Sep-24	Amber

Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R10. The Health Board must install CCTV cameras in the mortuary, including the PM room, to monitor the security of the deceased and safeguard their privacy and dignity.	CCTV camera to be installed into PM Room at GGH and Viewing Rooms at WGH, GGH, BGH and PPH.	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R11. The Health Board must proactively share HTA reports with organisations that rely on HTA licensing for assurance of the services provided by the mortuary	HTA inspection reports available online for General Public – however, not actively sent to all service users but can ensure this is done as requested.	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R12. The council should examine their contractual arrangements with the Health Board to ensure that they are effective in protecting the safety and dignity of the deceased	Review Draft SLA for Carmarthenshire PM's & send to Sian Marie in Legal Team to review.	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R13. The Health Board must review its governance structure and function in light of this report	Awating response on amat	Jan-24	N/K	Red
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R14. The Health Board must have greater oversight of licensed activity in the mortuary. It must ensure that the DI is actively involved in reporting to the board and is supported in this	An annual report regarding HTA compliance is submitted to the Effective Clinical Practice Advisory Panel	Sep-24	Sep-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R15. The Health Board should treat compliance with HTA standards as a statutory responsibility for the Health Board, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the DI.	Any findings from external inspections are entered onto the Health Boards risk and assurance tracker. An annual report regarding HTA compliance is submitted to the Effective Clinical Practice Advisory Panel	Aug-24	Aug-24	Amber
Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R16. The Chief nurse should be made explicitly responsible for assuring the Health Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.	Information required of who currently reports directly to Board with assurance of all Mortuary Activity; Service Level and at Executive Board Level. Who reports into Nurse Directors of each Hospital site as well as the Health Board Executive Nurse Director?	Aug-24	Aug-24	Amber

Jan-24	2023/24	Welsh Government	Fuller Inquiry Part One	Open	N/A	Pathology	Pathology	Mr Craig Baker	Director of Therapies and Health Science	N/A	R17. The Health Board must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients	Any time dignity of a deceased patient is breached within the Health Board – DATIX reported by Mortuary Management Team and investigated by the Senior Team responsible. Health Board Policy currently being revised and updated for Care of the Deceased Patient (Responsibility?) Full Audit Schedule of Mortuary Activity including Mortuary Security and Dignity of the Deceased Patient monitored and recorded on Q-Pulse by Mortuary and Quality Team. Lack of Health Board and Local Authority Policy surrounding Long stay deceased patients and Hospital Funded Funerals, impacting on Dignity of the Deceased – under review by HB Legal Team.	Aug-24	Aug-24	Amber
Apr-24	2024/25	Human Tissue Authority	HTA- Glangwili General Hospital Mortuary inspection April 2024	Open	N/A	Pathology	Pathology	Craig Baker	Director of Therapies and Health Science	N/A	R3. The establishment did not provide any completed training records for porters involved in mortuary activities and informed the inspection team that refresher training for porters does not take place. Whilst mortuary staff have been trained and have completed previous rolling programmes of competency assessment, locum/bank staff were not up to date with the current cycle of competency assessment in key tasks. Competency assessments reviewed by the inspection tam lacked specific details. For example: - Staff describing identification procedures for viewings did not make it clear what three identifiers could be, what they be checked against prior to a viewing taking place and the process for checking these identifiers with the family prior to viewing.	Establish a porter training manager role or an existing manager with responsibility for ensuring porters are trained in mortuary procedures	Sep-24	Sep-24	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Mar-19	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open	N/A	Primary Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Ensure engagement with key stakeholders as to how services set out in the strategy will be provided	The development of the strategy will follow the Clinical Services Plan methodology and will include all of the recommended areas. Engagement has been proposed to happen at Cluster and Pan Cluster level to ensure appropriate levels of engagement with key stakeholders and members of the public.	Mar-25	Mar-25	Amber
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Ensure that the strategy encompasses a detailed workforce plan and is fully costed	Workforce data is currently only available for GP Practices and has been identified as an area of concern in the issues paper. Community nursing workforce information is available and included in the issues paper.	Mar-25	Mar-25	Amber
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Use the 2023-24 budgetary information as a baseline position of the cost of primary and community care to enable the shift of resources to be reported on an annual basis.	Budget for 2024/25 to be confirmed. A number of Cluster projects have been identified that could be considered for scale up and roll out where system wide and patient benefits are identified. Potential through strategy to identify pathways that can transition across to being primary care led.	Apr-24	~~Apr-24~~ N/K	Red
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Once the strategy is approved, ensure periodic update reports are provided to the relevant committee demonstrating progress on delivery of the strategy.	An implementation plan to support the development of key themes coming out of the strategy development which will be overseen by the project group and reported through the relevant Board level committee.	Mar-25	Mar-25	Amber
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R2. The Health Board should improve oversight at Board and committee level of performance within primary care by: Increasing the focus on outcomes and experience.	Further work needs to be done data on outcomes and experience as currently that is limited to information held by GP Practices only. Some work has started to look at the use of PROMS and PREMS in the Community Dental Service. PROMS and PREMS will be introduced as part of the service manuals for Optometry WGOS and will form part of a national framework. Public engagement to be a key part of the strategy development with a strong focus on quality outcomes.	Mar-25	Mar-25	Amber

Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R1. The health board must ensure that all policies are drafted to ensure they are practice specific, version controlled, dated, with a review date and who is responsible for the policy. These include: -The process to be followed, for DNAs at both the practice and for hospital appointments. -A practice chaperone policy -Communication policy -The workflow of documents -Consent policy -Patients being admitted to hospital or when patients passed away -Equality, diversity and inclusion policy -Practice specific infection control policy -Safeguarding policy -Complaints protocol -Privacy notice -Information governance policy.	To undertake a review of all policies listed. Development of the outlined policies to recognise that they are Managed Practices and that they are establishment specific. Communication with Health Board Information Governance team as well as Clinical Supervisory teams (eg chaperone policy) in supporting development. Practices directly managed by Hywel Dda adopt already approved, All Wales Policies. An appendix will be added to localise already existing organisational Policies to make directly applicable to the practice.	May-24	~~May-24~~ N/K	Red
Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R3. The health board must address the issues raised by patients in the questionnaire regarding discrimination and access to all patients to the practice, regardless of any protected characteristic.	All staff to book a space on Making A Difference training supported by the Organisation Development Team	May-24	~~May-24~~ N/K	Red
Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R3. The health board must address the issues raised by patients in the questionnaire regarding discrimination and access to all patients to the practice, regardless of any protected characteristic.	Staff meeting following finalising of this report to examine and discuss patient feedback to highlight areas of improvement regarding patient experience and discrimination	May-24	~~May-24~~ N/K	Red
Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R12. The health board needs to ensure that the practice patient clinical records link medications to problems for repeat prescriptions and to record the language of choice of patients	Carry out a mapping exercise to quantify medications and problems that are not linked. Reminding all clinicians when initiating prescription of a drug or do a repeat medication review that the medication prescribed needs to be linked to a problem and recorded during the initial consultation.	Jun-24	Jun-24	Amber
Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R13. The health board need to ensure that there is a localised induction programme documented for new staff, including locums	The Practice needs to produce a local onboarding day-by-day induction pack for newly appointed substantive staff following their initial 2 days Corporate Induction. Hywel Dda's Corporate Induction Programme is a six-month long onboarding process giving new members of staff the skills to use new systems and how to access services within our organisation. The practice needs to produce a practice specific locum-pack for Locum GPs attending the practice to work.	Jun-24	Jun-24	Amber
Jan-24	2023/24	HIW	Neyland and Johnson Health Centre Inspection January 2024	Open	N/A	Primary Care	Primary Care	Matthew McGivern	Director of Primary Care, Community and Long Term Care	N/A	R17. The health board needs to ensure that all staff at the practice understand the full implications of the duty of candour.	Ensure all staff know and understand how the Duty of Candour standards apply to their role.	May-24	~~May-24~~ N/K	Red
Jun-24	2024/25	Internal Audit	Accelerated Cluster Development Final Internal Audit Report June 2024	Open	Reasonable	Primary Care	Primary Care	Jill Paterson	Director of Primary Care, Community and Long Term Care	Medium	R1. Cluster and pan-cluster group terms of reference should be reviewed and agreed with a unified approach taking in to account national guidelines.	At the forthcoming meeting of the locality leads meeting a review will be undertaken of the terms of reference for both the clusters and pan-cluster groups. Final approval of the terms of reference will take place by November 2024	Nov-24	Nov-24	Amber

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Jun-24	2024/25	Internal Audit	Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024	Open	Reasonable	Public Health	Public Health	Ardiana Gjini	Director of Public Health	Medium	R1. The Industrial Action Planning Group terms of reference should be updated and formally approved by the Executive Team.	The Terms of Reference were issued to IAPG members on 10 May 2024 for formal review and comments back by 24 May 2024. As the group is not currently meeting, the final version will be re-circulated and signed off by the IAPG electronically. However, at this point in time, there is no further Industrial Action scheduled as negotiations between the BMA/WG continue. Should any future rounds of Industrial Action occur, by any Trade Union, then the Terms of Reference will be revisited at the first meeting of the re-established IAPG, and subsequently signed off by the group.	Jun-24	Jun-24	Amber
Jun-24	2024/25	Internal Audit	Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024	Open	Reasonable	Public Health	Public Health	Ardiana Gjini	Director of Public Health	Medium	R2. Guidance should be developed to supplement the Major Incident Plan that outlines whether a Command and Control structure is required for business continuity issues. Where a Command and Controls structure is required, a clear and consistent approach should be explicitly outlined including, but not limited to, roles, responsibilities and reporting arrangements within the guidance document.	Terms of Reference for all command & control group activations drafted for future rounds of IA. Will be applied as necessary.	Jun-24	Jun-24	Amber
Jun-24	2024/25	Internal Audit	Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024	Open	Reasonable	Public Health	Public Health	Ardiana Gjini	Director of Public Health	Medium	R2. Guidance should be developed to supplement the Major Incident Plan that outlines whether a Command and Control structure is required for business continuity issues. Where a Command and Controls structure is required, a clear and consistent approach should be explicitly outlined including, but not limited to, roles, responsibilities and reporting arrangements within the guidance document.	The Executive Team will be notified of any future rounds of Industrial Action and the re-establishment of the IAPG. Command & Control structures will be considered and agreed as appropriate at that time reflecting the circumstances.Reporting structures for internal Command & Control structures to be included in the Major Incident Plan 2024/25.	Jul-24	Jul-24	Amber
Jun-24	2024/25	Internal Audit	Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024	Open	Reasonable	Public Health	Public Health	Ardiana Gjini	Director of Public Health	Medium	R3. The Industrial Action Planning Group should provide formal reports to the Executive Team and Operational Planning, Governance and Performance Group in line with the arrangements outlined in the terms of reference. Where reporting arrangements differ, this should be accurately reflected in the terms of reference.	Reporting arrangements to be clarified in the reviewed Terms of Reference.	Jun-24	Jun-24	Amber

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Feb-23	2022/23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	High	R2. The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients.	Instigate a process whereby the service will only send printed copies of letters and not photocopy any letters with immediate action.	Feb-23	Jan-25	Red
Feb-23	2022/23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	High	R17b. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Sep-23	~~Sep-23~~ N/K	Red
Dec-23	2023/24	Public Service Ombudsman (Wales)	202208381	Open	N/A	Radiology	Radiology	Gail Roberts-Davies	Director of Operations	N/A	R2. b) Within 6 months of the date of this report the reporting radiologist should include a reflection on this event in their Line Manager and Clinical Lead review meeting and the imaging should be reviewed at the local Radiology Events and Learning meeting for shared discussion and learning.	Reporting radiologist to present this case to the Radiology Clinical Audit meeting within the REALM section. Case to be discussed at Reporting Radiologists Line Manager and Clinical Lead Review meeting. Minutes of Radiology Clinical Audit meeting Evidence of discussion at Line Manager and Clinical Lead Review meeting	Jul-24	Jul-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R1. The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure and flow chart for pregnancy enquiries for staff must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered and how the result will be effectively communicated	Employers Procedure 8 to be reviewed and updated to reflect the circumstances when a pregnancy test should be considered, recorded and communicated.	Jul-24	Jul-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R2. The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure for pregnancy enquiries to include gender inclusive language.	Employers Procedure 8 to be reviewed and amended to include gender inclusive language.	Jul-24	Jul-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R3. The employer must ensure that outcomes and changes to practice following clinical audits are clearly documented for multidisciplinary teams through the department to ensure that audits sufficiently demonstrate action plans, re-audit and leaning points. The use of a consistent audit report template should be instigated for all clinical audits performed by radiology across the health board.	Review compliance of audit template after Clinical Audit Meeting in July 2024.	Aug-24	Aug-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R4. The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	Jul-24	Jul-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R5a. Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	Non-medical referrers (NMRs) to have ongoing bi-annual review. Historic NMRs to be identified and to undergo same process.	Apr-26	Apr-26	Amber

Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R5b. Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	All Medical/third party referrers to be identified by implementation of the new PACS and RIS system which will move entirely to electronic referrals.	Dec-25	Dec-25	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R5c. Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	Mitigation Six monthly Health Board wide communication from Medical Director/ Director of Therapies/ Executive Director of Nursing, Quality and Patient Experience to all medical and non-medical referrers working within their teams, to ensure they are aware of their referrer responsibilities and required training under IR(ME)R 2017. This will also be disseminated via "quick guide for e-IRMER support for Radiology" and global intranet communication.	May-24	~~May-24~~ N/K	Red
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R6. The employer must provide HIW with details of action taken to review and update the process of non-medical referrer clinical evaluation to ensure appropriate up to date training on how to clinically evaluate chest and musculoskeletal general radiography is being performed.	This will be escalated to the Executive Director of Therapies/ Executive Director of Nursing, Quality and Patient Experience. An action plan will be developed to ensure that an ongoing process is undertaken, whereby all non-medical referrers are aware of their responsibilities under IR(ME) 2017.This is to ensure that all non-medical referrers undertake up to date training and provide assurance to the employer that this has been completed in line with Ionising Safety Policy.	Aug-24	Aug-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R7. The health board must provide HIW with details of action taken to ensure that all staff are aware of the duty of candour and the implications for their role.	Training provision has been identified via the Health Board lead for training and in addition staff will attend online training to ensure compliance with Duty of Candour.	Dec-24	Dec-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R8. The department should review and update information in leaflets and appointment letters to improve inclusivity.	Patient information will be reviewed and amended to remove gender specific language and improve inclusivity. This will be translated. This will also be replicated across all radiology departments within the Health Board.	Aug-24	Aug-24	Amber
Jan-24	2023/24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Open	N/A	Radiology	Radiology	Faith Whitecross	Director of Operations	N/A	R9. The health board must consider the feedback percentages from staff and make a plan to address the issues.	Patient information will be reviewed and amended to remove gender specific language and improve inclusivity. This will be translated. This will also be replicated across all radiology departments within the Health Board.	Aug-24	Aug-24	Amber

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Jan-16	2016/17	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	Jan-16	~~Apr-22~~ ~~Oct-22~~ ~~Nov-22~~ Dec-24	Red
Jan-16	2016/17	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	Jan-16	~~Mar-23~~ ~~Apr-23~~ ~~Jul-23~~ ~~Mar-24~~ Aug-26	Red
Jan-16	2016/17	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Jan-16	~~Mar-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Dec-23~~ Aug-26	Red
Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red

Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	~~Jul-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red
Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Mar-23~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red
Jan-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ ~~Apr-22~~ ~~Jun-22~~ Aug-26	External
Mar-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Aug-22~~ ~~Mar-23~~ ~~Jun-23~~ ~~Mar-24~~ Aug-24	Red
Mar-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ ~~Jun-23~~ ~~Mar-24~~ Sep-24	Red
May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12h. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	June 2022 -Recommendation was accepted by HDUHB - Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	Jun-22	~~Oct-23~~ ~~Dec-23~~ ~~Mar-24~~ ~~Apr-24~~ Mar-25	Red

May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12i. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	June 2022 -Recommendation was accepted by HDUHB - Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	Jan-16	~~Oct-23~~ ~~Dec-23~~ ~~Feb-24~~ ~~Apr-24~~ Mar-25	Red
May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12j. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	June 2022 -Recommendation was accepted by HDUHB -Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	Jun-22	~~Dec-23~~ ~~Feb-24~~ ~~Apr-24~~ Mar-25	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	N/A	R2. HDUHB to establish a robust mechanism for capturing procedure level data of impatient day case and outpatient procedures.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~May-24~~ Sep-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R5. WGH to review emergency appendicectomy minimal access rates and develop an improvement strategy.	Awaiting management response.	Jun-23	~~Jun-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~May-24~~ N/K	Red

May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R6. GGH to review emergency readmission within 30 days following emergency appendicectomy and develop an improvement strategy.	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~May-24~~ N/K	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R7. BGH to review their Emergency laparotomy pathway in order to improve length of stay rates.	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~May-24~~ N/K	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R8. HB to review the care of patients having emergency laparotomy at WGH at this site is an outlier on the NELA data with an extremely high 30-day mortality rate	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ ~~Mar-24~~ ~~May-24~~ N/K	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R9. HB should develop plans to implement and staff dedicated surgical SDEC on acute sites	Awaiting management response.	Aug-23	~~Aug-23~~ ~~Mar-24~~ Oct-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R12. HB should develop both the pelvic floor service and concentrate elective IBD surgery in the hands of fewer surgeons to develop and maintain expertise.	Awaiting management response.	Aug-23	~~Aug-23~~ ~~Oct-23~~ ~~Mar-24~~ Dec-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R14. HB to review their internal criteria for day surgery and benchmark them against this outlined in the National Day Surgery Delivery Pack.	Awaiting management response.	Jun-23	~~Jun-23~~ ~~Nov-23~~ ~~Mar-24~~ Jul-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R18. HB should conduct a review of the preoperative assessment system and take action to implement the Guidance from CPOC of Pre-Operative assessment and optimization.	Awaiting management response.	May-23	~~May-23~~ ~~Nov-23~~ ~~Mar-24~~ Jul-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R19. HB to review pathway for patients with diabetes and to consider developing a preoperative diabetes team led by nurse specialists.	Awaiting management response.	May-23	~~May-23~~ ~~Nov-23~~ ~~Mar-24~~ Jul-24	Red
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R20. Action Plan to increase operating capacity to above pre-Covid levels in order to deal with the backlog of patients waiting for surgery.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ ~~Mar-24~~ ~~Jun-24~~ N/K	Red

May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R22. HB to review the current processes for obtaining and documenting patients consent for Surgery.	Awaiting management response.	Aug-23	~~Aug-23~~ ~~Dec-23~~ N/K	External
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack /Marta Barreiro Martins	Director of Operations	N/A	R3. Review the line management structure and explore whether a MDT cataract or whole ophthalmology surgical team across all areas (OP, day case, theatres, preop, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care	1) Workforce review to be undertaken by head of nursing and Senior Nurse Manager 2) Workforce development plan to be written and implemetnted.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R4. Appoint a formal clinical lead who has enough time in their job plan, and appropriate stable, senior service manager support to deliver.	1) Clinical lead JD to be reviewed and updated 2) Clinical lead role to be advertised for recruitment	Apr-24	~~Apr-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R5. Review the reasons with local optometrists as to why conversion rates lower than should be and take action to improve. Use a formal shared decision making tool, such as the NHS England one, in primary care	1) Review data for conversion rates 2) develop decision making tool for use in primary care	Jan-24	~~Jan-24~~ ~~Feb-24~~ ~~Mar-24~~ ~~Apr-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6. Hospital optometrists and nurses to undertake phone calls to screen out patients who don't need surgery and to counsel and prepopulate pre-op assessment documents at same time for those who do go ahead; consider using a health questionnaire.	1) Telephone assessment document to be developed. 2) Telephone assessment of patients on backlog to be undertaken. 2) Pre-operative documentation to be developed.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R7. Do all cataract pre-ops as a one stop, even GAs and complex cases, especially for patients living far away – aim for no more than 3 months before the date of surgery. For those done a long time ago or second eyes, do phone assessments and get "obs" from local GP or pharmacist.	1) One stop cataract pathway to be developed. 2) One stop cataract pathway to be introduced.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R8. Expand the staffing of pre-op assessments and the remit of the MDT, with techs and HCSWs doing more of the routine work up and biometry, and practitioners including nurses, orthoptists and optometrists able to undertake the fundal checks and consent; obtain IOLMaster 700s in all relevant sites to support the wider range of those who can undertake biometry. Consultants need to be present in the preops to give short input to all patients.	1) Workforce review to be undertaken by head of Nursing and Senior Nurse Manager 2) Workforce development plan to be written.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R9.Consent patients for both eyes at the first eye preop visit. Consent by phone for second eye or very long waiters already assessed and on list and post consent form out to read +/- sign at home.	1) Review of current consent process for bilateral cataracts 2) Review of current consent forms to align with above process.	Apr-24	~~Apr-24~~ N/K	Red

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R11.Offer ISBCS to all suitable patients..	1) Review current process for Bilateral cataract delivery. 2) Develop pathway for Bilateral cataract delivery. 3) Implement delivery of Bilateral cataract operations.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R12. Introduce standardised risk (in line with College guidance) and priority ratings for cataract surgery and change waiting list forms to support this	1) Review current waiting list forms and agree clear priority ratings. 2) Develop protocol to align with waiting list forms with clear priority ratings. 3) Implement new waiting list forms.	Apr-24	~~Apr-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R14. Create a protocol on managing co-morbidities based on GIRFT/RCOphth guidance, simplify relevant pre-op and on the day of surgery documentation in line with this and train staff to implement.	1) Identify patients with co-morbidities (e.g.via telephone screening) 2) Agree a pathway for patient with co-morbidities prior to theatre attendance (GGH and BGH theatre)	Apr-24	~~Apr-24~~ ~~May-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R15. Introduce high flow principles and processes to cataract lists and patients of ANY complexity to drive higher numbers of cases in all lists. Send for patient early enough to ensure they are ready in the anaesthetic room to enter theatre once the last case finished.	1) Review BGH and GGH suitability for high flow lists 2) If environment is not deemed suitable review process for current delivery of complex patients. 3) Review patient pathway and reduce delays with patient arriving in theatre.	Apr-24	~~Apr-24~~ ~~May-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R16. Do cataracts on cataract only lists and do GAs on GA only or primarily GA lists.	1) Review list of procedures delivered on theatre lists 2) Ensure dedicated cataract only lists are formulated on all three sites.	Apr-24	~~Apr-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R17. Non-medical MDT staff admitting the cataract patients should be trained and empowered to mark the eye, check or take consent etc – consider whether to involve the clinical nurse and optometrist practitioners and/or train the day surgery staff. Do not do routine obs on the day.	1) Review staff training to mark the eye with Senior Nurse Manager. 2) Review process for baseline obs	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R18. Eliminate the surgeon preop ward rounds. Trust each others' assessments OR put the patients on the same consultants list as assessed them at one stop. Consultants then only check notes (ideally before list begins or before the day of surgery) and greet and reassure the patient, ideally in the anaesthetic room. If really necessary to check the eye, provide a hand held slit lamp.	1) Consent patient in pre-assessment prior to procedure 2) Develop protocol for pre-checks prior to surgeon review on the day of operation.	Apr-24	~~Apr-24~~ ~~May-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R19. Stagger greeting of patients by surgeons, so that there is no delay to the start of surgery on the list. Ensure there is a "golden patient" listed first. Do not make patients wear gowns and hats.	1) Stop use of hats and gowns for patients where possible. 2) Consent patients in pre-assessment.. 3) Staggered arrival times can be introduced when patient consented in pre-assessment.	Apr-24	~~Apr-24~~ Nov-24	Red

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R21. Do not have patients climbing on and off a trolley in the operating room - position patients in the anaesthetic room and wheel the patient in and out on trolley or couch.	1) Check if theatre trolleys are fixed in theatres or if surgical trolleys can be wheeled in AVH- BGH- GGH-	Dec-23	~~Dec-23~~ ~~Jan-24~~ ~~Feb-24~~ ~~Apr-24~~ Jun-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R22. Organise some HVLC lists pilot and prove the principle, then roll out the learning. Use those consultants particularly who have done this elsewhere and consider using senior trainees from other health boards where available. Consider a “cataractathon” or “cataract month” to start – ABUHB have done this.	1) Scope outsourcing options. 2) Scope costs and possibility of cataractathon within own HB.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R23. Agree more cases per list and do not finish early or start late routinely or take a leisurely approach. Patients are waiting a long time for sight restoring surgery and this must drive everyone to operate efficiently and optimise surgical time. If high volume surgery with high numbers are achieved, early finish should be acceptable as a bonus to teams who achieve this.	1) Review start and finish times of theatre lists. 2) Feedback start and finish times to Consultants at QSE meeting. 3) Reduce delays to theatre lists following audit detail and discussion. 4) re-audit start and finish times.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R24. Rationalise cataract surgery to only units that are, or can be changed to be, suitable for high flow. Move other work out of the most suitable units to accommodate this.	1) Move IVT out of AVH OPD back to Pembrokeshire. 2) Move IVT service out of day theatre into AVH OPD. 3) Increase cataract delivery through AVH theatre	Apr-24	~~Apr-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R25. Urgently explore greater regionalisation and ability to offer cataract surgery for the region at Swansea as a surgical hub.	1) Explore outsourcing options with Swansea Bay.	Apr-24	~~Apr-24~~ ~~May-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R26. Non-medical MDT staff should be trained and empowered to routinely prep the skin with iodine, apply the drape, insert speculum, position microscope for surgeon, draft the operation note, print the op note/letter/discharge medication.	1) Train staff to prep the patient for surgery to reduce delays -Iodine -Drape -Speculum -Position microscope	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R27. The unit should undertake a whole MDT workforce review, pushing everyone to the top of their licence and assessing numbers and training requirements for cataract and HVLC.	1) Scope current workforce. 2) Scope current workforce competencies. 3) Develop a training pathway and competency assessment framework.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R28. RNOH/GIRFT recommends use of the Modelling software available RCOphth cataract workforce calculator.	1) Establish demand and capacity tool for cataract service. 2) Increase capacity through HVCL and inreased delivery of cataract lists. 2) Develop trajectory for recovery.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R31. Do not duplicate recording the same data on both paper and IT records	1) Review current process on paper and electronically. 2) Remove any steps that are duplicating information.	Jan-24	~~Feb-24~~ ~~Mar-24~~ ~~May-24~~ ~~Jun-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R33.Recommndation 33: Ensure regular internal cataract audits are done looking at PCR AND visual loss for the whole unit and individual surgeons	1) Review current audit data and identify gaps. 2) Establish audit timetable. 3) Feedback audits at QSE.	Apr-24	~~Apr-24~~ ~~Jun-24~~ N/K	Red

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R34. Undertake regular observational audits to measure and monitor the flow in cataract lists - Consultants and managers to go and observe the timings and flow of other consultant lists.	1) Review theatre lists and udertake initial audit. 2) Present report at QSE. 3) Repeat audit 6 monthly and report back to QSE.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R35. Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R36. Undertake a pilot of patient self dilating and, if successful, roll out to all suitable patients.	1) Discuss self dilation with ophthamology team around logistics. 2) Meet with Pharmacy to explore possibility and risks of self dilation.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R37. Consent must be taken before the day of surgery. Consider supporting the primary care optometrists to do more and share the consent form. Consider posting the consent form out to patients in advice, nurses and optometrists in clinic to be trained to consent and all consents done within the one stop clinic.	1) Explore consenting patient at pre-assessment. 2) Review consent form format and update as necessary. 3) Explore nurse led consent.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R39. Review methodology for ophthalmology/glaucoma activity and waiting times data collection, validation and sense checking and ensure all of the relevant team have sight of this and can discuss any actions required.	1) Review of Demand and Capacity. 2) Review of outpatient delivery. 3) Increase primary care delivery to Glaucoma A and B patients.	Feb-24	~~Feb-24~~ ~~Mar-24~~ ~~Jun-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R41. Ensure tests are done by techs and HCSWs were possible, ideally in layouts which support high flow, freeing up MDT clinicians in primary, community and secondary care to be clinical decision makers.	1) Review tech support in secondary care to increase virtual capacity 2) Continue to increase patient flow through Optometrists for Glaucoma A&B.	Feb-24	~~Feb-24~~ ~~Mar-24~~ ~~Jul-24~~ Aug-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R42. Ensure accurate data is regularly reported on the performance of referral filtering as well as ODTC's to drive improvements – as well as the % of first hospital glaucoma attendance discharge, what % of patients are kept out of new hospital visits by the repeat measures and ODTC refinement separately?	1) Discuss referral refinement delivery and delivery with primary care colleagues. 2) Undertake agreed audit of referral pathway. 3) Feedback data at QSE.	Apr-24	~~Apr-24~~ ~~Jun-24~~ Oct-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R43. Ensure consistent risk stratification is used for all patients at every glaucoma visit. This needs to be done at all sites and at all types of visit, including, as the pathway develops, in community optometry. Use this data to create a view of the whole glaucoma patient population who are at high, medium & low risk - this is critical to ensure they are managed appropriately and that resources can be deployed appropriately. This needs to be delivered as a matter of urgency.	1) Review of current waiting list and risk startification. 2) Optometrists to support with completing risk startification. 3) Glaucoma Consultants to assist with completing risk staratification process.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R44. Rationalise where ophthalmic outpatients are delivered to fewer better sites with dedicated ophthalmic spaces.	1) Undertake review of current delivery for Glaucoma clinics. 2) Plan increase in delivery of Glaucoma clinics including review of infrastructure. 3) Commence delivery of increased Glaucoma clinics	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R45. Re-explore the use of remote consultations after diagnostic data collection, to reduce the burden on outpatient space. Virtual reviews have to be carried out on a hospital site, but ensure they and remote consultations are not being done in clinical consulting rooms, as long as the clinicians can see the diagnostics data and records.	1) Introduce further virtual Glaucoma sessions for Consultants. 2) Scope delivery of virtual Glaucoma sessions for SAS doctors.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R46. Review the footprint and usage of all the outpatient areas and create ophthalmology and subspecialist areas with teams and all equipment in one or two area/sites for glaucoma.	1) Review current structure and delivery. 2) Plan new structure and delivery. 3) Commence new structure and delivery. This action may be restricted by cost to implement.	Apr-24	~~Apr-24~~ Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R47. Work with the health board and the regional team to find a better outpatient solution, fit for modern ophthalmic care and the longer-term rising population demand which can support training the MDT. Consider all options for the regional collaboration with other relevant health boards.	1) Review where SAS doctors currently support Consultant clinics to identify training opportunities. 2) Develop SAS doctors and non medical staff in line with training needs and liaise with SBUHB for support with development.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R48. HDUHB working within the regional context needs also to ascertain the required community ODTC footprint to support the long-term outpatient capacity, taking into account population demand over time and the likely implementation of the new WGOS contract. Plans need to describe how this is to be established on a sustainable basis, ensuring all sites can support high flow efficient, technician/HCSW led assessments.	1) Review of Glaucoma categories and suitable pathways for management. Glaucoma A - optom Glaucoma B - ODTC Glaucoma C - general clinics Glaucoma D - Specialist clinics 2) Implement management plan for all categories.	Apr-24	~~Apr-24~~ ~~May-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R49. Consider mobile vans and units - "the glaucoma bus".	1) Scope the need for a Glaucoma bus and what this would deliver. This action may be restricted by cost to implement.	Apr-24	~~Apr-24~~ Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R52. Urgently link up regionally to use resources to their best availability including medical and MDT manpower for cataract, glaucoma and other areas.	1) Continue to develop open eyes project as a regional development. 2) Scope possibility of cataract delivery through SBUHB.	Jan-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R53. Fund more ophthalmic (optometrist, orthoptic and nurse) practitioners and develop them. Fund more technicians and health care support workers and train them to deliver a wider scope of practice.	1) Scope the recruitment of 1.9 WTE Glaucoma practitioner. 2) Plan development of Glaucoma practitioners. This action may be restricted by costs to implement.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R54. Consider adapting UKOA Guidelines across all 3 professions including training SLT practitioners using UKOA guidance. Utilise the OPT framework for training MDT staff.	1) Develop a rolling programme of staff to go through OCT training. 2) Identify a training lead for the HB.	Apr-24	~~Apr-24~~ ~~Jun-24~~ N/K	Red

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R55. Undertake a comprehensive review of the roles, job plans, numbers and professional development of the MDT, in glaucoma services in hospital and the ODTCs. Utilise the capabilities of non-medical staff to maximum so that the consultants can concentrate on the complex cases, training and service improvement.	1) Undertake review of current roles in delivery of Glaucoma pathway by Head of Nursing and Senior Nurse manager. 2) Map development of workforce within pathway to align with service plan.	Apr-24	Nov-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R58. Undertake proper demand and capacity work and explore realistic options for change, and how much and how quickly they will deliver. Accelerate business cases to imrpove capacity and implement.	1) Utilise demand and capacity work recently undertaken to build a robust model of service delivery. 2) map recovery plan in line with the above.	Feb-24	~~Feb-24~~ ~~Mar-24~~ ~~Jun-24~~ N/K	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R59. The very long waiters need to be assessed now (e.g. by virtual assessments) regardless of the original risk rating to avoid cases of serious harm.	1) Scope potential Increase in virtual capacity in the HB to virtually review high risk cohort of longest wait patients.	Apr-24	~~Apr-24~~ Jul-24	Red
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R40. Develop two stop/virtual diagnostics sessions in the ODTC's, hospital sites and optometry practices even when the decision maker is not the hospital consultant, to optimise new patient throughput. Separate interactions to differentiate between diagnostics (tests) from the virtual clinical review.	1) Meet with Optometrists to discuss further development of ODTC pathway. 2) Increase delivery through ODTC for Glaucoma B patients.	Feb-24	~~Feb-24~~ ~~Mar-24~~ Oct-24	Red
Feb-24	2023/24	Internal Audit	Follow-up: Theatre Loan Trays & Consumables Final Internal Audit Report	Open	Reasonable	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	Medium	R1. Management to decide whether: • Patient details are required to be provided by the private hospital (subject to information governance implications) and manually recorded on the Health Edge system; or • Given the infrequency of such requests, the risk associated with the lack of patient traceability is deemed tolerable / acceptable. 3.1 Previous Matter Arising 3: Patient Traceability (Design)	Risk assessment to be considered via the Directorate Q&S Group in March 2024. Adoption of an alternative patient traceability solution will require confirmed sign off from the Directorate Management Team (Clinical Director, General Manager and Head of Nursing).	Jun-23	~~Mar-24~~ Mar-25	Red

Feb-24	2023/24	Internal Audit	Follow-up: Theatre Loan Trays & Consumables Final Internal Audit Report	Open	Reasonable	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	High	R2. Previous recommendation reiterated: High value consumables such as implants and prostheses should be treated as controlled stock with appropriately restricted access and a record of stock balances, purchases and issues maintained. This should include both Health Board-owned and consignment stock 7.1a Previous Matter Arising 7: Consumables – Stock Control (Design)	There is limited access to Theatre spaces and inventory. All sites have either swipe or code access to Theatres. No stock is in plain view and is stored in dedicated storage areas. The implementation of Scan for Safety (S4S) and related Inventory Management System (IMS) into Bronglais is progressing with support of NWSSP All Wales Implementation Lead, NWSSP Hywel Dda project partner, and HDUHB Theatre Commodities lead. (Endoscopy and Critical Care have recently launched). The inventory build for Bronglais theatres is due to commence mid-February with some 3500+ itemdetails to be loaded. Theatre teams are working on PAR levels, restock trigger levels, minimum stock numbers, and items to be directly scanned to patients which will ultimately be placed on against the inventory database. Proposed launch date for Bronglais Theatres: 22 April 2024. Proposed order of launch – dates to be determined based upon ease or challenge of BGH Theatre launch: • PPH Endoscopy, PPH Critical Care, PPH Theatres • GGH Endoscopy, GGH Critical Care, GGH Theatres • WGH Endoscopy, WGH Critical Care, WGH Theatres Introductory visits to PPH have taken place; outlining intentions of S4S and IMS, steering staff interest to related website and what the next steps will be.	Dec-24	Mar-25	Amber
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R1. Apologise to Mrs R for the failings identified and distress caused in pursing this complaint.	Reflect on Final Report and issue an appropriate apology letter	Apr-24	~~Apr-24~~ N/K	Red
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R2. Offer a financial redress payment to Mrs R of £1000 for the failings identified including lack of nutrition for Mr R and the ongoing uncertainty and distress caused to her.	Include offer in apology letter	Apr-24	~~Apr-24~~ N/K	Red
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R3. Share the final report with relevant clinicians, to reflect upon its findings and the failings identified.	The Clinical lead for General Surgery will circulate the final report to all concerned within the Scheduled Care Directorate	Apr-24	~~Apr-24~~ N/K	Red
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R4. Remind relevant staff of the need for close collaboration between professionals for complex cases, timely referrals for procedures and to other disciplines.	Suggested: Could the outcomes together with the final report be fed into the whole-hospital audit?	Apr-24	~~Apr-24~~ N/K	Red
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R5. Remind staff of the need to complete a nutritional screen within 24 hours of admission, rescreen weekly, consider alternative measurements when a weight is not available and ensure timely referrals to dietetic services particularly for patients who have prolonged periods of being nil by mouth/have inadequate nutrition/obstructive symptoms.	The recommendation will be raised at the Nutrition and Hydration Group, an email will be sent to SNMT for wider dissemination and to medical staff and therapies (dietetics and SLT) through their management/professional routes.	Apr-24	~~Apr-24~~ N/K	Red
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R6. Arrange for the report to be discussed at an appropriate clinical governance meeting.	To be presented at the March 2024 M&M meeting for General Surgery	Jun-24	Jun-24	Amber

Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R7. Review its training of staff in relation to nutritional screening and referring on to dietetic services.	The completion of the WAASP screening tool scoping work and agreed actions to support improved screening practice, including further Nutrition & Hydration Champion Training are underway. This improvement work is being monitored by the acute site operational nutrition and hydration assurance meetings, with exception reporting to Nutrition and Hydration Group	Jun-24	Jun-24	Amber
Feb-24	2023/24	Public Service Ombudsman (Wales)	202207759	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R8. Provide an update regarding the implementation of the new guidance on malignant bowel obstruction.	SBUHB MBO guideline has been circulated to the HDUHB clinicians as a basis of what we need to adopt. Further discussion will be had at the February 2024 General Surgery Business meeting	Jun-24	Jun-24	Amber
Mar-24	2023/24	Public Service Ombudsman (Wales)	202203963	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R3. Liaise with Swansea Bay University Health Board to provide evidence that the failure to properly consider or respond to the PET scan report has been considered at a relevant clinical governance meeting of the specialist MDT and that relevant learning points have been identified and shared with all members of the specialist MDT.	Mr Harries to liaise with colleagues in Swansea Bay to establish what would be an appropriate clinical governance meeting of the specialist MDT	Jul-24	Jul-24	Amber
Mar-24	2023/24	Public Service Ombudsman (Wales)	202203963	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Director of Operations	N/A	R4. Provide evidence that the failings which led to Mrs A receiving an inappropriately high level of buprenorphine over 6 days have been considered at a relevant clinical governance meeting of the surgical team and that relevant learning points have been identified and shared with all members of the team.	To be discussed at the Morbidity & Mortality meeting and the Surgical Business Meeting	Jul-24	Jul-24	Amber

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Jun-21	2021/22	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	High	R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked.	As part of Targeted Intervention, the Health Board is undertaking an assessment of its planning maturity, incorporating the alignment of plans. In addition, an Independent Review is being conducted by Sally Attwood on behalf of Welsh Government. Once complete the Health Board will develop action plans to respond to both of these pieces of work. The capacity and role of the planning function will be important considerations within this, see below for an update on capacity.	Sep-21	~~Mar-24~~ Oct-24	Red
Jun-21	2021/22	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	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.	The Health Board has recently (January 2023) transferred the commissioning function in to the Planning Directorate. The alignment and amalgamation of the Planning and Commissioning team has provided additional resilience within the Directorate. However, it is worth noting the commissioning team only consisted of 2.0 WTEs (with 1.0 WTE split between Planning and Commissioning) and are responsible for a budget of circa £170m. As part of Targeted Intervention, there is an Independent Review being conducted by Sally Attwood on behalf of Welsh Government. It is anticipated this will consider the capacity and capabilities within the team, which the Health Board will then consider how best to respond.	Mar-22	~~Mar-24~~ Oct-24	Red
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R2. Consideration should be given to establishing the Programme Group as a formal Committee of the Board.	To be considered as part of the overall governance requirements of the programme.	Jan-24	~~Jan24~~ ~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R4. When linkage is required to the Executive Team/ Executive Steering Group, the accountability arrangements should be clearly defined.	Agreed.	Jan-24	~~Jan24~~ ~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R5. Linkage to the Major Infrastructure PBC will be defined.	To be considered as part of the overall governance requirements of the programme.	Sep-23	~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R9. The master programme should be activity/ task based.	Agreed.	Sep-23	~~Mar-24~~ N/K	External

Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R13. An activity-based resource schedule will be produced for the Outline Business Case stage.	A resource plan has been agreed for the current stage, however a full exercise is required for the next stage.	Sep-23	~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R14. Existing Health Board staff (including the SRO and Executive Team) will be advised of the expected level of commitment anticipated for the production of the Outline Business Case.	Agreed.	Sep-23	~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R15. Adequate representation will be secured from all key functions e.g. workforce, clinical, finance, IT, hotel services etc.	Agreed.	Sep-23	~~Mar-24~~ N/K	External
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R16. Having identified the resource requirement to prepare each aspect of the Outline Business Case, the Health Board should seek to build its own internal resource/ expertise.	Agreed.	Sep-23	~~Mar-24~~ N/K	External
Feb-24	2023/24	Internal Audit	Decarbonisation , issued February 2024	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategic Development and Operational Planning	High	R1. Matter Arising 1: Action Plan and Funding Strategies (Design) Management should ensure: - A fully costed plan should be developed to meet the 2030 target and re-evaluated to update the baseline projections; - A review of staff resources dedicated to decarbonisation should be undertaken and actions identified to mitigate any staff resource risk; and -A long-term financial model for the funding required to support the decarbonisation programme to provide assurance to the Board regarding achievement of WG targets should be developed. A clear timeline should be determined for undertaking this exercise, with progress monitored at a relevant forum. Management should review the current service level risk entry for decarbonisation (Risk No. 1544) with a view to escalating to the corporate risk register where the above cannot be progressed and impacts the Health Board's ability to meet national targets.	The Health Board's Decarbonisation Delivery plan provided indicative costs for the first phase of the programme, where those costs could be quantified. Given the scale and duration of the Decarbonisation programme it isn't possible to fully cost all elements, ahead of knowing the options and implications of plans. Feasibility studies for example will be required to create the costing outputs and there is currently little/no funding available to conduct these. In addition work continues nationally to define the measurements for carbon reporting and therefore the baseline against which the plan needs to deliver is yet to be determined. In response to the action the Decarbonisation Task Force will formally consider: - The potential to provide updated cost estimates for the delivery plan, recognising the limitations on this as noted above; - A review of staff resources and potential mitigations; - The actions we anticipate will be funded through the HB (either revenue or capital) and the actions which will require Welsh Government funding, this will then be shared with the national programme and recommended for discussion at the National Programme Board; and - The directorate risk for decarbonisation and requirement for escalation to corporate risk register.	Mar-24	~~Mar-24~~ Jul-24	Red
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Low	R1. The project plan should include time-tabled outputs from sub-groups as part of their defined operation and accountabilities. Matter Arising 1: Sub-group scheduling (Design)	Agreed. Stage plans and outputs will be defined at appropriate stages.	May-24	~~May-24~~ N/K	Red
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R2. Project reporting should be enhanced to include contractual attribution of delay, funding, anticipated out-turn and associated variance commentary. Matter Arising 2: Cost & funding reporting (Operation)	Agreed. These matters will be addressed at future reporting.	Sep-24	Sep-24	Amber

Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R4. The Project Group will be provided with assurance of value for money attained in relation to the business case fees charged by the SCP at the Target Cost stage (e.g. by way of benchmarking and priced activity schedules). Matter Arising 3: FBC Value for Money assurance – SCP Fees (Operation)	Agreed – to be actioned at future stages / projects.	Mar-24	Mar-24	Amber
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R5. The Health Board should confirm that design sign-off has been appropriate recorded and records retained in the event of future user queries/design change requirements etc. Matter Arising 4: User sign-off (Operation)	Agreed – Full user/tenant sign-off will be confirmed to the Project Board and retention arrangements determined.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R6. Agreements should be signed with tenants based on the final design at the earliest opportunity to mitigate risk, and confirm design, occupancy modelling and target benefits. Matter Arising 4: User sign-off (Operation)	Agreed. – Tenancy agreements are currently being discussed, and will be agreed at the earliest opportunity.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R7. The Project Group should be afforded the ability to scrutinise an appropriate range of lessons learnt reports (NHS and other) and their application to the Cross Hands development Matter Arising 5: Lessons learnt (Operation)	Agreed. The Project Group will confirm that appropriate lessons learnt and benchmarking information has been appropriately applied in the Cross Hands development.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R8. Management should consider how key project benchmarking data can be collated, retained and accessible to inform the design and development of future Health Board projects Matter Arising 5: Lessons learnt (Operation)	Agreed. We will look to collate and assess an appropriate range of available information to inform future developments and associated design requirements etc.	Dec-24	Dec-24	Amber
Mar-24	2023/24	Internal Audit	Cross Hands Health & Wellbeing Centre Final Internal Audit Report	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategy and Planning	Medium	R9. Future Assurance The Full Business Case should demonstrate how the overall value of assessed risks, and design development allowances (e.g. benchmarked area allowances), have been managed down from the Outline Business Case in accordance with Welsh Government guidance. Matter Arising 6: Cost increases (Operation)	Agreed. The FBC will apply Welsh Government guidance requirements.	Sep-24	Sep-24	Amber
Jun-24	2024/25	Internal Audit	Planning Maturity Matrix Final Internal Audit Report June 2024	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategic Development and Operational Planning	Medium	R1. The approach to future self-assessment scoring sessions should involve scoring based on available evidence to demonstrate achievement of the criteria within the planning maturity matrix domains.	The evidence to support the discussions was collected proactively, and was used to shape these discussions. In future we will ensure that all evidence is made available for those discussions in advance. We will include this in any future reviews) of the Maturity Matrix – which we would expect to undertake in March 2025	May-25	May-25	Amber
Jun-24	2024/25	Internal Audit	Planning Maturity Matrix Final Internal Audit Report June 2024	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategic Development and Operational Planning	Medium	R2. In future, planned sign-off arrangements should include presentation to the Board prior to submission to Welsh Government.	It was agreed with Welsh Government that the assessment would be submitted in April following conclusion of the annual planning round and committee sign-off (initially it was not intended to take it to Board). When it was decided it should go to Public Board, to avoid delaying the submission to WG, it was agreed we would submit in April noting that the assessment would go to Board in May and WG informed of any material changes if necessary. In future, we will ensure any revised scoring of the maturity matrix and relevant evidence is factored into the timeline such that review by the Board is enabled prior to submission to Welsh Government. We will include this in any future review(s) of the Maturity Matrix – which we would expect to undertake in 12 months' time.	Jun-25	Jun-25	Amber

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Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	Medium	R1. Previous Matter Arising 2: Governance Arrangements 1.1 Quality and safety orientated supporting groups and meetings should report into the Quality Forum ensuring key issues and risks are brought to the attention of hospital management.	Band 3 "committee support" post has been advertised with interviews scheduled for late February. This post will support the formalisation of the various meetings that need to feed into the Quality Forum, ensuring risks are flagged up to management.	Dec-23	~~Apr-24~~ Oct-24	Red
Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	Medium	R2. Previous Matter Arising 2: Risk Register 2.1 Outstanding overdue risks recorded on the directorate register should be promptly addressed.	Risks are being reviewed on an ongoing basis. Actions being taken are sometimes open-ended (such as recruitment campaigns) and a review of how much this, along with other mitigations, reduces the presenting risk level is underway.	Oct-23	~~Apr-24~~ Oct-24	Red
Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	High	R3. Previous Matter Arising 5: Incidents Management A review of the remaining open incidents are promptly investigated and correctly assigned for clearing.	New incidents are reviewed and assigned quickly; the Head of Nursing for Quality and Safety is working with service areas to fully investigate and close incidents. The priority incidents will be those where harm has been identified. This process has begun.	Nov-23	~~Aug-24~~ Oct-24	Red

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Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	To ensure work alongside estates to review refurbishing staff changing rooms, shower facilities and toilets	Sep-23	~~Sep-23~~ ~~Mar-24~~ ~~Jun-24~~ Sept-24	Red

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Jun-16	2016/17	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	Jan-16	N/K	Red

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Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R4. Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R11. Welsh Government should consider strengthening its promotion of the Help Us to Help You campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R13. WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R14. Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R15. WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R30. Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R32. Recommendation 32 WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	N/A	N/A	N/A	External
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R44. Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.	N/A	N/A	N/A	External

Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Estates	Senior Nurse Manager	Director of Operations	N/A	R1. Ensure that IPC practises within the department are strengthened and environmental issues escalated to ensure that the risks to patients, staff and visitors are mitigated	Issue related to roof/gutter temporarily rectified by Estates, but requiring further maintenance to resolve.	Sep-23	~~Sep-23~~ Dec-24	Red
May-24	2024/25	Public Service Ombudsman (Wales)	202300406	Open		Unscheduled Care (WGH)	Unscheduled Care (WGH)	Bethan Andrews	Director of Operations		R1. Apologise to Mrs O and her family for the shortcomings identified in this report.	Reflect on the Ombudsman's finding and draft an appropriate apology letter.	Jun-24	Jun-24	Amber
May-24	2024/25	Public Service Ombudsman (Wales)	202300406	Open		Unscheduled Care (WGH)	Unscheduled Care (WGH)	Bethan Andrews	Director of Operations		R2. Offer Mrs O financial redress of £1000, in recognition of the impact of Mrs W's uncontrolled tacrolimus levels, and the uncertainty around their significance in her ultimate outcome.	Include the offer in the apology letter and if accepted provide confirmation from Finance once paid	Jun-24	Jun-24	Amber
May-24	2024/25	Public Service Ombudsman (Wales)	202300406	Open		Unscheduled Care (WGH)	Unscheduled Care (WGH)	Bethan Andrews	Director of Operations		R3. Share this report with all staff involved in and consulted on Mrs W's care during her admission, and also across the Health Board for wider learning and reflection.	Including narrative to highlight the learning taken from this case, and signpost to the Blood Science Test Requirements area on its intranet to ensure that staff without access to the medical induction app trial are aware of where to access that information.	Jun-24	Jun-24	Amber
May-24	2024/25	Public Service Ombudsman (Wales)	202300406	Open		Unscheduled Care (WGH)	Unscheduled Care (WGH)	Bethan Andrews	Director of Operations		R4. Provide evidence to the Ombudsman that specific information and instructions for requesting tacrolimus blood tests and sending samples to the Laboratory are readily available, either through the medical induction app or the Blood Science Test Requirements section for tacrolimus on the Health Board's intranet.	Evidence of the Induction Biochem uploaded to the EOLAS Medical App and the information available on EOLAS re tacrolimus. Blood Sciences Test Requirement guidance on the Intranet.	Jun-24	Jun-24	Amber

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Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R2. HDUHB to review with urgency the allocation of outpatient / day case and theatre sessions for gynaecology patients. There is inequity, at the moment, as demonstrated by a lack of ring-fenced beds.		Jun-23	~~Jun-23~~ Dec-24	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R3. HDUHB to encourage more nurses to be promoted and developed into Advanced Nurse Practitioners, recognising the training period of approximately 2 years and to further protect the service against the UK wide crisis of workforce recruitment and retention.	Awaiting management response from service	Sep-22	Jun-26	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Primary Care	Lyndon Freeman	Director of Operations	N/A	R4. HDUHB to carry out a full demand and capacity assessment with Primary Care, AHPs and in collaboration with neighbouring Health Boards. Together they need to develop standardised pathways of common gynaecological symptoms that should also include the mutual aid across health boards to enable more effective triage. This will also feature as a National recommendation in the all Wales report.	Awaiting management response from service	N/K	N/K	External
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R5. HDUHB to standardise procedure-level clinical pathways (HVLC) by adopting or adapting the GIRFT gynaecology pathways as required. These pathways were developed by 'expert advisory panels' supported by professional societies.	Awaiting management response from service	Sep-22	Dec-25	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R6. HDUHB to standardise referral pathways for common gynaecological complaints.	Awaiting management response from service	Sep-22	Dec-24	Red

Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R8. HDUHB to consider establishing an intermediate service or a Women's Health Hub of primary and secondary care expertise that is commissioned and funded appropriately – to triage patients appropriately. In addition it is recommended that diagnostic facilities are available (ultrasound scanning as a minimum) alongside allied health professional able to provide conservative management advice and supervision (menopause advice service, pessary management, physiotherapy, dietitians) as well as sexual and contraceptive health advice. Within this context Advice and Guidance/ Virtual and face to face appointments should be planned for maximum efficiency	Awaiting management response from service	Sep-22	Jun-26	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R9. HDUHB should carry out an audit of gynaecology theatre utilisation linking with demand, capacity and waiting list numbers to optimise available resource and establish the requisite needs for ambulatory/outpatient care, day-case or inpatient sessions. Size of waiting list and prioritisation will dictate the allocation of resource equitably and potentially provide an opportunity for mutual aid between specialties.	Awaiting management response from service	Sep-22	N/K	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R10. HDUHB to promote the "right place, right person, right time' principle for gynaecological patients requiring surgery embracing the trend to ambulatory /day case treatment with appropriate facilities and equipment adequate to provide the service for the immediate and medium term. This action should consider the opportunity of a central ambulatory hub in Cardigan.	Awaiting management response from service	Sep-22	Dec-25	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R11. HDUHB to increase and improve day surgery rates wherever possible by adopting GIRFT theatre principles (a link to the National Day Surgery Delivery Pack is provided in the original report containing further information):	Awaiting management response from service	Sep-22	Mar-25	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Digital	Lyndon Freeman	Director of Operations	N/A	R12. HDUHB to establish a robust mechanism for capturing procedure level data of in-patient, day case and out-patient (ambulatory) procedures in gynaecology. HDUHB should also develop a mechanism to capture diagnostic procedure coded operations of emergency Surgery (management of ovarian cysts, miscarriage/ectopic pregnancy and sepsis requiring surgery). This will be a recommendation in our all Wales Report.	Awaiting management response from service	Sep-22	N/K	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Digital	Lyndon Freeman	Director of Operations	N/A	R13. HDUHB to develop a relationship between clinical coders and consultants to improve data capture. HDUHB also to consider arranging regular meetings to review a sample of operation notes and develop an improvement strategy.	Awaiting management response from service	Sep-22	Mar-25	Red
Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R14. HDUHB to encourage the development of minimal access and vaginal surgery for benign and malignant conditions where appropriate and open abdominal surgery for a decreasing proportion with the emphasis on reducing length of stay for gynaecological inpatients along the lines of the BADS targets and the GIRFT "top decile" performance. This should include post-operative catheterisation.	Awaiting management response from service	Sep-22	Dec-24	Red

Sep-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Open	N/A	Women and Children's Services	Women and Children's Services	Lyndon Freeman	Director of Operations	N/A	R16. HDUHB to undertake a review of the therapeutic pathway of early pregnancy complications in order to improve timely management of care. The availability of staff able to perform ultrasound scanning to be included in this review.	Awaiting management response from service	Sep-22	Mar-25	Red
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R9. 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	Jul-24	Red
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R10. All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R12. 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	Nov-24	Red
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R22. Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	Jul-24	Red

Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R24. 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	Jul-24	Red
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R38. Congenital Heart Networks must demonstrate arrangements to minimise loss of patients to follow-up during transition and transfer. The transition to adult services will be tailored to reflect individual circumstances, taking into account any special needs. 'Lost to follow-up' rates must be recorded and discussed at the network multidisciplinary team meeting.	Network to link up audit evidence to include Helen Wallis' audit from 2019 patient lists.	Jul-24	Jul-24	Amber
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R39. The Children's Cardiac Transition Nurse will work as a core member of the children's Cardiac Team, liaising with young people, their parents/carers, the Children's Cardiac Nurse Specialist, ACHD Specialist Nurse and wider multidisciplinary team to facilitate the effective and timely transition from the children's to adult services.	All Wales Transition guidance will inform approach.	Jul-24	Jul-24	Amber
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R10a. The health board should develop and implement a system for tracking mandatory training levels for all clinical staff across the unit to ensure that they can address low levels of mandatory training compliance in a timely way	An Excel spreadsheet has been developed to support tracking of medical compliance with mandatory training	Jan-24	~~Jan-24~~ N/K	Red
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R10b. The health board should develop and implement a system for tracking mandatory training levels for all clinical staff across the unit to ensure that they can address low levels of mandatory training compliance in a timely way	Monitoring will sit with the Directorate Quality, Safety and Experience Meeting which meets on a monthly basis.	Jan-24	~~Jan-24~~ N/K	Red
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R2. The health board is required to provide HIW with details of the action taken: •to promote patient safety in the interim until compliance has improved.	Awaiting management response	Sep-23	~~Sep-23~~ N/K	Red
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R3b. The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits and informed patient consent should be gained	Audit compliance with the use of and documentation of care plans that evidence women having access to the information to make informed decisions/choices	Jan-24	~~Jan-24~~ N/K	Red
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Radiology	Head of Midwifery	Director of Operations	N/A	R7c. The health board must provide details of plans to mitigate the risks of not following national guidance regarding antenatal scanning as well as plans to increase antenatal scanning capacity for all women in line with guidance	HEIW funding secured to train to midwifery sonographers, programme commencing in January 2024	Jan-24	~~Jan-24~~ Jan-25	Red

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	Medium	R2. We found that there are several regional transformation projects at various stages, which have workforce implications and will need regional workforce modelling and plans. The Health Board should ensure these are adequately reflected in workforce plans to ensure it has the resources needed to support their development.	We are alert to ensuring that the needs of the Regional Workforce Planning activity is met, and are reflecting on how best we can approach this. At present, this is being absorbed through ARCH, Mid & West Wales Group and the Regional Board for Workforce. Resources for a) modelling and planning the workforce and b) associated workforce pipeline developed to ensure resource for delivery of the programmes themselves will be explored in partnership with other HB's and wider partners. A joint solution would be preferable however mitigations of risk may need to be introduced in the interim.	Apr-25	Apr-25	Amber
Mar-24	2023/24	Internal Audit	Agency & Rostering March 2024	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	Medium	R1. To ensure actions are taken to address anomalies within rosters and encourage thorough review, consideration should be given to amending the roster audit process to include a deadline for completion of actions to be taken by the Ward Manager/SNM, and confirmation to be provided to the Roster Team when they have done so.	The audit process will be updated to include a deadline for completion of the actions taken by the Ward Manager/Senior Nurse Manager and for confirming to the Roster Team.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Agency & Rostering March 2024	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	Medium	R2. Consider the merits of providing training on effective rostering practices to support efficient rostering.	Develop a training guide on how to roster to ensure optimum efficiency, and develop a training programme and schedule to ensure all new roster managers are trained on effective rostering practices.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Agency & Rostering March 2024	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	Medium	R3. Monitor additional duties shifts to scrutinise rationale for use and identify those added and/or approved retrospectively or added well in advance of the shift. Rosters with high incidence should be further investigated in conjunction with the Nurse Staffing Team to establish and address the root cause. Reports of additional duties shifts should be included in the weekly/monthly reporting to SNMs.	Reporting to be enhanced to provide information on additional shifts added, report to be distributed to Heads of Nursing and Senior Nurse managers. Usage across all areas to be discussed with the Nurse Staffing Team to establish and address the root cause.	Sep-24	Sep-24	Amber
Mar-24	2023/24	Internal Audit	Agency & Rostering March 2024	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	Medium	R3. Monitor additional duties shifts to scrutinise rationale for use and identify those added and/or approved retrospectively or added well in advance of the shift. Rosters with high incidence should be further investigated in conjunction with the Nurse Staffing Team to establish and address the root cause. Reports of additional duties shifts should be included in the weekly/monthly reporting to SNMs.	Metrics within 'Our Performance' dashboard to be developed to include Additional duties, with usage feeding into the Directorate Improving Together reporting pack.	Dec-24	Dec-24	Amber

Reports opened on the Audit Tracker since ARAC June 2024

Report name	Lead Executive/Director	Number of recs	Final report received at
Audit Wales - Review of Operational Governance – Hywel Dda University Health Board	Chief Operating Officer	4	Audit and Risk Assurance Committee
HIW - Neyland and Johnson Health Centre Inspection January 2024	Director of Primary Care, Community and Long-Term Care	18	Quality Safety and Experience Committee
HIW- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Review	Interim Director of Nursing, Quality and Patient Experience	17	Quality Safety and Experience Committee
HTA - Glangwili General Hospital Mortuary inspection April 2024	Director of Allied Health Professionals and Health Sciences	9	Health and Safety Committee
Internal Audit - Reinforced Autoclaved Aerated Concrete Programme – Withybush General Hospital	Chief Operating Officer	3	Audit and Risk Assurance Committee
Internal Audit - Emergency Response Planning – Industrial Action Final Internal Audit Report June 2024	Director of Public Health	3	Audit and Risk Assurance Committee
Internal Audit - Accelerated Cluster Development Final Internal Audit Report June 2024	Director of Primary Care, Community and Long-Term Care	1	Audit and Risk Assurance Committee
Internal Audit - Health & Care Quality Standards Final Internal Audit Report June 2024	Interim Director of Nursing, Quality and Patient Experience	3	Audit and Risk Assurance Committee
Internal Audit - Planning Maturity Matrix Final Internal Audit Report June 2024	Director of Strategic Development and Operational Planning	2	Audit and Risk Assurance Committee
MWWFRS - Letter of Fire Safety Matters Premises: Central Core, GF Block 6, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Chief Operating Officer	9	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Chief Operating Officer	4	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Morlais Ward - Block 21, West Wales General Hospital, Dolgwili, Carmarthen SA31 2AF	Chief Operating Officer	7	Health and Safety Committee

MWWFRS - Letter of Fire Safety Matters Premises: Cwm Seren PICU Ward, Hafan Derwen, Jobs Well Road, Carmarthen SA31 3HB	Chief Operating Officer	9	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Chief Operating Officer	4	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Chief Operating Officer	15	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Chief Operating Officer	12	Health and Safety Committee
MWWFRS - Letter of Fire Safety Matters Premises: Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth, SY23 1ER June 2024	Chief Operating Officer	10	Health and Safety Committee
PSOW - 202300406	Chief Operating Officer	4	Listening and Learning Committee
NHS Wales Cyber Resilience Unit - Cyber Assessment Framework Report March 2024	Director of Finance	7	Information Governance Sub Committee
HEIW - Trauma and Orthopaedics Glangwili Hospital March 2024	Interim Medical Director	8	People Organisational Development Culture Committee
Welsh Government - Fuller Inquiry Part One	Director of Allied Health Professionals and Health Sciences	17	Health and Safety Committee
CIW - Withybush Hospital Creche Report October 2023	Chief Operating Officer	15	Quality, Safety & Experience Committee
CIW - Withybush Hospital Creche Follow-Up Report March 2024	Chief Operating Officer	12	Quality, Safety & Experience Committee
Total: 23			

Reports closed on the Audit Tracker since ARAC June 2024

Report name	Lead Executive/Director
HIW - Prince Philip Hospital Minor Injuries Unit	Chief Operating Officer
Internal Audit - Records Management	Chief Operating Officer
Internal Audit- Cyber Security	Chief Operating Officer
Internal Audit - Glangwili Hospital - Women & Children's Development, issued February 2023	Chief Operating Officer
Internal Audit - Fitness for Digital - Use of Digital Technology	Chief Operating Officer
PSOW - 202202950	Interim Director of Nursing, Quality and Patient Experience
PSOW - 202108316	Director of Allied Health Professionals and Health Sciences
NHS Wales Cyber Resilience Unit- Cyber Assessment Framework Report	Director of Finance
Total: 8	

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales- Primary Care Follow-up Review – Hywel Dda University Health Board	1	April 2024	1 - Original completion dates lapsed	Primary Care	Since the data was extracted for this report, a revised timescale of July 2024 has been provided for this recommendation. This will be reflected in the next report to ARAC.
Care Inspectorate Wales - Withybush Hospital Creche October 2023	3	October 2023	3 – Action 'Not Started' on AMaT	Estates	The report was originally received by the service in October 2023 and added to AMaT in May 2024. The 3 recommendations are noted as 'Not Started' on AMaT. Progress updates and timescales are required from the service on AMaT, with updates to be reflected to ARAC in October 2024.
Care Inspectorate Wales - Withybush Hospital Creche Follow-Up Report March 2024	1	May 2024	1 - Awaiting QAST update via AMaT.	Estates	This recommendation is noted as 'In Progress' on AMaT, with the service advising that this recommendation is no longer applicable. Advice is awaited from QAST, with updates to be reflected in the next report to ARAC.
Community Health Council - Palliative End of Life Care	3	September 2023	1 - Original completion dates lapsed	Ceredigion	This system-wide report is aligned to Ceredigion on AMaT, noting that responsibility for actions spans the 3 Counties. As a result of discussions at the Ceredigion escalation meeting in June 2024, clarification is being sought regarding the alignment of this report for future reporting and monitoring, with an action to address the lack of a Health Board lead for Palliative Care. Progress updates, revised timescales and evidence to support completion will be required from service leads on AMaT.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Delivery Unit- All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	1	March 2024	1 - Original completion dates lapsed	Mental Health & Learning Disabilities	Since the data for this report was extracted, the recommendation has now been noted as 'Fully Complete – Awaiting Approval' on AMaT.
HEIW- Revalidation Quality Review Report	1	May 2024	1 – Original completion date lapsed	Medical	Since the data was extracted for this report, an update has been received from the Assistant Director of the Medical Directorate and a revised completion date of August 2024 has been set for this recommendation.
HEIW- Surgical Specialties Glangwili General Hospital	1 External	April 2024	1- External	Medical	This recommendation has been noted as 'external', as an action assigned to Health Education and Improvement Wales (HEIW) to increase the risk rating assigned to the concerns in this report following further visits must be completed first before this recommendation can be progressed.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - Mental Health Discharge Review	5	April 2024	2 - Original completion dates lapsed 2 – Action 'Unable to Complete' on AMaT 1 – Action 'Fully Complete, Approved' on AMaT	Mental Health & Learning Disabilities	Since the data for this report was extracted, 2 recommendations have been noted as 'Unable to Complete' - National Patient Safety Programme with initial focus on inpatients will supersede work within one related to standards for discharge and the action related to providing Care Partner access to temporary staff has been explored and is not viable without significant investment in infrastructure to facilitate. 1 recommendation is noted as 'Fully Complete Approved'. Progress updates and revised timescales are required from the service on AMaT for the remaining 2 recommendations.
HIW- Neyland and Johnson Health Centre Inspection January 2024	3	May 2024	3 - Original completion dates lapsed	Primary Care	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected in the next report to ARAC.
HIW - Bronglais Hospital Maternity Unit	3	January 2024	3 - Original completion dates lapsed	Women and Children's Services	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected in the next report to ARAC.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW- St Non, St Caradog, Canolfan Bro Cerwyn WGH	2	February 2024	2 - Revised completion dates lapsed	Mental Health & Learning Disabilities	The recommendations are aligned to Estates & Facilities on AMaT. Progress updates were provided for all recommendations in May 2024, but revised dates for completion were not provided. Progress updates and revised timescales are required from the service on AMaT.
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November	1	September 2023	1 - Original completion dates lapsed	Radiology	Progress updates and revised timescales are required from the service on AMaT.
HIW IRMER - HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	1	May 2024	1 - Original completion dates lapsed	Radiology	Progress updates and revised timescales are required from the service on AMaT.
Internal Audit - Cross Hands Health & Wellbeing Centre Final Internal Audit Report	1	May 2024	1 - Original completion date lapsed	Strategic Development and Operational Planning	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected in the next report to ARAC.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - A Healthier Mid & West Wales Programme	8 External	March 2024	8 – External Original completion dates lapsed	Strategic Development and Operational Planning	These recommendations are noted as 'external' as the service are unable to complete their actions until WG have decided on the submitted Strategic Outline Case (as agreed with Internal Audit). Progress updates and revised timescales are required from the service on AMaT.
Internal Audit - Falls Prevention and Management	1 External	June 2023	1 – External	NQPE	This recommendation relating to an 'in person' training package for the Falls Strategy was presented to the Clinical Education Governance Group (CEGG) Panel in June 2024 for approval. The Assurance and Risk Team are awaiting confirmation from IA if this recommendation can be closed.
Internal Audit – Deprivation of Liberty Safeguards (DoLS) (August 2023)	1	March 2024	1 – Original completion date lapsed	Long Term Care	The Assurance and Risk Team are awaiting confirmation from IA if this recommendation can be closed.
Internal Audit- Regional Integration Fund	1 External	September 2023	1 - External	Finance	The recommendation relates to the finalisation of a Memorandum of Understanding (MOU), setting out key roles and responsibilities for the governance and accountability arrangements of the Regional Integration Fund for the next financial year. It was assigned an 'external' status in December 2023 as the Health Board is awaiting an update from the Integrated Executive Group (IEG) to progress and confirm a revised timescale.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit- Transforming Urgent & Emergency Care (TUEC)	1	April 2024	1 – Awaiting timescales from service	Acute Services	The Head of Assurance and Risk is scheduled to meet with TUEC Programme Manager and USC Lead in July 2024 to obtain progress updates.
Mid and West Wales Fire and Rescue Service - Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	1	May 2024	1 – Awaiting timescales from service	Estates	Progress updates and revised timescales are required from the service on AMaT.
Mid and West Wales Fire and Rescue Service - Letter of Fire Safety Matters Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	1	May 2024	1 – Awaiting timescales from service	Estates	Progress updates and revised timescales are required from the service on AMaT.
Mid and West Wales Fire and Rescue Service - Letter of Fire Safety Matters Premises: Template 25, Ty Bryngwyn Hospice, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	4	May 2024	4 – Awaiting timescales from service	Estates	Progress updates and revised timescales are required from the service on AMaT. .

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Mid and West Wales Fire and Rescue Service - Letter of Fire Safety Matters Premises: Morlais Ward - Block 21.West Wales General Hospital, Dolgwili ,Carmarthen SA31 2AF	7	June 2024	7 – Original completion date lapsed	Estates	Since the data for this report was extracted, original and revised completion dates have been provided of October 2024. Progress updates and revised timescales are required from the service on AMaT.
NHS Wales Executive - Review of Psychology & Psychological Interventions for Children and Young People	1	May 2024	1 – Original completion date lapsed	Mental Health & Learning Disabilities	This recommendation is aligned to Community Paediatrics service, aligned to Women and Children's Directorate on AMaT as the supporting service. Mental Health & Learning Disabilities are reliant on Community Paediatrics to provide an update. Progress updates and revised timescales are required from the service on AMaT.
Peer Review- Respiratory Cancer Review, issued June 2016	1	July 2016	1 – Revised completion date lapsed	Unscheduled Care (PPH)	Agreement on how to progress with this recommendation is currently being sought by the Head of Assurance and Risk.
Peer Review- Colorectal Cancer (Third Cycle), issued January 2022	1 External	March 2024	1 – External Revised completion date lapsed	Cancer Services	Since extracting the data for this report, this recommendation has been closed by the service.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review- Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	1 External	June 2023	1 - External	Women and Children's Services	The Congenital Heart Defect Network have confirmed there is no further action required by the Health Board at this time until a standardised national template is agreed and made available. In the interim, other actions have been put in place to ensure the high quality of information exchanged when children and young people are transferred between different networks.
Peer Review - GIRFT - Gynaecology Review - September 2022	3 (1 External)	September 2022	3 – Original completion dates lapsed	Women and Children's Services	The report was originally received by the service in September 2022 and added to AMaT in April 2024. These 3 recommendations were last updated in May 2024. No revised timescales were assigned to these actions, which relate to a demand and capacity assessment to develop standardised pathways, an audit of theatre utilisation, and establishing procedures for data capture. Progress updates and revised timescales are required on AMaT.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Out of Hours	2 (1 External)	September 2023	1 - External 1 - Original completion date lapsed	Central Operations	1 recommendation has an 'external' status and is reliant on national guidance on remote prescribing. Once received, a policy can be developed to support clinicians and build on current work to improve prescribing efficiency and communication with pharmacies. There has been no further progress with the recommendation to collaborate with the Urgent Primary Care Centre to develop integrated plans for 24/7 care delivery. The Assurance and Risk Team have now added this report to AMaT and will be arranging training with the OOH service during Q2 2024.
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	6	April 2024	2 – Noted as 'Unable to Complete' on AMaT 4 - Original completion dates lapsed	Mental Health & Learning Disabilities	Since the data for this report was extracted, 2 recommendations have been noted as 'Unable to Complete'. This is due to an internal revision of job roles with no internal specialist expertise or scope for development. Progress updates and revised timescales are required from the service on AMaT for the remaining 4 recommendations.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review- GIRFT General Surgery Review	6 (1 External)	December 2023	1 – Revised timescale lapsed	Scheduled Care	The implementation of this recommendation is currently outside the gift of the Health Board as the service await the rollout of a national E-consent programme.
Peer Review- GIRFT Ophthalmology Review	18	May 2024	5 – Original completion dates lapsed 13 – Revised completion dates lapsed	Scheduled Care	Updates have been received via AMaT for all recommendations on the report, and whilst recommendations are being progressed, many do not have revised timescales. Barriers towards completion noted against actions include staffing challenges, sickness and staff absence, slow turnaround of Theatre lists, a reluctance for consultants to take on Clinical Lead roles and a lack of allocated space preventing centralisation of services. Revised timescales are required from the service on AMaT, with updates to be reflected in the next report to ARAC.
PSOW- 202207759	5	April 2024	5 – Original completion dates lapsed	Scheduled Care	Evidence of compliance has been submitted by the service, however PSOW have advised that further discussions with the service are required prior to recommendations being confirmed as implemented. Updates will be sought from the Public Service Ombudsman case manager.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Public Health Wales- Llwynhendy Tuberculosis Outbreak External Review	6 External	July 2023	6 – External Revised completion date lapsed	Medical	6 recommendations are led by Public Health Wales (PHW), with support from Welsh Government and have been given an 'external' status. Updates have been provided by PHW including the development of the TB elimination strategic action plan, however revised dates have not yet been provided.
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	1	March 2024	1 - Revised completion date lapsed	Medical	The Assurance and Risk Team have added this report to AMaT and currently arranging training with the service during Q2 2024.
Welsh Government - Fuller Inquiry Part One	2	March 2024	1 – Original completion date lapsed 1 – Action 'Not Started' on AMaT	Pathology	Progress updates and revised timescales are required from the service on AMaT for the recommendations, with updates to be reflected in the next report to ARAC.
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	1 External	March 2024	1 – External	Director of Operations	The recommendation relates to the development of a database of patient information leaflets used within the consent process. The Health Board is reliant on the development of the required database which is led by the All Wales Consent to Treatment Group, which has been delayed.

Appendix 4

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Welsh Risk Pool- Concerns Assessment	2	March 2024	2 - Revised completion dates lapsed	NQPE	Progress updates and revised timescales are required from the service on AMaT for the recommendations, with updates to be reflected in the next report to ARAC.
Total number of N/K Recs	**108**				