Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 June 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 April 2024.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** on the rolling programme to collate updates from services on a bi-monthly basis in order to report progress to the Committee; and
- **TO DISCUSS** and **AGREE** any relevant action for those services highlighted as a Service of Concern.

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 onto the Health Board central tracker, and progress regarding the implementation against each recommendation is monitored. The Audit Tracker utilises a traffic light system in relation to the timeframes to implement recommendations. The criteria for this system is as below:

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

Revised Governance Arrangements

Since the previous report presented to ARAC in April 2024, revised governance arrangements have been introduced in order to address the challenges which the Health Board are currently facing, highlighted by the fact that the organisation is currently in Targeted Intervention status with Welsh Government (WG). Governance is one of the six domains which are assessed by WG in order to determine the Health Board's escalation status. To ensure that the Health Board can provide the best possible patient and staff experience, and to continue with necessary improvements, adaptations to governance structures have been introduced and implemented. The existing Directorate Improving Together (DIT) sessions have been developed to support an internal escalation framework for directorates, who will be assessed against the six domains (including governance) to drive improvement in performance against several metrics. One of these metrics is how Directorates are progressing and implementing recommendations as raised by regulators and inspectorates. The Assurance and Risk Team, via a business partnering approach, continue to support Directorates in monitoring and providing updates against their recommendations.

A letter has also been sent in May 2024 (attached at Appendix 2) by the Chair of ARAC to the Executive Team to highlight concerns relating to overdue recommendations, also noting the limited assurance rating which was provided by Internal Audit for financial year 2023/24 in respect of the Health Board's arrangements to secure governance, risk management and internal control. An improved position is expected to be demonstrated to the Committee in August 2024.

Utilisation of the Audit Management and Tracking System (AMaT)

Since the previous report presented to ARAC in April 2024, work has continued to transfer recommendations to the Audit Management and Tracking (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) and the Effective Clinical Practice Team to improve system capabilities. The initial focus has been on transferring all operational services' reports to AMaT during Q1 of 2024/25, with 14 operational services now on the system. Corporate functions will be transferred from July 2024. This will allow services to update progress against all recommendations via one system to alleviate operational pressures, ensure consistency in approach with regards to processes and reporting, and support services with their governance as the Health Board implements its new escalation process.

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

Progress Since April 2024

Since the previous report, 12 reports have been closed or superseded on the Audit Tracker, and 18 new reports have been received by the Health Board, as detailed in Appendix 4.

As of 13 May 2024, the number of open reports has increased from 136 to 143. 60 of these reports have recommendations that have exceeded their original completion date, an increase from the 51 reports previously reported in April 2024.

There is an increase in the number of recommendations where the original implementation date has passed since the previous meeting, from 205 to 277.

The number of recommendations that have gone beyond six months of their original completion date has decreased slightly from 114 to 110, as reported in April 2024, as although there has been some progress with long-standing recommendations, 41 additional recommendations have lapsed since the previous meeting.

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 table below provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

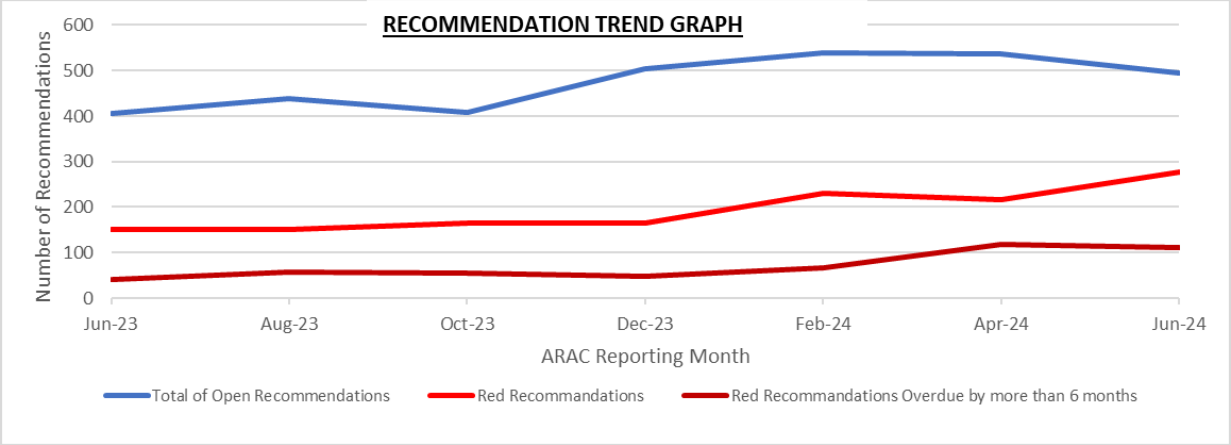
Summary of open reports per Inspectorate / Regulator

Inspectorate / Regulator	Open reports at ARAC April 24	New reports since April 24	Closed reports since April 24	Open reports at ARAC June 24	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	9	0	1	8	5	16	5
HEIW	2	0	0	2	1	3	1
HIW	15	1	1	15	10	66	31
Independent Review	1	0	1	0	0	0	0
IA	24	9	4	30	12	20	9
Llais[3]	5	0	1	4	3	7	7
MWWFRS	48	5	0	53	11	34	2
NHS Wales Cyber Resilience Unit[4]	1	0	0	1	1	4	4
NHS Wales Executive[5]	8	0	0	8	3	12	6
Peer Reviews	10	1	1	10	9	97	41
PSOW - S21	7	2	3	6	1	8	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	8	2
WLC	1	0	0	1	1	0	0
Welsh Government	1	0	0	1	0	0	0
TOTAL	**136**	**18**	**12**	**143**	**60**	**277**	**110**

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 3 due to the sensitive nature of the information.
5 Formerly Delivery Unit.

There are currently **493 open recommendations** (a decrease from the 531 reported in April 2024) on the audit tracker and detailed in Appendix 3, split per service / directorate for ease of reference. The appendix includes the 51 recommendations that are considered to be outside the gift of the Health Board to currently implement, for example being reliant on an external organisation. These recommendations are marked as 'External' in the RAG status column.

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.



Appendix 3 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 reports which have been added to the Audit tracker, and those which have been closed since April 2024.

There are **150 recommendations that do not have revised timescales** (where the original date has passed and not known (N/K) is reported), an increase from 127 as presented to ARAC in April 2024. These recommendations are included in Appendix 5, which details the date at which recommendations became N/K, and the reasons why they are N/K.

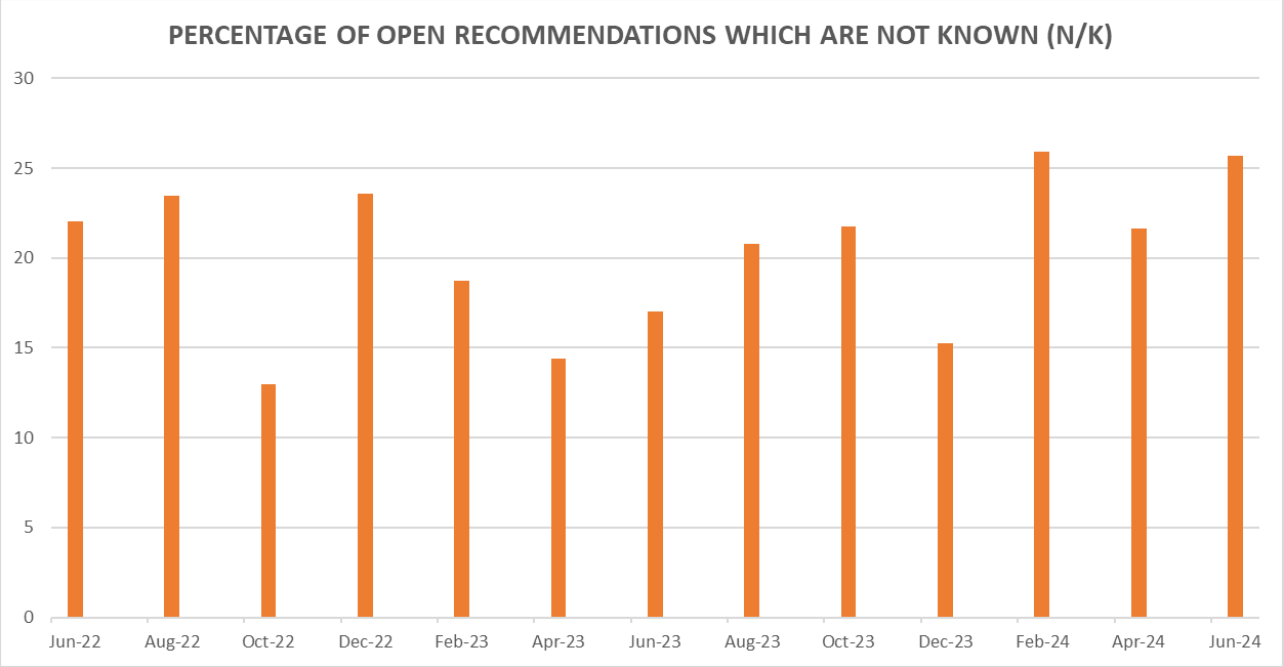
The 150 N/K recommendations are comprised of:

- 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
- 24 recommendations noted as 'external'.

A breakdown is provided below of the N/K recommendations split by how long overdue they are from their original completion date.

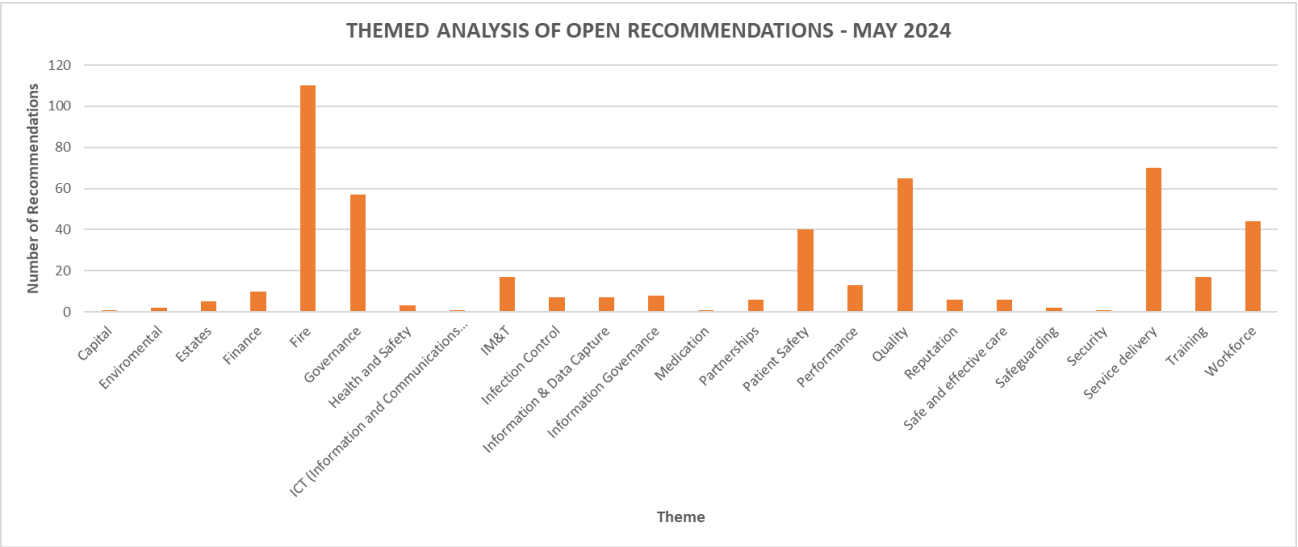
N/K recommendations* overdue by	Overdue N/K recommendations at May 2024	Overdue N/K recommendation at March 2024	Trend since previous meeting
1 month	28	14	↑
2 to 3 months	28	41	↓
4 to 5 months	20	9	↑
6 months and over	50	43	↑
Total**	**126**	**107**	↑

** Excluding 'external' recommendations*



Below is a chart detailing the percentage of open recommendations that do not have revised timescales (N/Ks) from June 2022 to this Audit tracker paper.
The Assurance and Risk team continue to liaise directly with services, and review the status of reports monitored via AMaT, 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.

Below is a chart providing a thematic analysis for all open recommendations on the Audit tracker as at May 2024, noting that the majority of recommendations relate to the themes of fire, governance, patient safety, quality, service delivery and workforce:



Audit Tracker Summary Per Service / Directorate

A snapshot of the audit tracker activity split by service/directorate as at 13 May 2024 is included from page 7 onwards, including trends since the last report to ARAC in April 2024. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager. Where services are identified as an area of concern for two consecutive reports, the service will be escalated to ARAC. The following Services/Directorates do not currently have any open reports on the audit tracker:

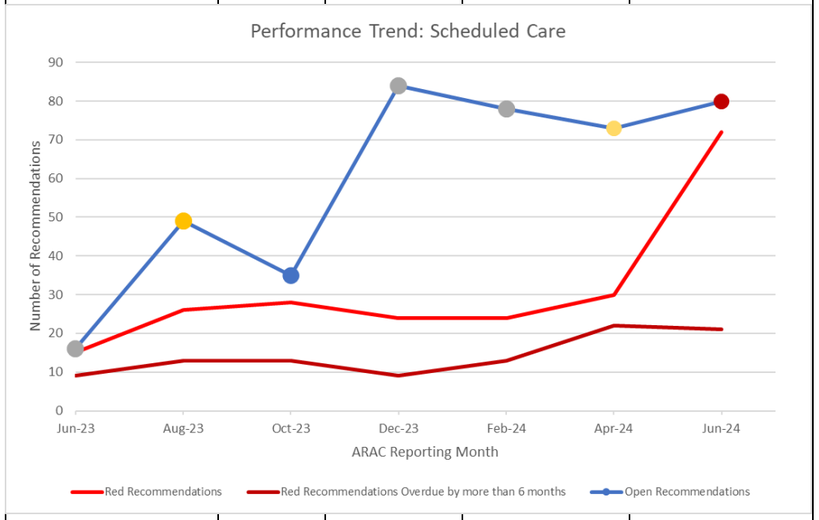
- Cardiology;
- Carmarthenshire;
- CEO Office (Welsh Language)
- Pathology;
- Performance; and
- Pembrokeshire

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

	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.

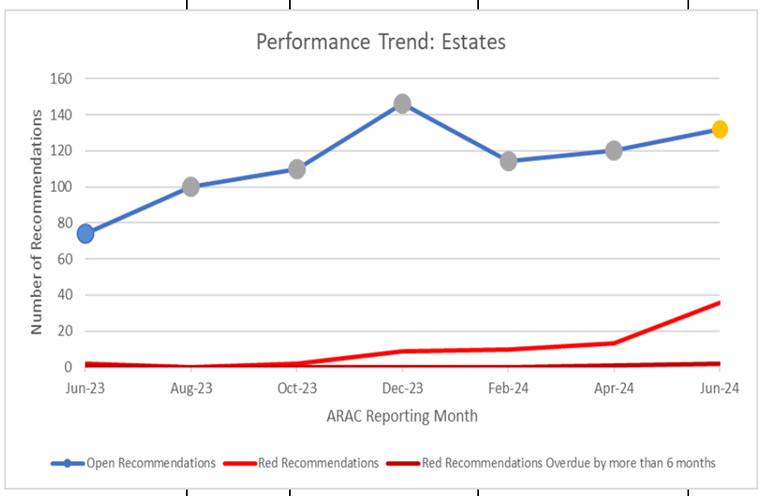
Service of Concern at May 2024

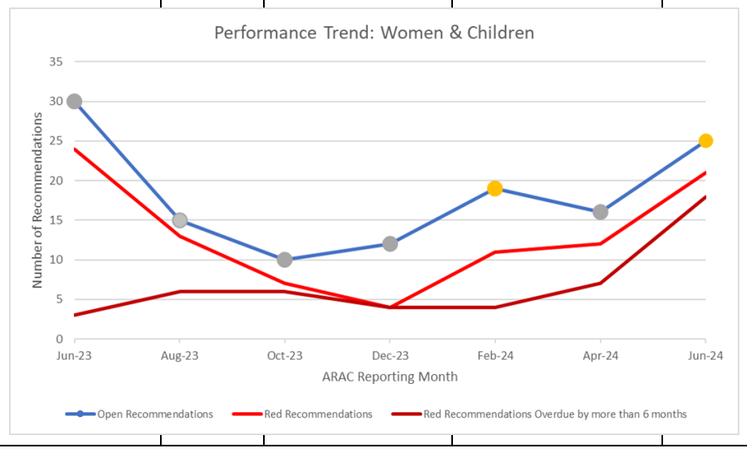
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Scheduled Care		Reports: 10 ↑ Recs: 80 ↑	Reports: 7 ↑ Recs: 72 ↑	Reports: 6 ↑ Recs: 21 ↓	Since the previous report, the number of recommendations that are overdue has increased from 30 to 72, with 21 of these being overdue by 6 months or more. Details of recommendations overdue by 6 months can be found in Appendix 3. There is good engagement with the service, with regular progress updates received and revised completion dates obtained for recommendations via the Directorate's newly delegated governance officer. However, the number of overdue recommendations has risen significantly, primarily due to 31 recommendations on the Getting It Right First Time (GIRFT) report on Ophthalmology lapsing since the previous report to ARAC. To note, a further 10 recommendations on this report are due to lapse in May 2024. Outstanding recommendations have been assigned revised timescales between June and November 2024, however 8 recommendations not been assigned revised timescales (N/K). An update is scheduled for the Strategic Development and Operational Delivery Committee in August 2024. This is the third time Scheduled Care have been called out as a service with a concerning variation since June 2023 due to the rising number of overdue (red) recommendations and recommendations overdue by more than 6 months. It is noted that the service is being highlighted as one with a concerning variation for the second consecutive time, therefore meeting the criteria to be considered as a Service of Concern for this report. However, it is recognised that 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. The Assurance and Risk Team will continue to work with the Directorate to report any further progress to the next meeting in August 2024.



Services with a Concerning Trend at May 2024

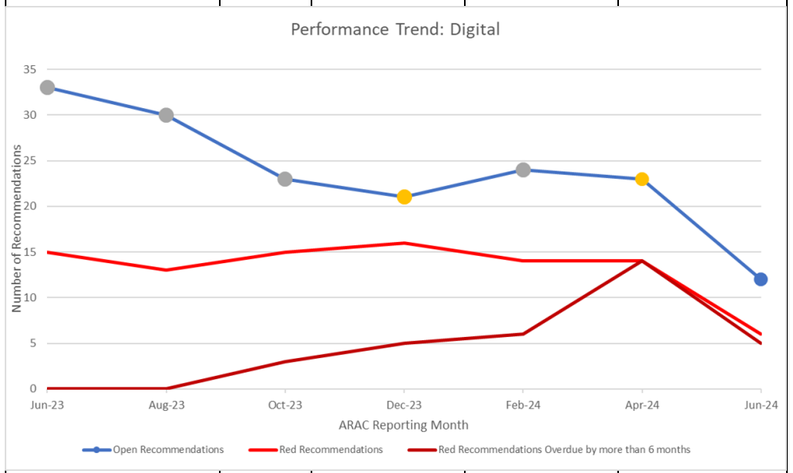
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Estates		Reports: 58 ↑ Recs: 132 ↑	Reports: 11 ↑ Recs: 36 ↑	Reports: 0 ↓ Recs: 2 ↑	The number of open reports has increased to 58 (April 2024: 50) due to the receipt of 5 new Letters of Fire Safety Matters (LOFSMs) and 3 new Internal Audit reports. It is noted that 22 of the 58 open reports are now complete and awaiting approval for closure from Mid and West Wales Fire and Rescue Service (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 all of the 36 overdue recommendations (April 2024: 13) have revised completion dates ranging between May and October 2024, it is noted that there has been an incremental increase in the number of overdue recommendations since October 2023. In addition to the reports assigned to Estates, they are noted as being a supporting service for 4 additional overdue reports aligned to other services: • Mental Health & Learning Disabilities (2 reports) • Nursing, Quality & Patient Experience (1 report) • Unscheduled Care, Glangwili General Hospital (1 report). There is regular engagement with the service to obtain updates, and a new process has been implemented to enable the service to provide progress updates directly on their reports and recommendations via a shared 'Tracker Spreadsheet', ahead of the transfer of reports to AMaT in quarter 2 of 2024/25.
Women and Childrens		Reports: 5 ↑ Recs: 25 ↑	Reports: 3 ↑ Recs: 21 ↑	Reports: 3 ↑ Recs: 18 ↑	Engagement with the service is good, however the service is identified as having a concerning trend due to the increase in recommendations from 12 to 25, of which 21 recommendations are overdue, with 18 being overdue by more than 6 months. The number of overall reports overdue by more than 6 months has increased from 1 to 3 since the previous report in April 2024. These numbers are driven primarily by the addition of the "GIRFT report on Gynaecology" which was issued in 2022 but added to the tracker in April 2024. The report contains 17 recommendations, 13 of which remain outstanding and are counted as being overdue by more than 6 months due to the absence of initial management responses and completion dates upon receipt. Timescales between December 2024 and June 2026 have been provided retrospectively for 10 of these recommendations, with unknown timescales for the remaining 3 (N/K). 4 recommendations are overdue with no revised timescales (N/K) on the HIW report on "Bronglais Hospital Maternity Unit". Of the 7 outstanding recommendations on the follow-up "Congenital Heart Defect Provider" report, 4 are overdue by more than 6 months and one is noted as "external", the details of which can be found in Appendix 5. All recommendations raised the Llais "West Wales Maternity Services" report are fully complete and approved on AMaT, with the report awaiting formal approval for closure.

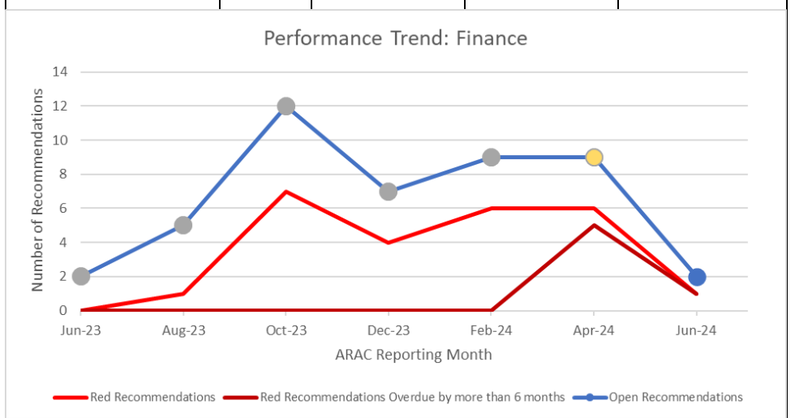




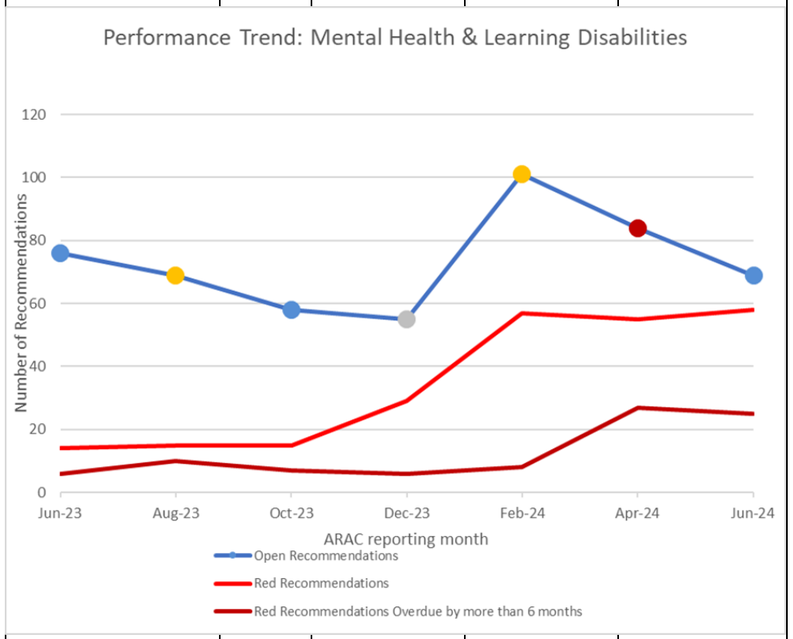
Services with an Improving Trend as at May 2024

Service	Trend - May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Digital		Reports: 5 → Recs: 12 ↓	Reports: 1 → Recs: 6 ↓	Reports: 1 → Recs: 5 ↓	Since the previous report presented to ARAC in April 2024, an improving trend is noted for Digital. Engagement with the Digital Director has been good, with a review of all reports recently undertaken by the Deputy Director of Finance. The Assurance and Risk team are also attending the Finance Senior Management Team meetings on a monthly basis in order to provide ongoing support. The number of open reports has decreased from 4 to 2 and the number of overdue recommendations has decreased from 6 to 1. This recommendation is overdue by more than 6 months and has a revised timescale of June 2024. An update on this recommendation will be sought by the Assurance and Risk Team in readiness for reporting at the next ARAC in August 2024. 1 follow-up IA report on “Strategic Programme Governance” has been realigned to the Strategic Development and Operations Directorate since the previous reported presented to the Committee, who are responsible for overseeing the remaining actions, and 1 AW report on “ISA 260 and Letter of Representation 2022/23” has been closed since the previous report to ARAC in April 2024.
Finance		Reports: 2 ↓ Recs: 2 ↓	Reports: 2 ↓ Recs: 1 ↓	Reports: 2 → Recs: 1 ↓	



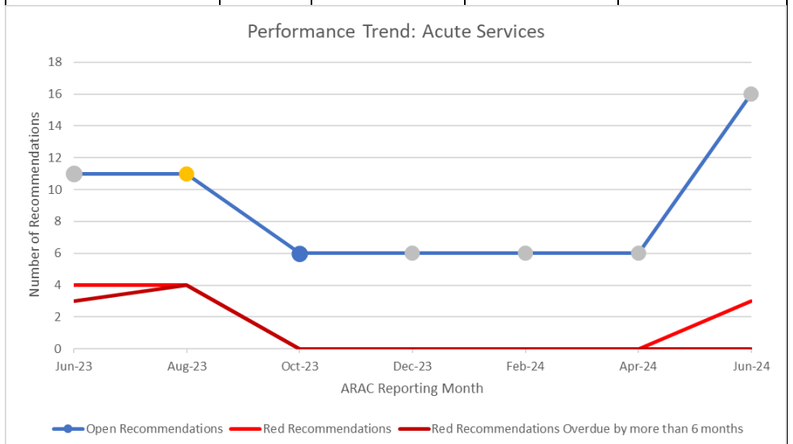


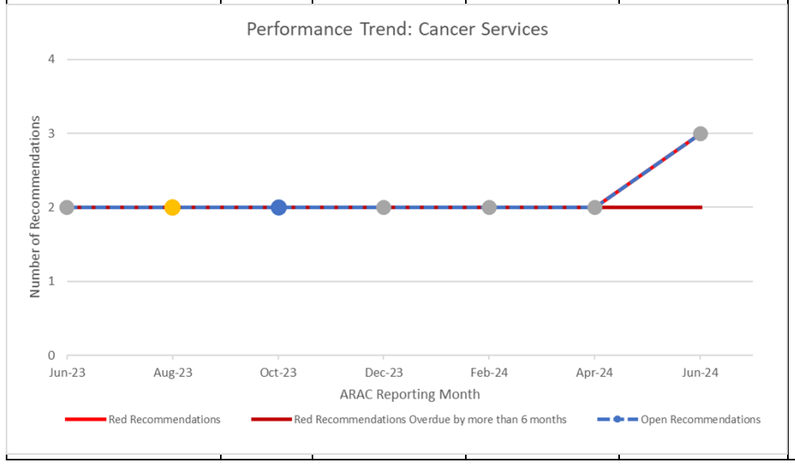
Service	Trend - May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Mental Health and Learning Disabilities		Reports: 15 ↓ Recs: 69 ↓	Reports: 5 ↓ Recs: 58 ↑	Reports: 2 ↓ Recs: 25 ↓	There has been an improvement in the Directorate's performance since the previous report presented to ARAC in April 2024, where they were identified as a service of concern, with 2 reports closed, and a reduction in the number of open recommendations from 87 to 69. Whilst there has been a slight increase in the number of overdue recommendations from 55 to 58, it is noted that the Directorate have provided progress updates on AMAT since the data was extracted for this report, and will be reflected to ARAC in August 2024. The Head of Assurance and Risk has met with the Director of Mental Health and the Assistant Director of Nursing MH&LD in April 2024 to discuss strengthening current governance processes in place which will support the setting of realistic timescales going forward, with a follow up scheduled for June 2024. 2 HIW reports are noted as being overdue by more than 6 months, namely "Bryngofal Ward – Prince Phillip Hospital" which had an original completion date of January 2024, and "St Caradog Ward, Withybush Hospital" which had an original completion date of November 2021. Both reports require the completion of works by Estates and Facilities in order to progress the recommendations and reports to closure. There continues to be good engagement with the service and this is now resulting in an improving performance. The Assurance and Risk team continue to work closely with service leads to obtain progress updates and revised completion dates, and monthly meetings are in place with the Assistant Director of Nursing MH&LD and service leads to provide ongoing support.



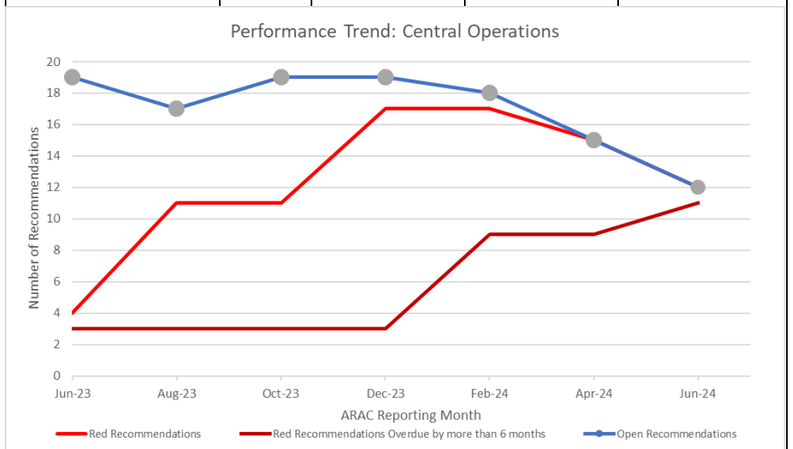
Services with Usual Trend at May 2024

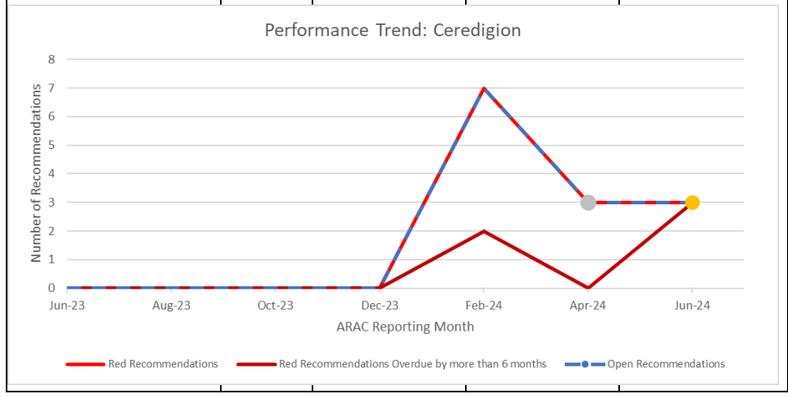
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Acute Services		Reports: 3 ↑ Recs: 16 ↑	Reports: 1 → Recs: 3 ↑	Reports: 1 → Recs: 0 →	Since the previous report to ARAC in April 2024, two new IA reports have been assigned to the service on Transforming Urgent and Emergency Care (TUEC), and TUEC – Discharge Management. The Head of Assurance and Risk is liaising with the Director of Secondary Care to obtain progress updates, which will be reflected in the report to ARAC in August 2024. In addition, the Head of Assurance and Risk attends Acute Leadership Group (ALG) on a monthly basis to provide support to service leads. 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.
Cancer Services		Reports: 2 ↑ Recs: 3 ↑	Reports: 2 ↑ Recs: 3 ↑	Reports: 1 → Recs:2 →	Since the previous report to ARAC in April 2024, 1 new IA report has been added on "Elective Waiting List Management: Single Cancer Pathway". 2 of the 3 recommendations on this report have been completed, with the remaining recommendation having a revised timescale of May 2024. 2 recommendations remain outstanding on the "Colorectal Cancer (Third Cycle) peer review" issued in January 2022 which became overdue in March 2022. One recommendation, around the regional approach for Pathology, has been given a revised timescale of January 2025, however the service is awaiting an update from ARCH (regional initiative with Swansea Bay UHB) in order to provide a revised timescale for the recommendation relating to cover for the single-handed Oncologist in Bronglais Hospital (N/K). 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 in readiness for reporting to ARAC.



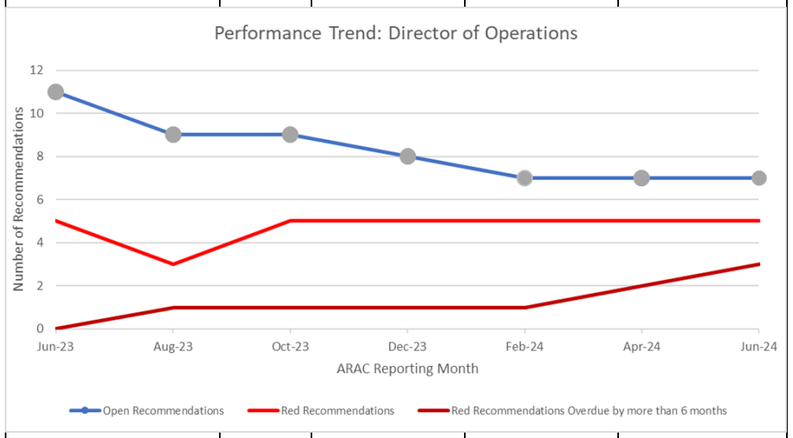


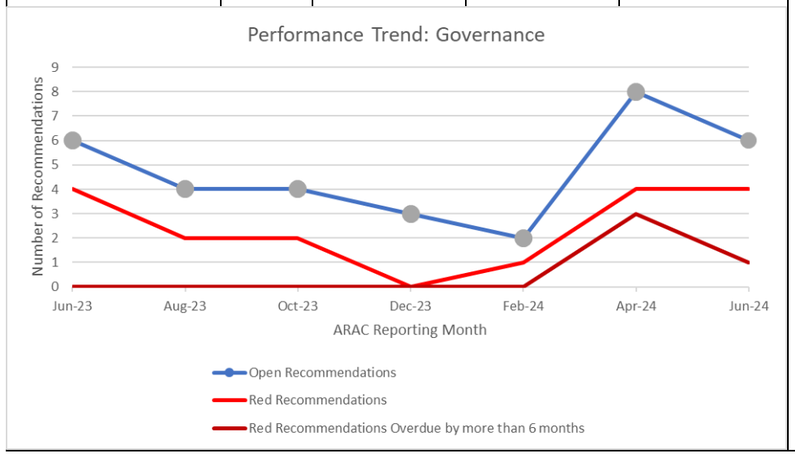
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Central Operations		Reports: 2 ↓ Recs: 12 ↓	Reports: 2 ↓ Recs: 12 ↓	Reports: 1 → Recs: 11 ↑	There is good engagement with the service, however the ability to fully implement some recommendations raised within the "Out of Hours Peer Review" remains 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, 8 of which are now overdue by more 6 months. IA are currently considering the closure of the 2 outstanding recommendations as included in the Records Management 2019 report, both of which are overdue by more than 6 months. A follow-up to the IA report on "Records Digitisation 2023", superseding the initial report and containing 1 recommendation, was issued in March 2024 and has since been completed.
Ceredigion		Reports: 1 → Recs: 3 →	Reports: 1 → Recs: 3 →	Reports: 0 ↓ 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 April 2024. 3 recommendations remain outstanding, all of which are now overdue by more than 6 months without revised timescales for completion noted on AMaT. It is noted that the recommendations contained within this report are system-wide and as such not specific to Ceredigion - responsibility for the progression of these recommendations sit with all 3 Counties. Despite risk being covered in considerable detail within the agenda of Ceredigion's County Management governance meetings, there is no "assurance" component, therefore engagement regarding the governance around this report has been minimal.



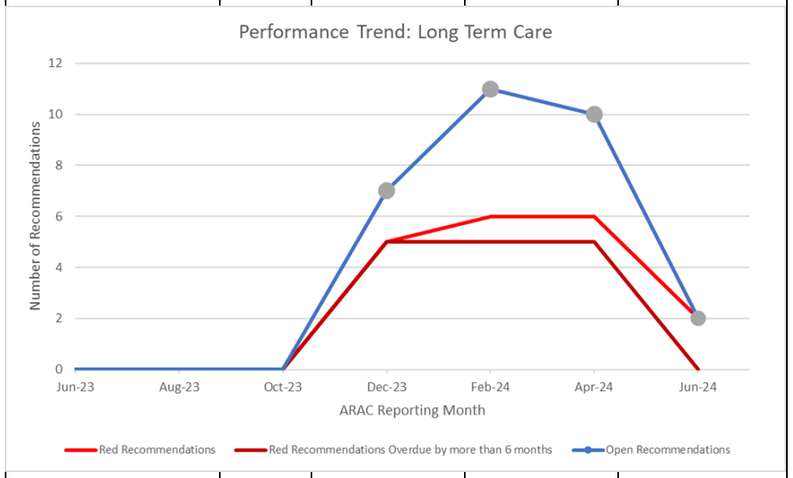


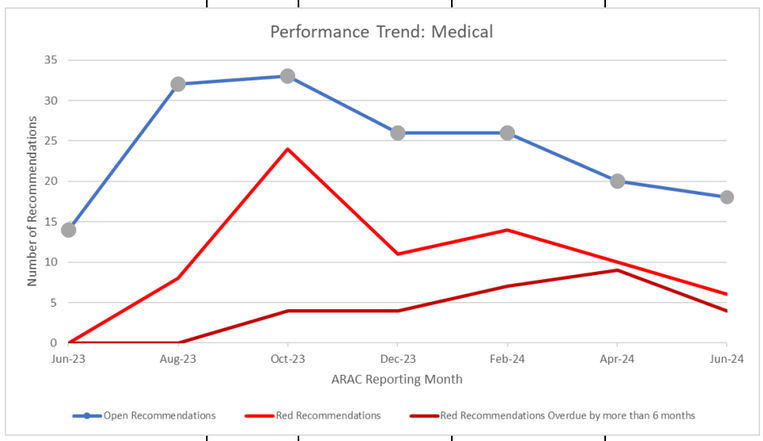
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Director of Operations		Reports: 2 → Recs: 7 →	Reports: 2 → Recs: 5 →	Reports: 2 → Recs: 3 ↑	The AW "Review of 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. The Assistant Director of Assurance and Risk, and Head of Assurance and Risk have monthly meetings in place with the Director of Operations to provide support on the progression of these recommendations. The WRP "National Review of Consent to Examination & Treatment Standards in NHS Wales" report has 1 'external' recommendation and 4 overdue recommendations with revised timescales of March 2024, 1 of which has become overdue by more than 6 months since the previous report to ARAC in February 2024.
Governance		Reports: 2 → Recs: 6 ↓	Reports: 1 → Recs: 4 →	Reports: 0 ↓ Recs: 1 ↓	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. There is good engagement with all recommendation owners, with progress updates and revised dates obtained which range to October 2024.



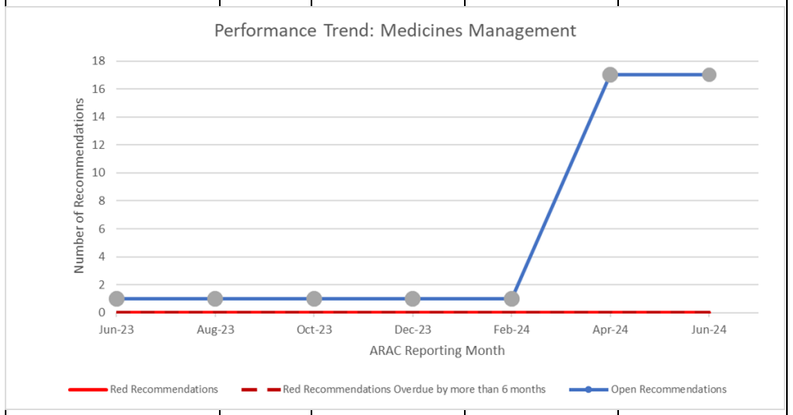


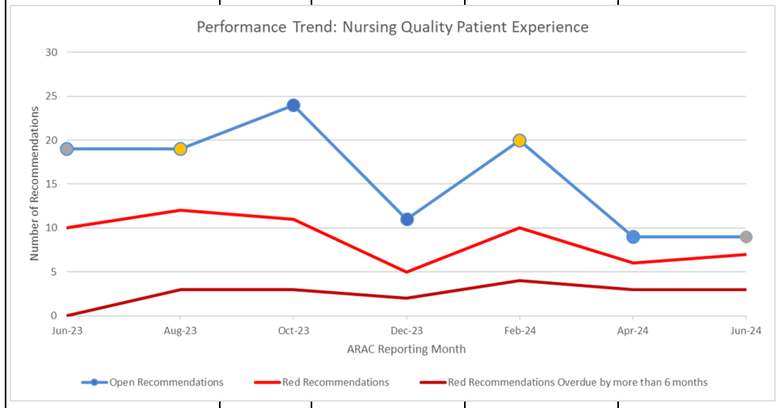
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Long Term Care		Reports: 1 ↓ Recs: 2 ↓	Reports: 1 → Recs: 2 ↓	Reports: 0 ↓ Recs: 0 ↓	Since the previous report presented to ARAC in April 2024, the total number of recommendations has decreased from 10 to 2. The 2 remaining recommendations from the IA report on "Deprivation of Liberty Safeguards", issued in August 2023, became overdue as of March 2024 and do not currently have revised timescales (N/K). The IA "Discharge Processes" report was closed on tracker in April 2024, superseded by a follow-up IA assigned to Acute Services, reducing the number of open reports for Long Term Care from 2 to 1. *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.*
Medical		Reports: 6 → Recs: 18 ↓	Reports: 4 → Recs: 6 ↓	Reports: 4 ↑ Recs: 4 ↓	Since the previous report presented to ARAC in April 2024, the number of open recommendations has decreased from 26 to 18, and the number of overdue recommendations decreased from 10 to 6. Recommendations overdue by more than 6 months has decreased from 9 to 4. Of the 6 overdue recommendations, one does 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 are therefore outside the gift of the Health Board to complete at this time. 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, with further progress to be reported to ARAC in August 2024.



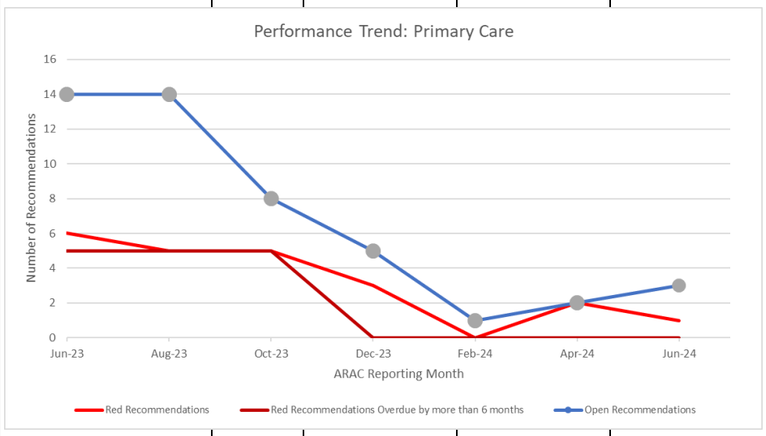


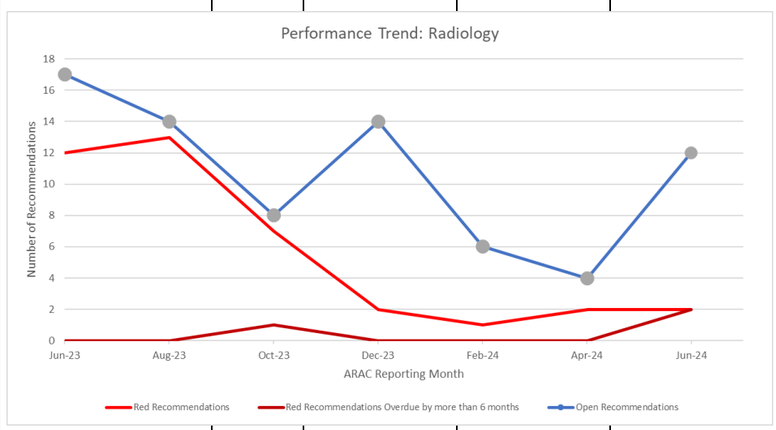
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Medicines Management		Reports: 2 → Recs: 17 →	Reports: 1 → Recs: 0 →	Reports: 1 → Recs: 0 →	Since the previous report presented to ARAC in April 2024, the number of outstanding recommendations has remained at 17. The recommendations in the report are comprised of sub-recommendations that are that have timescales ranging from September 2024 to April 2029. There is one recommendation in the report noted as "external" as it requires a further review to be carried out by Welsh Government. There is one "external" recommendation from the AW report on "Medicines Management in Acute Hospitals", relating to electronic prescribing/discharging. Systems have been approved on a national framework and are currently awaiting confirmation of 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 May 2024.
Nursing, Quality and Patient Experience		Reports: 6 ↓ Recs: 9 →	Reports: 2 ↓ Recs: 7 ↑	Reports: 2 → Recs: 3 →	Since the previous report to ARAC in April 2024, 1 PSOW report has been closed, with a further 3 reports currently awaiting formal approval for closure either by PSOW or IA. Of the remaining 2 open reports, it is noted that the two recommendations as raised within the Llais report on "Accident & Emergency Departments in the Hywel Dda Health Board area" have lapsed since the previous report to ARAC, however both recommendations are reliant wither on Estates and Facilities, or Procurement in order to fully implement. The IA report on "Falls Prevention and Management" became overdue in March 2024, however the recommendation to develop a delivery plan for the Falls Strategy is due to be presented to the Clinical Education Governance Group Panel on 28 May 2024, after which it is hoped the recommendation will be noted as complete. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.



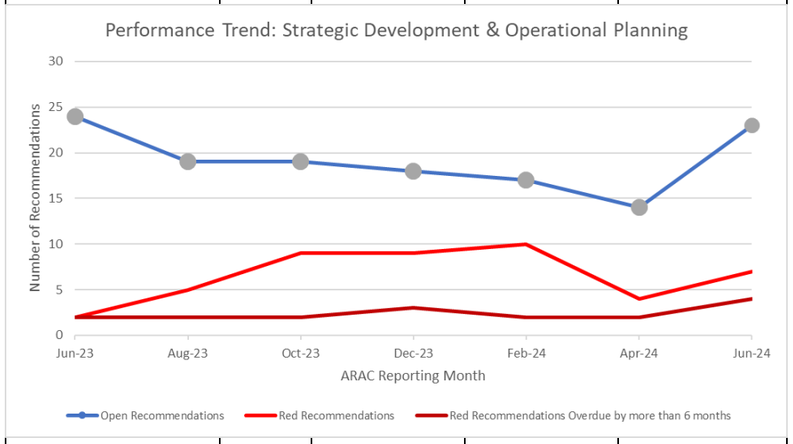


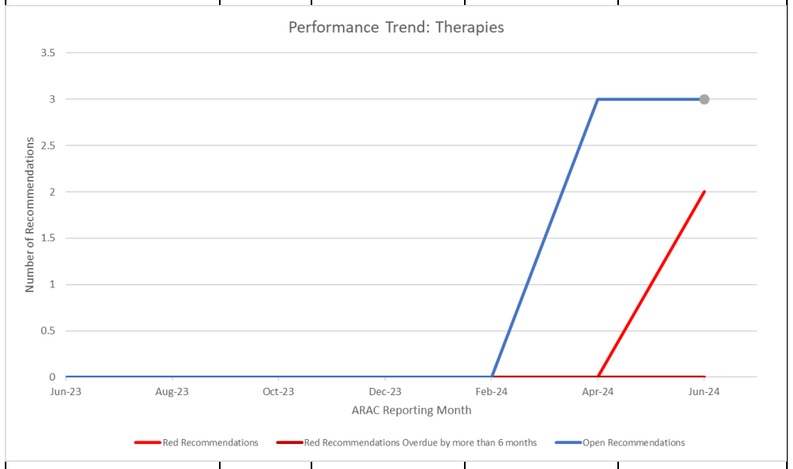
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Primary Care		Reports: 2 → Recs: 3 →	Reports: 2 → Recs: 1 ↓	Reports: 1 ↓ Recs: 0 →	Since the report to ARAC in April 2024, the recommendations on the AW "Primary Care Follow-up Review" have now been assigned timescales for completion via an updated management response. A revised timescale is now required for one recommendation which was originally noted as having a completion date of April 2024 (N/K). The Assurance and Risk Team will be seeking an update on this report in readiness for reporting to ARAC in August 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 May 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. *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.*
Radiology		Reports: 3 ↑ Recs: 12 ↑	Reports: 1 → Recs: 2 →	Reports: 1 ↑ Recs: 2 ↑	Since the previous report to ARAC in April 2024, a new report from HIW IRMER "Diagnostic Imaging x-ray department Withybush Hospital" has been added to the tracker. The report contains 9 recommendations, with completion dates ranging to April 2026. A PSOW report issued in February 2024 has one outstanding recommendation which is on track for completion by July 2024 once the case has been discussed at the reporting Radiologist's Line Manager and Clinical Lead Review meeting. The Public Ombudsman Case Manager will be seeking an update on this report in readiness for the next ARAC meeting in August 2024. The number of outstanding recommendations on the HIW IRMER report for GGH issued in February 2023 has increased from 1 to 2, with one recommendation re-assigned Red (i.e overdue). This is due to an action which has not progressed due to delays associated with the All Wales Radiology Information Systems Procurement (RISP) programme, with a revised completion date obtained of January 2025. A recommendation also remains open in relation 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. Both recommendations are noted as being overdue by over 6 months. There is good engagement with the service with regular updates provided by service leads.



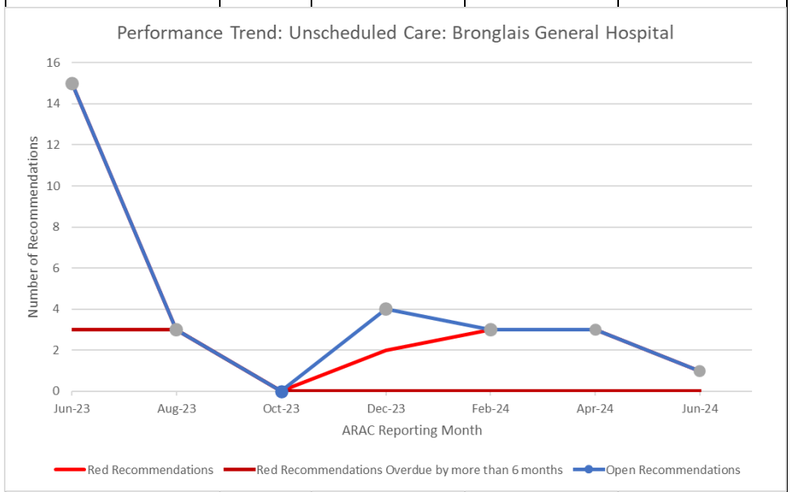


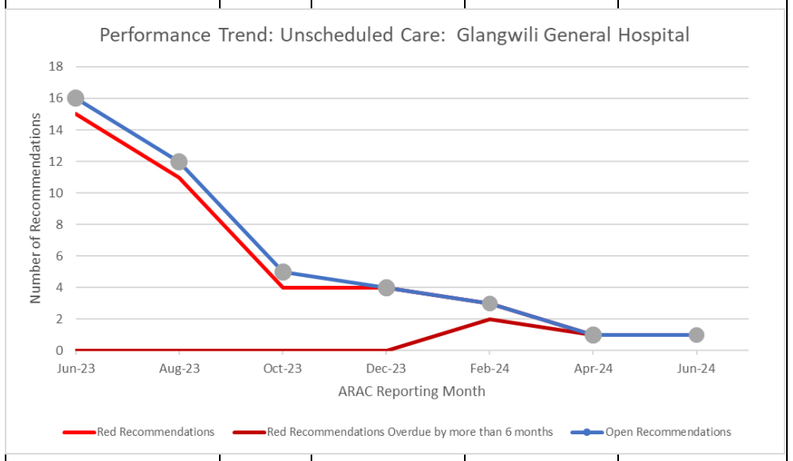
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Strategic Development & Operational Planning		Reports: 6 ↑ Recs: 23 ↑	Reports: 5 ↑ Recs: 7 ↑	Reports: 3 ↑ Recs: 4 ↑	Since the previous report to ARAC in April 2024, the number of open reports assigned to the Directorate has increased (April 2024: 4) due to 1 new report from IA on "Cross Hands Health & Wellbeing Centre", and the transfer of the IA on "Follow Up: Strategic Programme Governance" from Finance. The AW report on "Structured Assessment 2021 (Phase 1 Operational Planning Arrangements)" has been re-opened since the previous report to ARAC as a result of the review of recommendations as part of the "Structured Assessment 2023". 2 recommendations have been re-opened on the tracker since the previous report presented to ARAC in April 2024, with revised completion dates ranging to October 2024. The Assurance and Risk Team will liaise with the Deputy Director of Operational Planning and Commissioning to obtain progress updates and revised completion dates where required for all recommendations assigned to the Directorate, which will be reflected in the next paper to ARAC in August 2024.
Therapies		Reports: 1 N/A Recs: 3 N/A	Reports: 0 N/A Recs: 2 N/A	Reports: 0 N/A Recs: 0 N/A	Since the previous report to ARAC in April 2024, a new report from the PSOW (202108316) has been added to the tracker. The report contains 3 recommendations, 2 of which are noted as having passed their original completion date (March 2024), however, the evidence of compliance was submitted by the service in March 2024 to PSOW, and are currently awaiting confirmation from PSOW for closure.



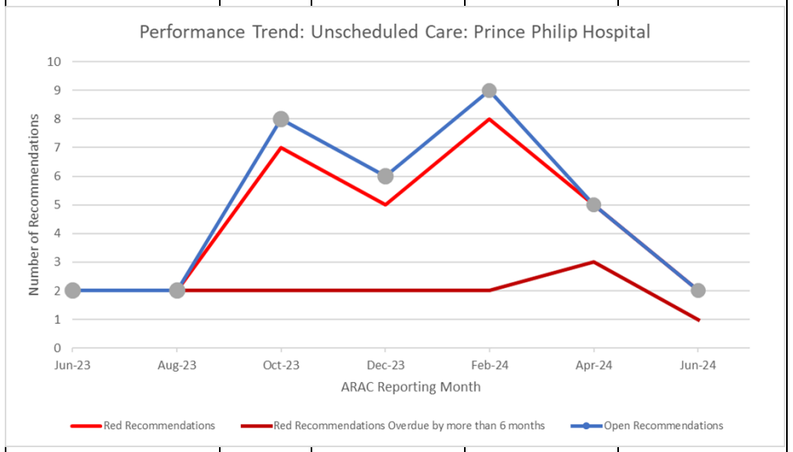


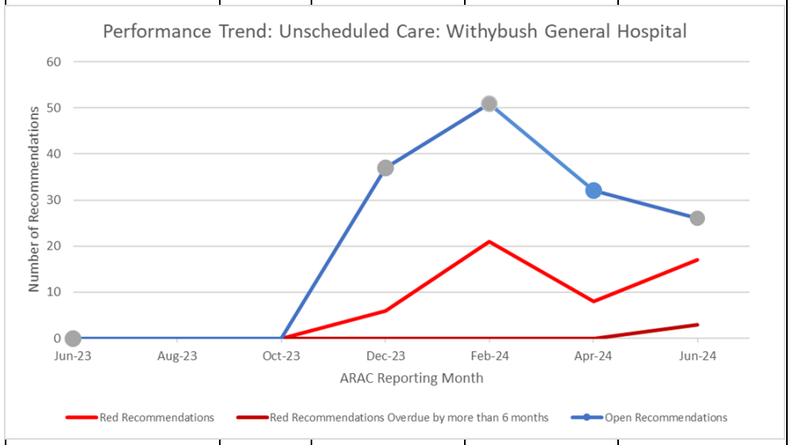
Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Unscheduled Care: Bronglais General Hospital		Reports: 1 → Recs: 1 ↓	Reports: 1 → Recs: 1 ↓	Reports: 0 → Recs: 0 →	The IA follow-up report on "Bronglais General Hospital Quality & Safety Governance" issued in February 2024, which superseded the original IA report from 2023, has 1 overdue recommendation, with a revised completion date of October 2024. Evidence has been submitted to IA for formal approval to close the other 2 recommendations, noted in this report to ARAC as complete (Green), with outcomes to be reported in the next tracker report.
Unscheduled Care: Glangwili General Hospital		Reports: 1 → Recs: 1 →	Reports: 1 → Recs: 1 →	Reports: 1 ↑ Recs: 1 →	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 in order to fully implement this recommendation. An update in February 2024 advised that the required refurbishment works may take up to 3 months to complete. The Assurance and Risk Team will be seeking updates for these recommendations in readiness for the next ARAC meeting in August 2024.



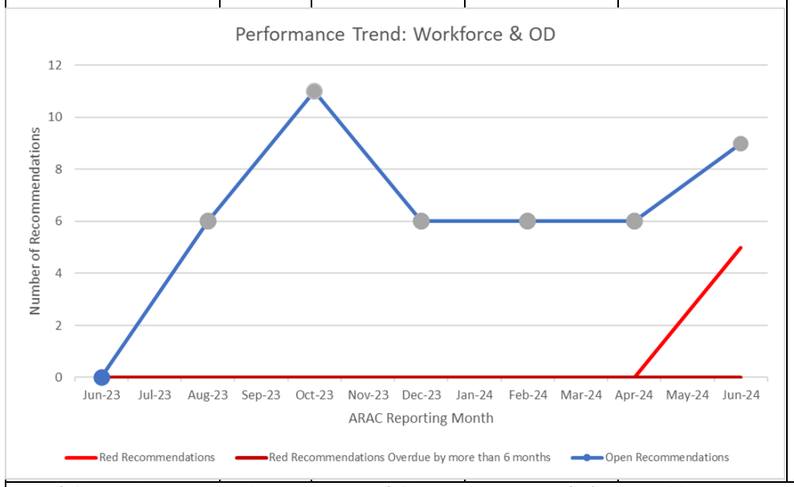


Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Unscheduled Care: Prince Philip Hospital		Reports: 2 ↓ Recs: 2 ↓	Reports: 2 ↓ Recs: 2 ↓	Reports: 1 ↓ Recs: 1 ↓	Since the previous report presented to ARAC in April 2024, the Peer Review "Hywel Dda UHB Lung Report" has been closed. 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. The Director of Operations has requested that evidence be submitted to confirm that the required strategic review as per the original management response has been undertaken, and that an action plan is in place to monitor going forward, after which the recommendation can be noted as completed.
Unscheduled Care: Withybush General Hospital		Reports: 3 ↓ Recs: 26 ↓	Reports: 2 ↑ Recs:17 ↑	Reports: 0 → Recs: 3 →	Since the previous report presented to ARAC in April 2024, the Llais report on "West Wales Regional Engagement" has been closed. Whilst the number of open recommendations has decreased from 32 to 26 since the previous report to ARAC in April 2024, the number of overdue recommendations has increased from 8 to 17. This increase relates predominately to the HIW report on "National Review of Patient Flow – a journey through the stroke pathway". It is noted that the service rely on support from 5 other services in order to address these recommendations - Acute Services, Public Health, Therapies & Health Sciences, Strategic Performance Improvement, and Unscheduled Care - Stroke Services.





Service	Trend – May 2024	Open reports and recommendations – May 2024	Overdue reports and recommendations – May 2024	Overdue reports and recommendations more than 6 months – May 2024	Analysis
Workforce & OD		Reports: 2 ↑ Recs: 9 ↑	Reports: 0 → Recs: 5 ↑	Reports: 0 → Recs: 0 →	Since the previous report presented to ARAC in April 2024, a new report from Internal Audit "Agency & Rostering March 2024" has been added to the tracker, with completion dates for recommendation ranging through to December 2024. Of the 6 outstanding recommendations on the AW "Open report on the Review of Workforce Planning Arrangements", 5 are overdue with completion dates lapsing in April 2024. The Assurance and Risk Team will be seeking updates for these recommendations in readiness for the next ARAC meeting in August 2024.



Total Open Reports = 143	Total Open Recommendations = 493	Total Reports Overdue by more than 6 months = 33
Total Overdue Reports = 60	Total Overdue Recommendations = 277	Total Recommendations Overdue by more than 6 months = 110

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Gofynnwch am/Please ask for: Emily Price
Rhif Ffôn /Telephone: 01267239644
Dyddiad/Date: 14.05.2024

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

Dear Colleagues

Re: Overdue Risks and Audit Recommendations

I am writing following concerns raised at the last two Audit and Risk Assurance Committee meetings in relation to the number of risks that are overdue for review. These concerns also apply to an increasing number of audit recommendations which have exceeded their target implementation dates with many now citing unknown.

The need to write to you has also been reiterated by this year's Head of Internal Audit Opinion which has provided a limited assurance rating in respect of our arrangements to secure governance, risk management and internal control. It is therefore more important than ever that we work together to reduce the Health Board's risk exposure through strong risk management and audit tracking.

The Risk Assurance Report to ARAC in February 2024 reported that there were 241 (39%) risks overdue for review (this was an increase from the 157 (26%) risks identified as overdue for review in August 2023). Having up-to-date, relevant, and accurate risks enable organisations to reduce harm, minimise loss and limit damage, and also enables organisations to have an up-to-date risk profile which helps to better inform planning, decision-making and prioritisation of resources.

Whilst winter is always a challenging time for health organisations, it is extremely disappointing that this has not improved as we move into Summer. At present, there are now 280 (45%) risks overdue for review and I would urge you to ask your teams to review their risks more regularly particularly given the scrutiny the Health Board is currently subject to. By taking a proactive approach to risk and risk management, we can make better strategic decisions, reduce operational disruption, reduce financial loss and improve stakeholder confidence. I also ask that the same approach is applied to outstanding audit recommendations. Can I please ask that this work is completed over the next two months as the Committee is expecting an improvement in both areas by the August 2024 Audit and Risk Assurance Committee meeting.

Thank you for your co-operation.

Rhodri Evans
Chair of Audit and Risk Assurance Committee

CC Chair
Audit and Risk Assurance Committee Members

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)	Progress update/Reason overdue
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	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care (TUEC) Final Internal Audit Report	Open	Reasonable	Acute Services	Strategic Development and Operational Planning	Keith Jones	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	Acute Services	Strategic Development and Operational Planning	Keith Jones	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	Acute Services	Strategic Development and Operational Planning	Keith Jones	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 (TUEC) Final Internal Audit Report	Open	Reasonable	Acute Services	Strategic Development and Operational Planning	Keith Jones	Director of Operations	Medium	R4. Updates to the groups within the TUEC governance structure should be more robustly captured, for example in the form of a paper (rather than verbal) or high-level notes of the meeting	The TUEC PMO will have noted this and will add in more detail to action and decision logs going forward (inclusive of context to actions). The team are also recording Programme meetings in Teams and the links to the recordings will be embedded in the meeting agendas for 60 days for members to check risks, actions, or decisions in more detail if required.	Apr-24	~~Apr-24~~ N/K	Red	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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 a flowchart of the agreed national discharge processes and pathways in line with the Discharge Requirements document and align with local variations from local authorities and third sector partners.	Jun-24	Jun-24	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	Acute Services	Acute Services	Keith Jones	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	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	Director of Operations	High	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Review and update the Policy Goal 5 action plan and share with the Discharge Strategy Group and Managing Complexity and Conversion Group as part of the TUEC reporting structure.	Apr-24	~~Apr-24~~ N/K	Red	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	Director of Operations	High	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Optimal Flow Framework Lead to be agreed, Local Operational Leads to be agreed and the Optimal Flow Task & Finish Group be re-established	Jul-24	Jul-24	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	Director of Operations	High	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Local robust roll out plans to be developed & implemented by Operational teams, supported by the QIST Practitioners, to ensure consistent application of the Optimal Flow Framework across all acute and community wards.	Jun-24	Jun-24	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	Amber	

Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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.	A review of potential WIFI connectivity issues limiting access to Frontier in some clinical areas to be completed and shared with the Managing Complexity Group and escalated as required.	May-24	May-24	Amber	
Apr-24	2024/25	Internal Audit	Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report	Open	Limited	Acute Services	Acute Services	Keith Jones	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	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)	Progress update/Reason overdue
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	Red	02/05/2024 - The Cancer Improvement Board are scheduled to meet on 31st May and will be updaitng and finalising the TOR.
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	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-25	Red	22/02/2023 - Cancer Services Delivery Manager has met with MDT lead and update sent to Mr Rao. Response said this is part of their Pathology program, building central facility in Morriston. FBC will be signed off in next 3-12 months - no progress expected until after this. 22/08/2023 - Update from the ARCH programme: The Programme is currently in Outline Business Case(OBC) phase working towards submitting the OBC to Welsh Govt in Jan/Feb 2024 work is currently ongoing to draft and cost the OBC. Building plans are due to go to the Programme Board in a few weeks time for its approval. Work is ongoing to determine what the desired regional service model should be for laboratory medicine/blood sciences Engagement on this will take place with representatives from hospital and primary care across both UHBs over the summer to help develop a preferred option. The timescale for completion has been revised to 2025. 19/12/2023 - Service confirmed that there has been no change since the previous update. 23/02/2024 - Update from the ARCH programme: An initial set of building plans for the proposed new Pathology Hub building were produced in July 2023. However, these plans are being revised following the subsequent publication of new Welsh Government guidance on the scope & cost of business cases. A revised Schedule of Accommodation has been produced, reducing the scale of the proposed Hub, and making more extensive use of the existing Pathology building at Morriston. The location of the proposed Hub building on the site is also being revised, in order to reduce build costs and timescales. Architects are currently working on a revised set of building plans, which will be made available to staff across Pathology disciplines after Easter for consideration and review. The work to establish a regional Pathology Service (via an Operational Delivery Network) is continuing. Subgroups have been established to take forward the workforce planning, finance & commissioning, and digital arrangements, processes and infrastructure needed to create a regional Pathology service. Current priorities include recruiting a senior leadership team for the service, creating a legal & governance framework to support regional decision-making, and preparing for the implementation of the new LIMS system across the region. The second set of staff engagement workshops have been held in January/February across the region (with sessions already held at GGH, Bronglais, PPH, Withybush, Princess of Wales and Singleton, and the final session set to be held in Morriston on 19th Feb). The sessions focused on identifying areas of good practice that could potentially be spread between sites, as well as common challenges that regionalisation may be able to help address. 02/05/2024 - Pathology services continue to be fragile with recruitment and retainment being the main issue. Capacity problem is nationwide with over reliance on locums. Our current capacity is 5 consultants with 3 locums and the situation is unlikely to change in the near future. The long-term plan would be a regional approach for pathology with plans for a new build in Morriston. Unsure about timescales after funding, but new build would not be imminent. We have not had a pathologist attending our MDTs for roughly 6 years in various cancer sites. This has been highlighted in peer reviews across cancer sites. Hence, we are not quorate as a cancer MDT. Pathology reports are discussed in the MDT after reports are loaded on Welsh Portal with no pathologist present. If clarifications are required, the pathology lead is contacted by email/phone call for their input. Inputs in general have been timely to avoid delays in the pathway.
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	Red	22/08/2023 - Currently working with SBUHB to update the Oncology Strategy that was put in place in 2015. This will include the BGH Oncology service. Cover is currently provided by Dr S Gwynne, SBUHB along with CNS support/ Telephone advice for Dr E Jones/CNS when away. SBUHB have now also appointed Dr C Barrington to cover the LGI Oncology service within HDUHB.The work on the updated strategy is still ongoing. 19/12/2023 - Service confirmed that there has been no change since the previous update. 23/02/2024 - Currently working with SBUHB to update the Oncology Strategy, this will include the BGH Oncology service. Scoping the possibility of support from HBs in the North for oncology in order to provide sustainable service. Working with SBU under the SPC to provide support to Bronglais in order to provide a sustainable service in the long term. 30.4.24 - work is still ongoing with the SWWCC to implement the updated SWWCC Programme Workstreams to replace the current strategy which was developed in 2015. Meetings are also in place with BCUHB to discuss long term plans to support Oncology in BGH 02/05/2024 - No timeframe for completion has been confimed as yet. The service are currently awaiting an update from ARCH in order to provide a revised completion date.

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Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	Medium	R4. Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.	As identified in the recommendation above following a report reviewed by the non-pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of the scoping working the groups will be required to identify any records outside of retention guidance and the relevant costs of destruction. As clarified above this work will be progressed early in the new year.	Mar-19	~~Jul 21~~ ~~Nov 22~~ ~~Mar 23~~ ~~Mar 24~~ Mar-27	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The Health Board continues to operate with the imposed UK government destruction embargo in situ, meaning no patient records can be destroyed. The relevant inquires could be completed early in 2023 and destruction processes can immediately go back into operation. The review of the offsite and private storage facilities, continues as part of the IG work programme and is identifying various records held at the localities. Work has also commenced in terms of returning Hywel Dda records to the central health records storage facilities, from private storage. Relocating records to one central management team will ensure retention and destruction schedules are followed diligently. 28/03/2023 - Each service area has an identified Information Asset Owner (IAO), who has responsibility for the management (including the destruction of the records). Following the lease of a new offsite storage facility the plan for the project moving forward will be to identify those services with greatest need of support from various viewpoints.Following this a plan will be agreed how the services implement strict records management arrangements, agree if there is a requirement to relocate records to the health records storage facility and ensure robust destruction procedures are implemented. 29/11/2023 – Since 2015 the Health Board has been under a destruction embargo, as a result of two national inquires. Fortunately the Health Board has recently received notification that they can now recommence destruction, however this must be completed in line with the Welsh Government, Records Management Code of Practice (COP). The COP has introduced some new retention timeframes which have previously only be utilised in England and discussions are ongoing if they are relevant or a legal requirement to follow in Wales. With this in mind services within Hywel Dda have started to destroy deceased records only, which provided easier review and assurances in terms of compliance. As discussions continue nationally, the Health Board has started to relocate various records types to the two health records storage facilities. Records are being recalled from private storage providers and from inappropriate internal storage locations so they are centralised at one secure locality, ready for review. This project will include a considerable number of records and a wide range of records type, which currently we are unable to accurately quantify. This project will take a sustained period of time to complete and we are only in the early stages. We envisage this being a 3 year project for completion. In conjunction with the relocation of records the Health Board Retention & Destruction Policy was approved in February 2023 and circulated across the Health Board and will be utilised to support the destruction process. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. As at January 2024, 308,000 acute patient records have been scanned, with another batch ready for distribution before the end of the financial year and to date 6,538 boxes (each containing a varied number of service records) and 16 filing cabinets have been transferred to the centralised storage facilities in Dafen and Llangennech, from both private storage providers and other internal Health Board storage locations. This allows for improved oversight of the identification and subsequent decision making where destruction or alternative courses of action of health records is concerned and is in line with Welsh Government Records Management Code of Practice and improved adherence to Information Governance requirements. The pace of the destruction of records can also now increase as a result of the lifting of both destruction embargoes arising from two national inquiries. Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.

Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	High	R6, section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The IG work programme to review storage facilities is ongoing and to date 4 locations have been reviewed, including 2 private providers (Lloyd & Pawlett and Logic Document) and the health records storage facilities based at Dafen and Llangennech in Llanelli. Concerns remain in regards the private storage providers and an SBAR was presented to the Executive Team in October 2022 proposing that the management and storage of all Hywel Dda records be streamlined to one Executive lead. Clearly this is a considerable project to undertake and complete and it will require significant support from a wide range of services and identified IAO's. Work has commenced in terms of developing a project plan and schedule of work, but initial progress has been made by relocating A&E and pharmacy records, with other services to follow. Once all records are relocated to the Health Board storage facilities this will negate any concerns. 28/03/2023 - As the knowledge centre of the organisation where record management is concerned the change would not be severe for the health records service and would simply be an extension of the business model currently operated for the acute patient record, to accept wider record types. This work has already commenced with the relocation of A&E cards for GGH and PPH and Pharmacy records and others will follow over the next 12 months as the digital records project is progressed. 29/11/2023 – As the IG team continue to undertake their review of both external private storage facilities and internal storage facilities the health records service has been extremely proactive in terms of continuing the relocation of records to its secure centralised storage facilities. Through proactive dialogue, with various service leads, across a wide range of Directorates including: Scheduled Care, Unscheduled Care, Therapies, Community, Women & Child Health, the health records service has already supported the Health Board in relocating approximately 136,950 records, 5800 boxes from A&E and Pharmacy (too many records in a box to equate) and also various boxes of charts and theatre registers and 12 filing cabinets, to ease storage pressure and relocate records to an appropriate and secure location. The services already located include: Dietetics, Physiotherapy, Maternity, Mental Health, Maternity, A&E, Long Term Care, District Nursing, Community Nursing, Pharmacy and Oncology. Further dialogue is ongoing with other services and will continue in the future. Again without a full inventory of all records held within these and other services we are dealing with an unknown quantity and the completion of the project will be a few years down the line, but already from the considerable piece of work undertaken in a relatively short timeframe the Health Board is already witnessing the benefits. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. As at January 2024, 308,000 acute patient records have been scanned, with another batch ready for distribution before the end of the financial year and to date 6,538 boxes (each containing a varied number of service records) and 16 filing cabinets have been transferred to the centralised storage facilities in Dafen and Llangennech, from both private storage providers and other internal Health Board storage locations. This allows for improved oversight of the identification and subsequent decision making where destruction or alternative courses of action of health records is concerned and is in line with Welsh Government Records Management Code of Practice and improved adherence to Information Governance requirements. The pace of the destruction of records can also now increase as a result of the lifting of both destruction embargoes arising from two national inquiries. Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.

Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	High	R6, section2. Management should establish what information is stored with the third party storage providers and that the retention and destruction of information is being undertaken in line with the Welsh Government arrangements.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non-pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – Please see update provided for recommendations R4 and R6 section 1. The SBAR presented to the Executive Team in October 2022 proposing to move the management, handling, scanning and destruction of all Hywel Dda records to one Executive lead and retained within the health records storage facilities will ensure all storage, governance, destruction issues are fully resolved. 28/03/2023 - identified what records (an other items) are being held in private storage, how we intend to relocate them back into the Health Board, under on service/lead and how destruction processes will be implemented. 29/11/2023 – As the IG team continue to undertake their review of both external private storage facilities and internal storage facilities the health records service has been extremely proactive in terms of continuing the relocation of records to its secure centralised storage facilities. Through proactive dialogue, with various service leads, across a wide range of Directorates including: Scheduled Care, Unscheduled Care, Therapies, Community, Women & Child Health, the health records service has already supported the Health Board in relocating approximately 136,950 records, 5800 boxes from A&E and Pharmacy (too many records in a box to equate) and also various boxes of charts and theatre registers and 12 filing cabinets, to ease storage pressure and relocate records to an appropriate and secure location. The services already located include: Dietetics, Physiotherapy, Maternity, Mental Health, Maternity, A&E, Long Term Care, District Nursing, Community Nursing, Pharmacy and Oncology. Further dialogue is ongoing with other services and will continue in the future. Again without a full inventory of all records held within these and other services we are dealing with an unknown quantity and the completion of the project will be a few years down the line, but already from the considerable piece of work undertaken in a relatively short timeframe the Health Board is already witnessing the benefits. All the records returned to the centralised storage facilities will be fully reviewed, inventoried into appropriate sections (ready for destruction/retain for agreed period before destruction/retained & scanned/scanned immediately) and ultimately destroyed in line with the Health Board's Policy and National Code of Practice. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. As at January 2024, 308,000 acute patient records have been scanned, with another batch ready for distribution before the end of the financial year and to date 6,538 boxes (each containing a varied number of service records) and 16 filing cabinets have been transferred to the centralised storage facilities in Dafen and Llangennech, from both private storage providers and other internal Health Board storage locations. This allows for improved oversight of the identification and subsequent decision making where destruction or alternative courses of action of health records is concerned and is in line with Welsh Government Records Management Code of Practice and improved adherence to Information Governance requirements. The pace of the destruction of records can also now increase as a result of the lifting of both destruction embargoes arising from two national inquiries. Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Paper drafted outlining transitional plan to institute the changes required, addressing the system-wide which will potentially reduce the on-shift requirement. Paper requires sign off by Deputy Director of Operations prior to being presented to the Executive Director of Operations. Resilience work is being done regarding the on-shift element, and may require additional time to implement compared to the in-hours role. 16/08/2023 - 1 WTE clinical lead in place, and currently formalising arrangements in terms of restructuring of the OOH senior management team. However review required for the rest of the structure given current Health Board financial constraints. 04/12/2023 - Clinical Lead continues to work Monday-Friday as previous information. There has been no progress in formalising this to extend the contracted hours to a WTE and so additional days are remunerated at sessional rates with the precedent set at hourly rates paid in HB Managed Practice. The value of Clinical Leadership and associated achievements can be expalined during the DITS session. 05/03/2024 - Clinical Lead continues to work up to 1.0 WTE with conversations open with the support of Senior Workforce colleagues to establish permanently. The OCP may have an impact on how this is continued but it should not be allowed to be a reason not to progress. 08/05/2024 - Due to the number of factors involved (e.g. oversight needed of new system, MDT development etc) this recommendation has been classed as a long-term goal for the service. The revised date has been amended to reflect this.

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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - a more balanced shift fill has been noted by the service, however due to financial constraints, review of bases are still ongoing. 04/12/2023 - Shift fill has improved over recent months and will continue to be evaluated. Christmas rotas are improved when compared to 2022 however there are significnat levels of reduced capacity due to the dominant locum workforce availability. 05/03/2024 - Rota stability on the whole remains improved with few base closures over the past 12 months compared to previous years. The bases that were closed overnight temporarily in 2020 remain closed during these periods however the clinical cover during the evenings and weekend/BH daytime periods is relatively stable. The OCP may influence direction of travel for these bases and the OOH service as a whole. 08/05/2024 - Creating a service that meets the needs of the Health Board and its populations very much depends on the success of Rec 1 e.g. MDT development. It is hoped that the OCP will present further opportunities in line with scale and 24/7 working.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model, and if it's feasible to be implemented within Carmarthenshire. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. The implementation of Salus may cause further delay (expected November 2023), therefore proposed revised timescale of December 2023. 16/08/2023 - work is ongoing by service leads who are due to meet with colleagues in Cumbria OOH services to identify areas of good practice which can be shared with the Health Board. In Carmarthenshire, a trial period is scheduled in terms of implementing a model similar to Airedale currently under the auspices of TUEC . 04/12/2023 - The proposed Airdale project has not yet commenced within HDUHB (as updated from USC Lead). A visit to assess the rural model in Cumbria has not been possible and so revised date provided to allow time to do so and integrate this where possible into the OOH delivery. 05/03/2024 - No further update available - beyond sphere of influence 08/05/2024 - There has been a lack of progression with this model so far in Hywel Dda for various reasons. In principle, a variation of this model may be accepted in the future. Executive steer may be sought for guidance on this recommendation. Daytime practices/GMS could potentially adopt the Airedale model to provide 24/7 care with OOH.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - due to management structure chanegs at WAST, and several APPs leaving, this has delayed the full implementation of the recommendation, however improvements beginning to be noticed and a new cohort of APPs are currently embedding. Ongoing financial constraints are also impacting on the ability to fully implement this recommendation as at August 2023 04/12/2023 - There has been a prolonged period of reduced APP shift fill that is being addressed by WAST with the assurance that shift fill is set to improve imminently. 08/05/2024 - Shift fill did improve however not sustained. This may be linked to the same APPs being used in other areas of the HB despite OOHs funding two WTE. Assessment of the sustainability and resilience of the APP relationship with WAST is being considered and a decision will be reached in Q1 24/25. This again may be influenced by the move to Primary Care and any opportunities this may present for 24/7 offering of Primary Care. The revised date has been amended to reflect realistic progress within this financial year.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - conversations ongoing and impacted by current financial position. Revised completion date noted. 04/12/2023 - Work ongoing to integrate with other systems utilising ACPs but plans needed to ensure OOHs are able to develop a MDT with these colleagues 05/03/2024 - Work will be continuing but no progress to report at this time. Linked to outcome of OCP. 08/05/2024 - UCP work is to be piloted in the HB within the next 3-4 months. This may provide an idea of what is possible. Workforce planning to continue after recent attendance at Variable Pay group where additional support has been offered.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Paper being presented at All Wales Urgent Primary Care Conference on 28/06/2023, with progress to be provided at next recommendation review meeting 16/08/2023 - work is ongoing, and impacted by current financial position. Revised completion date noted. 04/12/2023 - There was to be a UCP presentation at the Al Wales OOH Forum last week but this has been deferred until the new year whilst work is ongoing partly due to concerns of GP workforce. 05/03/2024 - Work is continuing but no further update at this time. Linked to outcome of OCP 08/05/2024 - UCP work is to be piloted in the HB within the next 3-4 months. This is a national initiative in collaboration with HEIW which is being piloted by Hywel Dda. This will give a clear insight into the opportunities in MDT work in the 24/7.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - conversations ongoing with relevant leads and Executives in order to promote recruitment and OOH and Primary Care for co-working, and developing rotational portfolios with areas such as SDEC to make the opportunities more attractive. However current financial constraints are limiting the ability to progress this recommendation at pace, therefore timescale moved to Mar-24 to reflect. 04/12/2023 - Renewed conversations and inclusion with ongoing TUEC/UPC work. 05/03/2024 - Workforce plan being developed. Expect to have in useful shape by the end of Q1 24/25. This action is also linked to outcome of OCP and involvement with the UPC work which is currently being reviewed. 08/01/2024 - This is dependent on the progression of Recommendations 1, 4, 6 and 7. Despite improvements in the recruitment/on-boarding process, there is still a reluctance on the part of GPs to embrace a salaried career.

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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further update on the further development and integration of HCSWs in to the OOH MDT. 05/03/2024 - Reviewing the job roles and where possible developing a single role within the OOH service to allow HCSW trained colleagues to work in this capacity on a frequent basis to support the service and maintain their skills 08/05/2024 - Since the pandemic, recruitment of a younger workforce interested in working in OOH has facilitated F2F work increasing, therefore there is a better opportunity to improve these skills and the efficiency of the service as these colleagues embrace the opportunities that HCSW bring.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. Interaction with Salus may cause further delay, therefore proposed revised timescale of December 2023. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further progress to date. 08/05/2024 - Those trained as HCSW are being encouraged to utilise their skills. Clinicians are being encouraged to support such colleagues and feedback has been positive. As the number of face to face consultations continues to increase these opportunities should also be more frequent. Evaluation of the role will be ongoing. All new recruits to the OOH operational team will be trained as HCSW through the Skills to Care programme.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023- There is no further progress to date as invite to visit CTM had to be cancelled due to work pressures. There has also been a change of clinical leadership in CTM with a greater focus on GPs. 05/03/2024- Conversation with colleagues in other HBs including CTM have been rekindled and opportunities to undertake visits are being sought with a view to understanding other models and bringing back examples that would suit the HDUHB model.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - No change to OOH structure with no opportunity to explore this further. 05/03/2024 - Support for DN/ART teams has reduced the demand for catheter and VoD in the OOH service and so the need is not so apparent at this time. If service redesign progresses there may be need to review this action again and ensure OOH HCSWs are supported to learn and maintain the appropriate skills. 08/05/2024 - Currently this has been put on hold due to improved rota filled of ART/DN but potential to be explored in the future.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures. 04/12/2023 - work recently reconvened following move of previous lead and restructure of leads in this domain. 05/03/2024 - OOHs is included in the submission to the Six Goals programme later in March. Likely will be influenced by the outcome of the OCP
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures. 04/12/2023 - conversations are underway with Primary Care colleagues to find a way to constructively interact with the wider systems 08/05/2024 - This is being discussed within the HB through the Primary Care Leads forum and UPC working group. Consideration will be needed to allocate this action to a new lead and this may also be influenced by the OCP.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - this links to electronic prescribing which is driven nationally. The Health Board await national guidance, and will update policies in light of these requirements. Recommendation status amended to External. 04/12/2023 - It is understood the newest version of Adastra is capable of remote prescribing however this wil require a national implementation. 05/03/2024 - Remote prescribing is a national initiative and so is outside of the direct influence of the OOH service. Within HDUHB options are being considered to make prescribing and communication with pharmacies more efficient. Discussion with Community Pharmacy colleagues is underway to jointly explore solutions to improve prescribing opportunties which will allow clinicians to choose the most appropriate pharmacy for the patient they are dealing with and improve efficiencies within the OOH service.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - Policy has been reviewed, and compromise discussions are ongoing with workforce and clinical lead with communications sent in August 23. 04/12/2023 - compromises have been reached to ensure HDUHB OOH service can function safely and efficient however there is a continued drive from 111 to allow direct booking into treatment centres without any limitation which continues to be a source of concern to the OOH medical workforce and DMD/AMD. 08/05/2024 - Arrangement remains in place to good effect although there is little appetite to allow 111 to book patients into any OOH Treatment Centre without minimum communication, especially as this system is unlikely to work in a more rural part of Wales. Presently being monitored.
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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Continues to be challenged nationally by all HBs. Professor Mark Lawrence has undertaken a survey to be published in the new year. Upwards of 60% of calls are passed as priority 1 (Emergency in general practice) however les than 1% of these maintain that level of priority following medical triage. 05/03/2024 - Regular feedback to 111 about the appropriateness of calls and disproportionately large numbers of Priority 1 calls. This is also a factor in the above action. The report by Professor Mark Lawrence has recently been shared and is being reviewed nationally. WAST are due to have a replacement for their front end Clinical Assessment programme and this will allow some changes including a change to some triage categories which may see the sensitivity reduced and less calls being categorised at Priority 1. 08/05/2024 - New system has been in place for 1 week and has seen a change in process. The data from this new system will be monitored and assessed over the next 6 months in order to determine whether it has improved the processes in place.

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	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Data gathering continues but reliable cooperation with frontline clinicians is poor to gather timely and accurate detail rather than anecdote. Work continues nationally on this subject also. 05/03/2024 - Continual gathering of information and feedback to 111 is in place. Reinforcing the need to use the Datix system when near miss incidents occur and adverse incidents linked to this recommendation 08/05/2024 - New system has been in place for 1 week and has seen a change in process e.g. better visibility in real time. The data from this new system will be monitored and assessed over the next 6 months in order to determine whether it has improved the processes in place.

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)	Progress update/Reason overdue
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	13/05/2024 - AMaT = Overdue (no revised date provided)
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	Update taken from AMaT: Sept 23 - Hywel Dda representative on the All-Wales AFCP Group. Feedback is given via the Hywel Dda Palliative and End of Life Group bimonthly meetings. All Wales digitalisation work is ongoing. Update 16/02/24 Hywel Dda representative on the All-Wales AFCP Group. Feedback is given via the Hywel Dda Palliative and End of Life Group bimonthly meetings. All Wales digitalisation work is ongoing. No timescale provided for completion.
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	Update taken from AMaT Sept 23 update All Wales work ongoing to develop a digital AFCP. Hywel Dda Specialist Palliative Care Team promote the use of all Wales recommended AFCP documents and websites. No revised timescale provided.
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	13/05/2024 - No update on AMaT - overdue (no revised date provided)

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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	Red	16/01/2023 - Work in progress. On track. 17/05/2023 - The integration of Solarwinds with FreshService is underway with requirements being scoped. 11/07/2023 - Regular meetings are currently being held around FreshService which incorporates asset management 02/11/2023 - Change to management response: The infra team will be configuring the Solarwinds and CISCO ISE Network Management to provide sufficient alerts and events for proactive problem mgt. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur. Revised date - May 24. 22/12/2023 - (Update from IA) Launch of ARMIS may supersede this management reponse if the project is monitored via a specific group/sub committee. 29/04/2024 - Awaiting configuration of ARMIS
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	Amber	29/04/2024 - Updates received (see In-Committee tab)
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	Amber	29/04/2024 - Updates received (see In-Committee tab)
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	Amber	29/04/2024 - Updates received (see In-Committee tab)
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~~ Sept-24	Red	29/04/2024 - Updates received (see In-Committee tab)
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ Jun-24	External	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Jul-23~~ ~~Dec-23~~ ~~Jul-24~~ Oct-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Low	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	~~Aug-23~~ ~~Jul-24~~ Oct-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ ~~Dec-23~~ Oct-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ ~~Mar-24~~ ~~Oct-24~~ Dec-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	~~Mar-24~~ N/K	External	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Jun-23~~ ~~Mar-24~~ N/K	External	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).

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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	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- update to ARAC provides revised date of December 2022 for the implementation of the new risk management system. This is an All Wales system therefore the implementation date is outside the gift of the Health Board. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 10/07/2023 – Fundamental issues with the new Datix risk system have come to light in respect of its functionality and reporting, which have led to the All Wales Datix Team agreeing with RLDatix that the current Datix risk module will remain in place until November 2024. At present, RLDatix are developing a roadmap for the work needed to address the issues with the new risk system for the NHS Wales Risk Group to consider and inform decision-making about proceeding with the new Datix Risk module or exploring other options. 14/11/2023 - discussions are continuing on an All Wales level with Datix, and outcomes awaited from Programme Board meeting scheduled for November 2023 to determine next steps
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	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 21/11/2022 - Assistant Director of Assurance and Risk with the Deputy Director of Operations to establish a revised process and timescale for implementation for the recommendation. 24/11/2022 - Recommendation changed from red to external as implementation will be dependent on the implementation of the new Datix system 23/03/2023 - no further progress or timescales. Risk raised to reflect the situation - 1607 - Risk that the UHB will not have a fit for purpose risk management system after 31Mar24 10/07/23 – Whilst waiting for the new risk system, the Operational Risk Report to Operational Quality, Safety and Experience Sub-Committee will now include a more detailed analysis, which will include grouping of similar risks. The Directorate Improving Together sessions provide high level oversight, identification and discussion of key risks and issues experienced by Directorates and Services. Work is also progressing to define 'fragile services' which will help the identification of increased risks in particular services. 14/11/2023 - discussions are continuing on an All Wales level with Datix, and outcomes awaited from Programme Board meeting scheduled for November 2023 to determine next steps
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	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 23/03/2023 - Directorate Improving Together Sessions commenced in January 2023, which now supersede the operational risk review meetings, of which the generated TOAs are monitored via DITS, as we as via Senior Operational Business Meetings. To confirm with Director of Operations in April 2023 that the recommendation can now be closed. 01/08/2023-Directorate Improving Together Sessions established in January 2023. Assistant Director of Assurance and Risk and Head of Assurance and Risk have requested confirmation from the Director of Operations in June 2023 to confirm if the recommendation can be closed in relation to Governance arrangements. 28/12/2023 - an OCP has been issued to operational teams in December 2023, with a consultation preiod extending in to 2024 following which further engagement may be required. A phased approach is being applied and that a new structure will be ready for implementation by 1st April 2024. Once the structure has been agreed and individuals appointed and in post, a review can then be undertaken on Datix to ensure it reflects the revised structures. 05/04/2024 - ADAR met with Director of Operations to discuss the revised structure
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~~ N/K	Red	11/05/2023 - The existing policy has been given a formal extension by CWCDG until 10/08/2023, whilst the review is undertaken. 15/06/2023- lead officer has contacted Consultant Haematologist for an update. 07/09/2023- This policy sits with Pathology.The Chair of the Blood Transfusion Committee has responded to say that they are working on the update and hope to get it approved at the Blood Transfusion Committee meeting in October 2023. 28/09/2023- Ownership of this policy sits with the Blood Transfusion Committee. The policy was given a formal extension by CWCDG until 10/08/2023, whilst a review was undertaken, however this timescale was overrun due to the need to prioritise the update of the more clinically urgent Major Haemorrhage Procedure. Chair of the Blood Transfusion Committee has provided assurance that the policy remains fit for purpose. The review and update are in progress and the intention is for the revised policy to be approved at the October meeting of the Blood Transfusion Committee. On track for revised date of October 2023. 26/10/2023- The latest review of this policy is still in progress, the task and finish group tookmplace prior to the BTC meeting on 26/10/2023 but with it being a 90 page document with several new national guidelines to reflect, the work is ongoing. It has been decided to take out the Emergency Blood Management Plan to form a separate document, for which we are awaiting an all Wales policy, which should minimise further delays. We had discussions around the irradiated products appendix and linking notifications to chemocare and are awaiting final arrangements around issue of andexanet alpha which is a new product. The current version is fit for purpose. Blood transfusion manager is leading on this review and will be progressing things over the next few weeks. The next meeting of the BTC has not been scheduled yet so we do not have a definite date for approval. 20/12/2023- Work on updating the Transfusion Policy is ongoing. A decision has been made regarding Andexanet Alfa therefore the Blood Transfusion Manager is liaising with pharmacy re the procedure for its prescription and issue. The Blood Transfusion Manager is not able to provide a date of publication at this stage. 27/02/2024- updated policy planned to be approved by the Blood Transfusion Committee in the meeting in March 2024.

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	15/06/2023- lead officer provided revised date of September 2023, as they hadn't anticpiated how long their phased return would be. 07/09/2023- at the next meeting of the MCA & Consent Group on the 25/09/23, the Head of Consent and Mental Capacity will be requesting an extension to December 2023, as they won't have time to complete this before the meeting. 28/09/2023- changed to 'external' rec. The MCA & Consent Group (25/09/23) was informed that WRP are currently working with EIDO to extend their patient information system into a central repository where each health board can store any locally produced patient information leaflets. Currently awaiting a response from WRP as to whether this negates the need for this recommendation. 20/12/2023- WRP have confirmed (03/10/23) that they are developing a new EIDO platform which will enable the health board to develop its own searchable database of local procedure specific consent leaflets. The health board will be required to advise WRP of local information leaflets used in the legal consent process that need to be uploaded so that this database can be developed. WRP hope that all Health Bodies in Wales will have migrated to the new platform by the end of February 2024.
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	R7. Put a process in place to comply with the 'Criteria for use of Procedure Specific Patient Information Leaflets following publication of RMA2020-01 namely – Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk.	Write that required procedure and take to Mental Capacity and Consent Group for approval.	Oct-23	~~Mar-24~~ N/K	Red	07/09/23- At the next meeting of the MCA & Consent Group on the 25/09/23, the Head of Consent and Mental Capacity will be asking for an extension to December 2023, as the Group doesn't meet again until the December 2023, therefore approval will not be received by October 2023. 28/09/2023- The MCA & Consent Group (25/09/23) recommended the timescale is updated from October 2023 to March 2024 to take account of the required development time, and MCA & Consent Group and CWCDG approval timescales.
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~~ N/K	Red	15/06/2023- lead officer confirmed December 2023 implementation date. Meeting held with Mark Henwood and Owain Ennis 15/06/23 to commence planning process. 07/09/2023- This is on track. Arrangements for this Welsh Risk Pool national peer review audit are well underway, with the plan to complete the data collection in September/October 2023, and report the findings to the MCA & Consent Group on 08/12/23. 28/09/2023- This action is on track. Arrangements for this Welsh Risk Pool National Peer Review Audit are well underway. A randomised sample has been generated for each specialty and issued to the clinical lead so the data collection can commence. However, as the data collection timescale set by WRP is until 31st December 2023, and the All Wales Consent to Treatment Group has reported that other health boards are finding clinical engagement in the audit challenging, the MCA & Consent Group (25/09/23) recommended the timescale is updated from December 2023 to March 2024 to allow for any delays in data collection due to clinical engagement issues, plus data analysis and production of the audit report.
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	R9. Continue to monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets.	Hold discussions with Scheduled Care, Women and Children's Directorate and Radiology to ensure processes are in place to monitor and assess shortfalls in use, provision and documentation of patient information leaflets.	Dec-23	~~Mar-24~~ N/K	Red	15/06/2023- lead officer confirmed December 2023 implementation date. 07/09/2023-No progress made with this action as yet, but should be on track for December 2023. 28/09/2023- Should be on track for December 2023. The peer review audit (recommendation 8) will provide up to date data on use of patient information which will facilitate the monitoring and assessment of use of patient information leaflets. 20/12/2023-Email sent to the relevant service leads. The Head of Radiology has confirmed that a process is currently being put in place by their Lead Radiology Nurse who will set up a procedure, including audit, by which compliance can be checked. This issue has been added to their Governance meeting agenda as a standing item.Response awaited from Scheduled Care and Women and Children's Services. The peer review audit (recommendation 8) will provide up to date data on use of patient information which will facilitate the monitoring and assessment of use of patient information leaflets. Revised date of March 2024 provided.

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)	Progress update/Reason overdue
Feb-22	2021/22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	~~Apr-24~~ N/K	External	11/11/2022-Progress to be requested in early 2023 to ensure this is on track. 27/04/2023- Senior Environmental Officer confirmed Waste Policy on track for update by October 2023. 12/10/2023- The UHB have been given a 6-month extension to update the Waste Policy as the HTM 07 01 is being updated in Wales and this is the key piece of guidance that informs the Waste Policy. Recommendation changed to 'external' whilst HTM 07 01 is being updated at an All Wales level.
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	03/01/2024- Head of Property Performance confirmed this is on track. 07/03/2024- Head of Property Performance confirmed this action is on hold pending the outcome of the above NWSSP – SES exercise on the 6 facet survey approach including a view on how surveys will be funded, given current constraints on finances. Head of Property Performance concerned how this action will be addressed with continued pressures on finances. Awaiting response from Internal Audit.
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	03/01/2024- Head of Property Performance confirmed this is on track. 07/03/2024- Head of Property Performance requested clarity from Internal Audit on how this recommendation can be closed.
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	03/01/2024- on track.
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	03/01/2024- Report notes timescale as 'future assurance'. On track.
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	Internal Audit	Standards of Cleanliness Final Internal Audit Report	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R1. Develop Terms of Reference for the Environmental Hygiene Group setting out the responsibilities, membership and reporting arrangements. Matter Arising 1: Governance, Monitoring & Reporting (Design)	Environmental Hygiene Group TOR currently in Draft, on agenda to be ratified at next EHG meeting on 14.05.24	Jun-24	Jun-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	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)	Training Supervisors will be located on all acute sites.	May-24	May-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)	A detailed implementation plan will be taken to OPGP in June 2024	Jun-24	Jun-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	Medium	R7. Health Board-wide implementation of successful practices identified following the pilot study. Matter Arising 4: Implementation of Revised Working Arrangements (Design)	In the meantime we will engage with staff who participated in the pilot study to explore early implementation on a volunteer basis.	Jun-24	Jun-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	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	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)	In the interim we will adopt a risk-based approach.	May-24	May-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	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	Completion date June 2024 (Subject to WG decision)
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	

Feb-20	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114 719- 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-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22. 20/12/2022- A programme completion date will be developed as the above BJC work is progressed to encompass the work content and complexity of this Phase 2 project. Early indications are that due to the multiple Decant needs of Ward areas the programme may need to be extended as part of the due diligence work within the Business Case. As this becomes more developed, MWWFRS will be fully involved in these discussions so that appropriate changes can be made to the Phase 2 Enforcement dates. This matter has been discussed with MWWFRS who appreciate that a revision may be required to this programme should the nature of the works dictate that an extension to this timeline becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2025 date. 26/04/2023- the UHB has recently presented a reduced scope of works for Phase 2, which the MWWFRS are considering, with a decision likely to be received the second week of May 2023. Subject to this being approved, there will be a significant reduction in cost. 06/12/2023- Completion date moved to October 2025, MWWFRS informed 10/11/2023. MWWFRS to write to confirm their agreement.
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.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ ~~Feb-23~~ ~~Aug-23~~ ~~Jan-24~~ Jul-24	~~Jul-22~~ ~~Feb-23~~ ~~Nov-23~~ ~~Jan-24~~ Jul-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. 20/12/2022- A revised completion date of November 2023 has now been accepted by the Project Management Team following all their due diligence checks. This programme update has been fully reported to the MWWFRS in a formal meeting held on 08/12/2022 and they fully accept the need for this adjustment. MWWFRS have noted that they will look to revisit the UHB prior to the currently set end date (February 2023), so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms they presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is November 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 31/08/2023- MWWFRS letter confirms extension to 31/01/2024. 06/12/2023- delays with contractor, to be discussed with MWWFRS. Timescale now possibly late 2024. 08/02/2024- Timescale being confirmed. 14/02/2024- extension letter received from MWWFRS confirming extension of KS/890/08 to 31 July 2024. Recommendation therefore turned back from red to 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.	~~Oct-20~~ ~~Feb-21~~ ~~Aug-24~~ Jun-25	~~Aug-24~~ Jun-25	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid-November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme, should the nature of the works dictate that an additional period of time becomes necessary. 20/12/2022- It is important to note that Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Regular discussions continue with MWWFRS, including a formal meeting held on 08/12/2022, who appreciate that a revision may be required to the FEN dates should the nature of the works dictate that an additional period of time becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2024. 26/04/2023- it is unlikely this works will be completed by August 2024 due to the scope reduction and complexity of the works. MWWFRS are fully briefed on the UHB position and will consider an official extension when the works programme is presented to them. The business case is currently being drafted. 06/12/2023- awaiting new agreed dates from MWWFRS. 14/02/2024- extension letter received from MWWFRS confirming extension of KS/890/09 to 30th June 2025.
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/00106 219	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.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivery plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.

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.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivery plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
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.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. All remaining doors under future phasing Overarching delivey plan for the site is to March 2025.Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
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.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Overarching delivery plan for the site is to March 2025. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
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.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
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	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022-AFT survey now completed.Site review with NWSSP-SES to agree prioritisation of door replacements for EFAB funding. 20/12/2022- Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber. 05/12/2023- Update to MWWFRS on 10/11/2023 states timescale date to be agreed. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to urgently review and update the revised completion date.
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	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to urgently review and update the revised completion date.

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	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
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	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
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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	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
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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	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
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-22~~ Dec-25	Dec-25	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion December 2022. 10/01/2023- Head of Estates Risk & Compliance to check if this has been implemented. 13/01/2023- A scheme has been completed to address all vertical escape routes with new emergency lighting, all remaining areas of the block will be considered as part of the main firecode scheme as agreed with MWWFRS. Revised date of December 2025 provided to encompass all works at the BGH site. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to December 2025. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.

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-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
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-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
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-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
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-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms this will be completed by November 2023.
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-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
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	R5. Keep waste material in suitable containers before it is removed from the premises. If bins, particularly wheeled bins, are used outside, secure them in a compound to prevent them being moved to a position next to the building and set on fire. They should normally be a minimum of 6 metres away from any part of the premises.	Full action plan held by Estates.	Mar-24	~~Mar-24~~ May-24	Red	06/12/2023- on track. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable.
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	06/12/2023- on track.
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, (Elderly Services & Mynydd Mawr ward), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • ~~Id~~ 1164a & 1164b • ~~Id~~ 1170a & 1170b 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. (Estates ref 1.4)	Full action plan held by Estates.	Sep-23	~~Mar-24~~ Jun-24	Red	20/10/2023- More work is needed to address defect. Doors are not repairable. Revised date March 2024. 05/12/2023-update to MWWFRS on 10/11/2023 states identified new doors needed to be changed with Fire Door scheme starting in January 2024. 14/02/2024 - Subject to funding being provided. 29/02/2024 - Date of completion revised to June 2024 due to delays with specific doors. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable. 27/04/2024 - Doors on order as at 7th March 2024, delivery date of 20th May 2024 expected. Fitting to be arranged with AFT. Date of completion revised to June 2024 due to delays with specific doors.

May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Surgical Day unit, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF. NE/BFS/00337255	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. •6FF55 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.	Mar-24	~~Mar-24~~ May-24	Red	05/12/2023- update to MWWFRS 10/11/2023 confirms March 2024 date and under warranty. 24/04/2024 - Discussed at Review Meeting today. Advised that this is subject to Defects Lists with Contractor. Recommendation Owner to review and advise if revised completion date is not attainable.
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	Red	05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable.
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	R6. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •2241 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. (Estates ref 3.7)	Full action plan held by Estates.	Mar-24	~~Mar-24~~ May-24	Red	05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable.
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	R7. 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. •2160 •2176 •2170 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. (Estates ref 3.8)	Full action plan held by Estates.	Sep-23	~~Mar-24~~ Jun-24	Red	20/10/2023- More work is needed to address defect. A new door is required for item 2170, this will now be March 2024 as doors are not repairable. 05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024. 14/02/2024 - Subject to funding being provided. 29/02/2024 - 2160 and 2176 completed. 2170 to be completed 01/06/2024. 27/04/2024 - 2160 and 2176 completed. 2170 to be delivered 20th May 2024. Fitting to be arranged with AFT. To be completed June 2024.
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	R2. Confirmation of the fire resistance of panels within Fire Resisting doors should be provided. Any Panels within the door should provide a similar degree of fire resistance as the door. 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.	Jan-24	~~Jan-24~~ May-24	Red	01/03/2024 - Revised date needed May 24 to agree with the Fire Brigade the exact scope. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable.
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	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.	Jan-24	~~Jan-24~~ ~~Apr-24~~ Jun-24	Red	08/02/2024: Revised date needed April 24 to agree with the Fire Brigade the exact scope. 24/04/2024: Transfer grilles installed on R02 Cleaners Store, R06 Staff rest, and R07 Dirty Utility. The grilles do not conform to BS8214:2016. Work ongoing to obtain quotations for compliant grilles, we are also considering whether the grilles can be removed altogether as they may not be required.

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	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - 50% completed. Operational demands in one or two wards have prevented relocation. Ward 4 future copier room enhanced fire stopping to be part of 2nd phase fire improvements. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
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	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - Ward 1 fridge relocated. Ward 3 copier relocated, see above re ward 4 copier, laptop charger units 50 % completed. Operation demands have prevented relocation in some areas. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
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	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - This forms part of phase two fire improvement works. Schedule to be confirmed. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
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	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 05/03/2024 - Head of Estates Risk & Compliance confirmed that this recommendation forms part of Phase 2 main FIRECODE work at WGH. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
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	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	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - This forms part of phase two fire improvement works 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
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	04/12/2023- Update to MWWFRS on 10/11/2023 confirms March 2024 date. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable. 27/04/2024 - Review completed by JW, awaiting costs for replacement doors. Order to be placed once costs obtained. Revised completion by 30/09/2024.
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 R4S 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	03/01/2024- Head of Operations to check with Head of Estates Risk & Compliance if this recommendation has been completed. 08/01/2024- Head of Estates Risk & Compliance confirmed this has been agreed with MWWFRS this forms part of the main GGH fire Project. 08/02/2024- to be checked if this forms part of phase 1 or phase 2. 01/03/2024 - Head of Estates Risk & Compliance has advised that this recommendation forms part of Phase 2 to be completed August 2024 (letter awaited).

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	05/12/2023- update to MWWFRS 10/11/2023 confirms June 2024 date.
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	05/12/2023- update to MWWFRS 10/11/2023 confirms June 2024 date.
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. •Bridge (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	Red	24/04/2024 - Discussed at Review Meeting. Head of Estates, Risk & Compliance to seek clarification that recommendations have ben undertaken and advise.
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	R3. 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	Full action plan held by Estates.	Mar-24	~~Mar-24~~ May-24	Red	24/04/2024 - Discussed at Review Meeting. To confirm whether the doors have been repaired. This recommendation may form part of Phase 2 Works - Head of Estates, Risk & Compliance to seek clarification and advise. 27/04/2024 - R37 door now repaired.
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	R5. 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. •3028 •To R55 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.	Full action plan held by Estates.	Mar-24	~~Mar-24~~ ~~Apr-24~~ Jun-24	Red	16/04/24 - Room R55 Intumescent strip repaired. Works to this door complete (Paul Hill). 23/04/24 - R28 is currently barrier nursing so we are unable to repair the intumescent strip until the patient has left the ward, or their infection clears. We have visited the ward multiple times, and have requested that the ward inform us once the room becomes available (Paul Hill).
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	22/12/2023- Timescales provided by Head of Estates Risk & Compliance. 24/04/2024 - Discussed at Review Meeting. Direct email sent to Digital Director for update on progress. Awaited.
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	R7. The following fire resisting door was found to be damaged. This door must be replaced. •B016B (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.	Full action plan held by Estates.	May-24	May-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.

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	R1. An Assessment should be undertaken throughout the building to ensure: - All openings in the walls, floors, partitions, and ceilings throughout the premises that are provided for the passage of service piping, ducts, or cables, are to be sealed or bushed to at least 30-minute standard of fire resistance. (e.g., Dental storage – First Floor). 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 A/1, A/2 of Approved Document B volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Awaiting quotation from fire stopping contractor	Mar-24	~~Mar-24~~ ~~Apr-24~~ May-24	Red	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024. 17/04/2024 - The First floor dental protected route doors (5) to be upgraded with new cold smoke seals and Fire door keep locked signage fixed to be completed by 30/04/2024 . 25/04/2024 - Signage completed by 30/04/2024. Awaiting materials for smoke seals, work to be completed by 31/05/2024.
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	07/02/2024- being clarified with MWWFRS if this needs to be actioned. 26/02/2024 - To be completed by 31/03/2024 17/04/2024 - Glazing above doors to be overboarded to FR30 standard estimated completion 30/04/2024. 23/04/2024 - Suspected Asbestos found on frame. Sample to be tested before progressing with work. Work will now be completed by 31/05/2024 27/04/2024 - Confirmation received that review completed by JW, awaiting costs for replacement doors as at 09/04/2024. Order to be placed once costs obtained. Revised completion by 30/09/2024.
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	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024. 17/04/2024 - The boiler room ceiling all penetrations sealed. The First floor dental storage area requires a greater amount of work at an estimated cost of 15k. Compensatory measures in place in the interim a) Means of escape has been protected with a compliant repair to the existing Fire Door. b) AFD upgraded to L1. 24/04/2024 - Discussed at Review Meeting today. Recommendation Owner to advise if the agreed revised completion date is not attainable. 30/04/2024 - The laser room is not classed as a hazard room and is adequately protected.
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	R13. • A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm. • Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so that the doors close completely into their rebates. • All self-closing devices are to be regularly inspected and maintained and records kept. • Wedges are not to be used to keep fire doors open.	Review current fire doors and repair as necessary. Review current hazard rooms	Mar-24	~~Mar-24~~ ~~Apr-24~~ May-24	Red	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024. 17/04/2024 - Materials for repairs delayed work will now be completed by 30/04/2024. 30/04/2024. Materials for repairs delayed work will now be completed by 31/05/2024.
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.		Apr-24	~~Apr-24~~ Jun-24	Red	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms April 2024 deadline against this recommendation, therefore turned back from red to amber.
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	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms Training scheduled 12/04/2024.
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	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms Training scheduled 12/04/2024.
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	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 from R07 to corridor (1st Floor) •Door 3003 Radio Studio (3rd Floor) 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	Engaging with contractor for a quote to replace	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024. 29/04/2024 - Position remains unchanged.

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	R3. The following doors should be reinstated with a 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. •Room 04 Printer room (1st floor) 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	Engaging with contractor for a quote to replace	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024. 29/04/2024 - Position remains unchanged.
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	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024. 29/04/2024 - Revised date of completion.
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	R7. The routes to emergency exits from premises must be kept clear and free of obstruction at all times to allow persons to evacuate the premises as quickly and safely as possible.The following items must be removed from the corridors •Ironing boards and irons (2nd & 3rd Floors) •Large linen trolleys (2nd & 3rd Floors) •Recycling bags of Waste paper in stairwell (1st Floor)	To be addressed by Hotel Services.	Apr-24	~~Apr-24~~ Jun-24	Red	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024. 29/04/2024 - Revised date of completion.
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	R8. The inner room situation located •Room 15 (GF) is unacceptable, one of the following must be provided: •Provide a smoke detector in the outer room, capable of initiating a warning of fire to the occupants of the inner room. The detector should be linked into the existing fire alarm system; or •Clear glazed vision panels should be provided so that the people occupying the inner rooms can see into the outer rooms from their normal working position. •The enclosures (walls or partitions) of the inner room should be stopped at least 500mm below the ceiling; This work should be done to conform to a relevant standard e.g. Approved Document B Volume 2 Buildings other than dwelling houses. All work involving the fire alarm should be carried out in accordance with BS5839-1:2017 Compliance with this or an equivalent standard will normally satisfy the requirement.	Merlin fire Improvement works identified	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024. 29/04/2024 - Position remains unchanged.
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	R10. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •Door 1013 A / B 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.	Carry out improvement works.	Apr-24	~~Apr-24~~ Jun-24	Red	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024. 29/04/2024 - revised date of completion.
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	01/03/2024 - Need to agree GGH phase that this is under - June 24 08/03/2024 - Head of Estates Risk & Compliance has advised that recommendation is due for completion August 2024 (Phase 2).

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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete April 2024.
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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete June 2024.
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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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. •B006 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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.

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; •~~B~~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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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. •~~S~~tore/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	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
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		Jun-24	Jun-24	Amber	29/02/2024 - The Estates & Facilities department have asked the fire brigade to confirm what door this relates to, as R8 not included in our system – Revised date of June 2024 provided.
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: •~~R~~39 Switch Room (Block 6) •~~R~~27 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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.
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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.
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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.
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. •~~R~~21 Anaesthetic Store (Block 6) Oxygen Cylinders should be stored in accordance with HTM 02 - 01		May-24	May-24	Amber	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.

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. •2003A (Block 6) •2010 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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.
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; •2004A/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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion.
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. •2007A/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	03/04/2024 - Head of Estates Risk & Compliance has confirmed dates for completion. 29/04/2024 - Position unchanged since previous update.
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.		Sep-24	Sep-24	Amber	03/04/2024 - Advised by Head of Estates Risk & Compliance that works will be complete by 30/09/2024.
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.		Sep-24	Sep-24	Amber	03/04/2024 - Advised by Head of Estates Risk & Compliance that works will be complete by 30/09/2024.
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.		Sep-24	Sep-24	Amber	03/04/2024 - Advised by Head of Estates Risk & Compliance that works will be complete by 30/09/2024.
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.		Sep-24	Sep-24	Amber	03/04/2024 - Advised by Head of Estates Risk & Compliance that works will be complete by 30/09/2024.

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		May-24	May-24	Red	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved.
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	R2. General Fire Precautions - Fire doors (throughout building). All fire resisting doors are to be examined and repaired or replaced to ensure that they are effictively self-closing onto their rebates and there are intumescent strips fitted to the doors or frame (e.g. fire doors were not closing fully onto their rebates)		May-24	May-24	Red	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved.
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		May-24	May-24	Red	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024 - Evacuation chairs have been installed. MG/BGH Estates.
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.		May-24	May-24	Red	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved.
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.		Jun-24	Jun-24	Red	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024 - Fire Drill planned for June 2024 (MG).
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	R2. The following cupboards to be cleared of all storage and kept locked shut when not in use. • Switch Room R41 • Duct Room R40		May-24	May-24	Amber	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Job card raised to clear rooms- Closing date 31/05/24.
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	R4. Extend the existing fire detection and warning system by providing automatic smoke detection in the following areas: • Duct Room R38 All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017		Jun-24	Jun-24	Amber	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Email sent to Merlin Fire requesting a quotation for additional fire detector- Closing date 30/06/24.
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. • 023A/B • 005A/B (Hole in frame for wiring) • 026A/B (Gap) • 014A/B (Gap) • 021A/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	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Email sent to Heather Williams enquiring if this action will be captured under the fire project - Closing date for reply 31/05/24, if captured under fire project then completion date for repairs June 2025.

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	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Email sent to Heather Williams enquiring if this action will be captured under the fire project - Closing date for reply 31/05/24, if captured under fire project then completion date for repairs June 2025.
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	R4. The following rooms are to be cleared of all storage and kept locked shut when not in use. •Switch Room R22		May-24	May-24	Amber	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Job card raised to clear switch room- Closing date 31/05/24.
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	24/04/2024 - Discussed at Review meeting. Letter received and added to the tracker w/c 21/04/2024. Officer to discuss with Fire Service and assess appropriate programme dates relevant to the works involved. 30/04/2024- Email sent to Heather Williams enquiring if this action will be captured under the fire project -Closing date for reply 31/05/24, if captured under fire project then completion date for repairs June 2025.

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)	Progress update/Reason overdue
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	11/05/2023 - Originally intended to be completed by 30/06/2023, but with it will need to be approved by the Board before it can be signed off (meeting scheduled for July 2023). 12/09/2023 - Linda Jones, who has been successful into the RPB Lead role, confirmed the remaining queries were being worked through with Ceredigion, who should look to provide their final views in late September 2023. 25/10/2023 - Action residing with RPB Lead, and response has been further requested for finalising and signing a MoU 20/12/2023 - IA to check if this recommendation has now been implemented. 21/12/2023 - The Memorandum of Understanding has been discussed at Decemeber Integrated Executive Group (IEG) and reported to each Board meeting due to the delays. This recommendation is now awaiting for progress to take place with the Local Authority. Recommendation changed from 'Red' to 'External'. 05/04/2024 - awaiting update from IEG to progress this recommendation further and to confirm revised completion date
Jun-23	2022/23	Internal Audit	Financial Management	Open	Reasonable	Finance	Finance	Senior Business Finance Manager (Corporate)	Director of Finance	Medium	R2. Management to review the current arrangement to ensure consistency in approach and level of documented actions.	Agree, document, and gain operational engagement and signoff for a framework that articulates a consistent agenda, frequency and action point outputs expected from all routine financial performance meetings. Ensure this approach is embedded within the Operational Delivery Framework - a Master Theme deliverable as part of Targeted Intervention led by the Executive Director of Operations.	Aug-23	~~Aug-23~~ ~~Oct-23~~ ~~Mar-24~~ Jun-24	Red	25/09/2023 - Revised timeline committed to delivering all framework elements with the exception of full alignment to the Operational Delivery Framework which is pending completion. This will then be updated on a continuous basis as and when required. 25/10/2023 - Reviewed within Finance during September, with Finance Director review on 30th October. Operational Delivery Framework engagement will be sought once structural changes communicated. 12/12/2023 - Framework has now been completed, work will be refreshed once the Operational Structure changes are announced. 04/01/2024 - IA Update - Operational Delivery Framework has been drafted, but has yet to be implemented due to departmental restructure and work pressures. 08/04/2024 - Recognising that the Operational Management structure changes remain a work in progress, the Finance team have been proactive and the framework is actively being applied in a number of areas. Due to capacity constraints (as framed in the Finance team resource risk included on the Health Board Risk Register currently) a consistent implementation of the approach has not been possible. Therefore the next steps are to pursue a consistent roll out across the Finance teams and to assess the effectiveness of the approach and any aspects that need refining based on the initial roll out.

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)	Progress update/Reason overdue
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	06/06/2023 - Update to ARAC- A proposed revision to the operational governance structure has been developed which needs further sign off from a Governance and Executive Team perspective. The work on operational structure continues in line with the outlined timeframe. 28/12/2023 - an OCP has been issued to operational teams in December 2023, with a consultation period extending in to 2024 following which further engagement may be required. A phased approach is being applied and that a new structure will be ready for implementation by 1st April 2024. (Revised completion date of September 24 noted to reflect the period to embed the new structure) 09/02/2024: Audit Wales Structured Assessment Report 2023 has advised that this recommendation will be followed up through their review of operational governance.
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	09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation will be followed up through their review of operational governance. Recommendation turned back from green to red and a revised completion to be requested from the Director Finance. 19/03/2024: Our Improving Together framework aligns teams to our strategic objectives and what matters to us as a health board. It focusses on key improvement measures, how we are performing and whether additional improvements need to be made. In January 2023, Directorate Improving Together Sessions (DITS) were established. DITS meetings give directorate leads an opportunity to meet with Executive Team members to discuss the challenges they are facing and if support is needed to unblock any issues. These discussions are supported by the Our Performance and Our Safety dashboards which provide triangulated data sets from across quality and safety, performance, risk and finance. Supporting reports are also provided from corporate teams for audit & inspections, job planning, finance and clinical audit. Executive Team, Directorate leads and corporate teams working together have collectively made some noticeable improvements during 2023. For example, there has been a reduction of 158 days for the average time a complaint is open and there has been a 30% improvement in the number of overdue risk actions. DITS meetings currently take place every quarter for operational directorates and bi-annually for corporate directorates. Executive Team are working on an escalation framework to ensure tighter scrutiny of those directorates who are not meeting their improvement goals. Our aim is for the new escalation framework to be signed off and implemented by the end of June 2024.
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	01/06/2023 - There is a Planning Objective to deliver a plan in the year, which will be taken to Board in September 2023 and form the basis of the development of the IMTP for March 2024. 09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation is in progress. 14/03/2024: Update requested from Director of Finance, along with revised timescales, if applicable. 02/05/2024 - A roadmap has been developed in each of the last three years, that continuously recognises the latest financial challenges facing the health board. The roadmap is shared amongst Executive Team and Board, and has most recently been shared as part of a 10 year clinical workshop as part of the health boards strategy development. The 2024/25 Annual Plan did not include sufficient plans to take the component parts of the roadmap and operationalise them. The health board has committed to de-risking the 2024/25 plan by the end of June 2024 (Q1). Following this revision, the roadmap will be updated to provide the latest view on what is remaining to enable the health board to still achieve financial sustainability
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 approporiate Committees of the Board for assurance purposes, and the revision of the BAF.	Mar-24	~~Mar-24~~ Oct-24	Red	22/04/2024: The Health Board will continue to integrate the learning from the annual plan recovery work phases into its ongoing planning activities, recognising the importance of embedding these lessons into day-to-day operations. This integration is a core part of the Targeted Intervention framework, which aims to ensure a seamless transition of insights and strategies into future plans. The Targeted Intervention framework, underpinned by the integrated planning process, serves as a live operational tool that brings together all aspects of the organisation, aligning efforts with the Board's objectives and risk appetite. Furthermore, the savings process, an integral part of operational planning, follows a cyclical approach where lessons learned and efficiencies identified in one cycle inform the planning of the next. This dynamic and responsive approach reinforces the UHB's commitment to quality care and service improvement while addressing financial sustainability challenges. By embedding TI into its day-to-day plans and processes, the UHB aims to drive systemic change from within, leveraging the insights and requirements of the framework to achieve its strategic and planning objectives. In summary, the UHB is committed to embedding the updated maturity matrix and TI framework into its day-to-day plans and processes, driving systemic change from within the organisation. By integrating TI principles into the new organisational structure and the continuous planning process, the UHB aims to align its efforts with its strategy and focused set of 10 planning objectives, which are fully aligned and linked to the reporting groups and Welsh Government's ministerial priorities. Moreover, in line with the recommendations from Sally Attwood's report, the UHB is focusing on building organisational capacity in the interim by leveraging expertise and resources across various Directorates to support the TI effort and internally escalated Directorates. This collaborative approach, coupled with the integration of learning from annual recovery work, demonstrates the UHB's commitment to driving systemic change and achieving sustainable improvements in planning and delivery.

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)	Progress update/Reason overdue
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	30/11/2023 - Project has now been accepted and work commenced. Digital services have given an interim date of March 2024 to begin training and rollout of the new processes.
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	Medium	R2. An action plan setting out the projected impact of additional resource and training programmes should be developed, including milestones and deadline for delivery. Regular progress updates should be provided to an appropriate group or committee.	Initially measurement of the impact of the additional resources and training programmes will focus on two key measurements: 1. The number of potentially inappropriate DoLS referrals received by theteam, expressed as a percentage of all new referrals received. 2. The total number of DoLS assessments completed by the team. Success would be shown by a decrease in inappropriate referrals and an increase in assessments completed. We will set a 6 month target to reduce inappropriate referrals by 30% and to increase completed DoLS assessments by 10%. Data for both measurements will be collected and reported monthly to the LTCT and quarterly to the Consent and Mental Capacity Group.	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)	Progress update/Reason overdue
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	19/06/2023- Report was formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. No formal management response presented for this recommendation. Date of HEIW visit has yet to be confirmed. 10/10/2023 - Next visit to take place on Wednesday the 18th October 2023. 30/10/2023 - Re-visit took place on the 18th October. Some progress made with regards ENT, Surgery and Urology and going forward these specialties will not form part of the visit which will be made in 6 months time. 22/12/2023 - Date of visit has yet to be confirmed. 30/04/2024 - Follow up visit to T&O took place on the 13/03/2024. Management response to new recommendations has been submitted and will be included on the SPEG agenda. Further follow-up visit date yet to be confirmed.
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	22/12/2023 - overwhelming response to Appraiser recruitment drive initiated. We are in the process of carrying out interviews for appraisers with a view to then recruiting further appraiser leads. 01/03/2024 - We have successfully recruited 7 new appraisers with a further interview scheduled to take place over coming weeks. We are keen to ensure that we have recruited sufficient appraisrs before recruiting appraisal leads and so this will be the next stage. 30/04/2024 - We have now appointed a total of 10 new appraisers with a further 2 appraisers being interviewed over coming weeks. It is felt that although an Appraisal Lead specifically for IMGs would be perhaps an option for consideration for the future, we have yet to appoint 2 appraisal leads that we need to cover the appraisers on the Withybush and Glangwili sites and as these roles are funded by the operational teams, the Lead specific to IMGs is perhaps not a priority in the current financial climate. The new appraisers which we have appointed will help to relieve the pressure on our existing appraisers, we have increased the Appraisal and Revalidation support offerred during induction, regular training sessions are held, relevant information is regularly communicated via the Medical Directors Newsletter etc. This action can now be closed.
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	Red	10/10/2023 - The team have been informed that we will need to identify an alternative individual to sit as lay member on the ROAG meetings. We will approach the Revalidation Support Unit to find out if one of the QA visit lay representatives could also act as lay representative for the Health Board. 30/04/2024 - The Revalidation Support Unit has been approached to ask if they have anyone they nominate. They have a team of lay reps that we can reach out to but they get paid for any activities participate in for HEIW and so we need to agree on whether payment is an option. This will be discussed at the next ROAG meeting which will take place on the 21/05/2024
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	22/12/2023 - Once the full appraiser recruitment drive is complete we will ask for expressions of interest in the role of appraisal lead. 01/03/2024 - Closure of this action will be dependent upon the recruitment of further appraisal leads and this will be progressed over coming months now that we have appointed additional appraisers. 30/04/2024 - Appraisal Lead roles for Withybush and Glangwili have been advertised with the closing date of Friday the 24th May 2024. Interviews will then be arranged and it is hoped that we will have recruited into these posts by August 2024. This will be dependent upon applications.
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	10/10/2023 - Meeting attended and first local QA event to take place on 25th October 2023. 01/03/2024 - All Wales QA event clashed with the event due to be held locally and so a local event has been scheduled to take place at the beginning of November 2024.
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	29/09/2023 - Original report specified the timescale as Ongoing. Date for completion date to be requested from the service. 10/10/2023 - Completion date of August 2024 received from the service. 01/03/2024 - Closure of this action will be dependent upon the recruitment of further appraisal leads and this will be progressed over coming months now that we have appointed additional appraisers.
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	08/08/2023 - Update from NWSSP. Evidence of new reporting was requested from senior finance business partner in April 2023. Pending review of the evidence, this recommendation can be closed. A sample of the work done has been provided, however IA still need to see a bit more around the controls and processes before they are happy to close this rec. A meeting is being scheduled to discuss the new process. 05/10/2023 - Progress has been made in implementing the management actions. The papers are going to a Panel meeting in October 2023. 06/12/2023 - The reports have been presented at Panel for non-drug IPFR cases (Q1 - 22/08/23; Q2 - 14/11/23). The evidence on the non-drug reports has been shared with the Internal Audit team. However the team is still awaiting input from the Pharmacy department in relation to the drug IPFR spend. Once the report is available this will be shared at the IPFR Panel and the evidence can be shared with the Internal Audit team. 23/02/2024 - The IPFR Panel are scheduled to meet on the 27th February 2024 and the report is on the agenda. pharmacy colleagues will be chased for their input in to the report. 01/05/2024 - IPFR met on April 16th, with report presented however data still required to address the recommendation. Discussions ongoing with colleagues in Pharmacy, with a view to present the report at the next IPFR meeting scheduled for July 2024.
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning

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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	03/04/2024- This recommendation supersedes the recommendation in the original report - HDUHB-2223-20 - Job Planning
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	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response recieved from PHW as follows: PHW - The TB elimination strategic action plan has been developed with input from TB clinicians, behavioural science experts and inclusion health teams. In relation to raising awareness of TB it includes the following recommendations: All HBs to ensure that clinical staff have completed the Wales Institute of Clinical Science and technology (ICST) TB training. A multiagency partnership will work with local authorities, communities and third sector organisations to raise awareness and improve health education regarding screening for latent TB infection. HBs in collaboration with PHW will also work to raise awareness and tackle stigma among populations at high risk of TB and who could self-present to health services. As part of monitoring towards TB elimination HBs will be asked to provide an annual update on completion of TB training and collaborative activities undertaken to raise awareness. The All-Wales TB Group (AWTBG) will work with PHW Comms to promote the launch of the TB elimination action plan. It is proposed that this is launched to coincide with World TB Day in March 2024.
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	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - A specific TB OCT policy is not in place for PHW. However, part of this work falls under the review of the Outbreak Control Plan for Wales. The outbreak control plan for Wales is being revised and the learnings from the external review have been taken on board and will reflect in the next version, which is due towards the end of this calendar year. From a Health Board perspective we have completed contacts with all 470 contacts identified. We are also now in receipt of the Communicable Disease Outbreak Control Plan for Wales.
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	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - The outbreak control plan for Wales is being revised and the learnings from the external review have been taken on board and will reflect in the next version, which is due towards the end of this calendar year. In addition to the work being undertaken with the All Wales Communicable Disease Outbreak Plan the All Wales TB Group has recommended to WG that they consider commissioning a cost effective and targeted mobile outreach and intervention (informed by proven models such as 'Find and Treat' in London) including specific services for active case finding for pulmonary TB among inclusion health groups including people supported by justice and probation services, homeless people and those engaged with substance misuse service Such a service may also be utilised to support TB screening exercises and 6/11 7 case finding as part of cluster or incident/outbreak management and control as well as provision of screening for other diseases (e.g blood borne viruses) where appropriate.
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	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. WG/PHW have not provided a completion date for this recommendation to date. 06/03/2024 - response received from PHW as follows PHW - Cohort review is the systematic review of all notified TB cases in a 3– 4-month period, to ascertain outcomes for these patients and to facilitate learning for the multi-disciplinary team attending the cohort review meetings. The AWTBG has recommended that an All-Wales TB Nurse Consultant post is created whose role would be to oversee and strengthen the Cohort review process. There is a 10-year evaluation of the Cohort Review in progress and outcomes from this evaluation will allow further recommendations to be identified to improve Cohort review. Changes are being made to the process of identification of cases for Cohort review to ensure that cases that need further review are resubmitted. Cohort review will also include additional details on the identification and outcomes of contact tracing. Part of the work of the AWTBG will be to help to develop a TB service specification as recommended in the TB elimination action plan.

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	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planne WG/PHW have not provided a completion date for this recommendation to date.d for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - Part of the work of the AWTBG will be to help to develop a TB service specification as recommended in the TB elimination action plan. Welsh Government are currently exploring funding for the Getting it Right First Time (GIRFT) programme for TB which would enable evaluation of TB services across Wales and support the development of a comprehensive service specification.
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	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. WG/PHW have not provided a completion date for this recommendation to date. 06/03/2024 - response received from PHW as follows: -PHW have supported WG in the development of a national health pathways for Asylum Seekers and Refugees which incorporates standards for TB screening. PHW have also supported WG to develop guidance for NHS and private healthcare settings on the health clearance requirements for staff in relation to TB with a particular emphasis on those staff from countries of high incidence. PHW have supported the publication of an evidence review of TB screening in Wales among the Ukraine refugee population (the only country to do so) There are additionally a number of recommendations in the TB elimination action plan with regards to screening of those at higher risk of TB including the development of a business case for the resources required to implement screening for 9/11 10 active and latent disease for all new entrants from high prevalence countries as this may require additional funding.
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	23/03/2022- Covid has been problematic in progressing this recommendation however there are Immensely improved relationships between BGH and scheduled care. Working with team to deliver elective care and repatriate back where appropriate. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - BGH have a large capacity to deliver int erms of Theatre space, with greater engagement received from Powys' Consultant Surgeon for Scheduled Care. Plans for the new hospital will require for this continued engagement to be in place. Request to be made to Lead Execuitve to close this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023.
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	23/03/2022- GM to liaise with officer on digital strategy of the UHB for current progress on virtual systems. A lot of changes still taking place and Covid still presents challenges for this. Revised date of March 2024 provided 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Attend Anywhere system in use, and BGH are also taking part in the Telemed roll-out. Assurance and Risk team to enquire if BGH's participation is reported anywhere to support closing this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023.
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	23/03/2022- GM will pick up with recommendation owner for current position of this recommendation. 05/05/2022- Requested revised timescale from GM, no response received as of 18/05/2022. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 10/03/2023 - BGH are not able to do the core training for trainees in the current set up. BGH are accredited but cannot recruit. The new SAS contract came into force last year (2022) for specialist grade, which provides mid-grade specialist with acknowledgement of their skills. There is a SAS tutor in place (from Surgery) for support. Leadership and management training is offered to clinical fellows and SAS doctors. All trainees are provided with self-directed learning and teaching time (quality improvement) with a few doctors following into the teaching path now. There is a monthly middle grade meeting where the doctors can discuss training, issues, and areas for improvement. There is also a regular meeting for junior doctors with consultants in attendance where training for juniors is part of the agenda. Due to the improvements made the GM is requesting this recommendation be closed. 20/04/2023 - BGH have developed everything within their gift. BGH are unable to develop anything further from the site. The qualification would need to be formally recognised to encourage core trainees to not leave BGH and go into formal training.. A Medical Education strategy would assist in establishing if this is a priority. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023. 16/10/2023 - Discussions are ongoing regarding the introduction of core medical trainees to BGH. Risks associated with training within the medical specialty at BGH have led to targeted visits from HEIW and so we are in the process of trying to improve the experiences currently offered with the aim of reducing the current risks before introducing additional trainees to this specialty and site. We are confident that this will occur and that we can revisit these discussions over coming months. Revised completion date 31st Dec 2023. 22/12/2023 - Discussions have started in terms of looking for opportunities to introduce IMTs/CTs. Site team needs to ensure that there are sufficient opportunities for trainees to meet learning outcomes and put a plan together which takes into consideration the following :- -We need to build on the excellent HEIW visit and 100% unanimous recommendation for education at BGH

															-Supervision of the trainees – who will fulfil this role, it's different to FP supervision -What clinics are there that the trainee will be able to have access to? -There will need to be a geriatric component in Year 1 – how will this be delivered? -There will need to be an ITU component (usually) in Year 2 as a 3 month block – how will this be delivered? Can it be delivered on site or will we need to look at one of the other hospitals to support? 01/03/2024 - Discussions are ongoing. Royal College Tutor needs to be identified to cover WGH and BGH. The role has been advertised a number of times with no interest and so we will need to undertake further work to attract a suitable candidate and support the introduction of these core trainees.

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)	Progress update/Reason overdue
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	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales. 30/12/2022- WG have provided some funding for a small pre-implementation team that is now in place to develop local business case to secure funding for Electronic Prescribing and Medicines Administration (ePMA). Nationally there are currently 3 systems that have been approved on the framework and once funding approved then a mini-procurement process will be undertaken to secure most appropriate system for the UHB. 28/06/2023- ePMA business case to be submitted to WG. 26/09/2023- at MMOG it was confirmed that an outline business case and SBAR to request approval to go to tender to suppliers that sit on the National Framework have been submitted to the Sustainable Resource Committee and awaiting UHB approval. 15/11/2023 - The Agile Digital Business Group are scrutinising the Electronic Prescribing and Medicines Administration (ePMA) full business case prior submission to November 2023 public Board. 28/11/2023 - Continued preparations ongoing for the national programme to be implemented. 17/01/2024 - The business case due to be reported to the Digital Oversight Group in February 2024. This is reflected in risk 1171. 08/02/2024 - EPS has gone live in the first GP practice and community pharmacy in Rhyl in November 2023, with the second site due to go live in March 2024 within Betsi Cadwaladr University Health Board. GP practices within Hywel Dda are not yet compliant with the new EPS system, therefore rollout is unlikely to commence prior to quarter 3 of financial year 2024/25. In addition, following a mini-procurement exercise, some GP practices within Hywel Dda have opted to switch from their existing systems to the Egton Medical Information Systems (EMIS). It is currently not known if these changes will impact on the EPS implementation timescale for Hywel Dda. The existing system supplier have also announced that they are pulling out of Wales and therefore these GP practice will be required to find new system suppliers.
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	This recommendation can be completed once the WG review is issued and actions arising from this for HDdUHB added to the tracker.
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	Staffing establishment review undertaken; including pharmacy professionals resourced outside the P&MM directorate. Pharmacy and Medicines Optimisation benchmarking with other NHS provided undertaken. Directorate vacancy control process and review panel in place to modernise roles in line with WG actions and directorate 4 strategic aims. Directorate subgroup structure developed around 5 pharmaceutical themes to empower the workforce to co-design and deliver the new models of service delivery. Gap and demand analysis to be undertaken by clinical integrated services group on the 11th April which will be reported back to director of pharmacy
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	To be discussed in meeting early April to identify gaps and determine if demand/funding present - *clinical integrated services and then transferred to workforce/senior management team if gaps identified.*
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	Action allocated to workforce and education and training groups to ensure when these roles developed as part of theor job plan/description they include the need to support clinical directorates/divisions
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	Pharmacy technicians from each site undertaking clinical prioritisation course, SOP in progress to be completed by end of April and sent through HB approval process. These technicians to help inform a process at the front door. - *clinical integrated services* Electronic prioritisation tools already exists in the Renal Pharmacy Service across Hywel Dda. This can be used as a blue print for development. This has had demonstrable productivity, quality and safety gains. Introduction of EPMA - *Digital and analytics/Dafydd* Pharmacy have engaged with Frontier to support and develop its use for the needs of our clinical pharmacy service - *clinical integrated services*
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	Allocated to *senior management team*

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	Will be analysed ince stocktake and demand plan established - *clinical integrated services*
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	Clinical pharmacy services are only sustainable if core pharmacy services are robust. In order to liberate time for clinical service development the access to medicines functions need to be modernised for centralised coordination and localised delivery. Creation of a hub within directorate budget can achieve this. This will include development into logistical support to increase the productivity of the clinical pharmacy service to expand their capacity e.g. dedicated IT support, data analytics and communications. *Senior Management team*
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	Pharmacists in each site undertaking IP qualification, plan in progress to facilitate new graduates with IP teaching. Currently included in job descriptions for all clincal roles. - *clinical intetgrated services*.
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	Chief pharms peer group has assigned an SRO to each theme.
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	Challenges with retention of staff in same day emergency care (SDEC) at acute hospital sites. Recent activity to review SDEC activities and sites to put forward plans 1. Review of current SDEC pharmacy structure - The pharmacist role should be supported by a primary care technicians to bridge the interface 2. Clear purpose and job plans. 3. Recruitment and development of clinical leadership – including co-creation with physician mentorship - *clinical integrated services and senior management team*
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	Change of working pattern being trialled by PPH admissions - to be evaluated. Group set up with admission pharmacists to share practice and obtain admission data for sites - *workforce*
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	Scope what that would demand there is for a pharmacy service in pre-admission and what would a pharmacy service in this area look like. Review and standardise any pre-admission leaflets used across the HB and discuss with Dafydd (copied in) how we could look at making them electronic. - *Surgical pharmacists from each site*
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	SOP for self administration policy being reviewed. Will need stocktake of infrastructure on wards (lockers with individual keys). - *Chief technicians/Meds safety and MI*
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	Contact details available on intranet for primary care staff, page to be created for secondary care. To discuss if possibilty for digital signposting/outward facing resource. - *chief technicians*
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	Pharmacy integration within directorates and specialities to ensure pharmacy is always considered in their workforce planning and IMTP. The Health Board, with P&MM taking the lead, need to establish a model for expectations for pharmacy staff employed outside the P&MM directorate to ensure core service delivery and pharmaceutical care is not overlooked. *workforce and senior management team*
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	Workforce plan post HB wide stocktake and gap analysis. Pharmacy technicians undertaking enhanced training for clinical prioritisation. Planning for RPS talk with pharmacists who would like more information on advanced practice/consultancy being organised. Discussions around job plans. *Workforce, education and training and clinical integrated services*

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	Pharmacy technicians now have a standard for minimum level of practice following new PRPT course structure. RPS meeting being planned to help with understanding of credentenialling. Job plans being discussed. *Workforce*
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	Job plans being discussed - *workforce*
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	Job plans being discussed - *workforce*
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	Job plans being discussed - *workforce*
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	Job plans being discussed - *workforce*
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	Plans to take an increased number of pharmacy student placements across the health board for next academic year with planning to increase again. Numbers to be decided early April. Foundation pharmacists and post registration pharmacists appointed for 2024-25. *Education and training*

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	Job plans being discussed - *workforce*
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	Chief pharms peer group has assigned an SRO to each theme.
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	Job plans being discussed - *workforce*
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	Chief pharms peer group has assigned an SRO to each theme.
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	Pharmacy integration within directorates and specialities to ensure pharmacy is always considered in their strategic planning cycle and IMTPs.
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	Senior Management Team to itemise value and sustainibility and ministerial priorities. To be formalised/documented. - *Senior management team*
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	GPHC requirements not in place yet - *workforce*
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	*Workforce*
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	Workforce to develop alongside job plans - *workforce*

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	Chief pharms peer group has assigned an SRO to each theme.
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	Evaluation of current workforce digital skills being undertaken. Determine training needed to prepare for EPMA - *digital and analytics*
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	Nationally: On chief pharmacist's agenda - working with Cath O'Brien DMTP . HB: Digital and analytics group to realise capabilities of ePMA and work with clinical personnel to develop tailored dashboard for HB.
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	2 pharmacists in the health board currently undertaking pharmacogenomics course. Develop plan for Hywel dda - *research and development*
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	08/05/2024 - Looking at how the HB currently views/uses AI at the moment and how we develop that Research and Development and Digital and Analytics Group
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	08/05/2024 - To await above recommendation - Research and Development and Digital and Analytics Group

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)	Progress update/Reason overdue
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~~ N/K	Red	31/08/2023 - Medical Staffing Committee audit lead identified, and a meeting scheduled for September 2023 to develop the audit framework and plan and to discuss its implementation. MHLD directorate themed audits have also been identified and have been accepted as part of the Health Board's Clinical Audit Plan. 03/10/2023- Associate Medical Director requesting update by 20/10/2023. 12/10/2023- The Associate Medical Director confirmed that a Medical lead has been assigned to support this work, however they are on leave returning beginning of November 2023. Associate Medical Director to meet with Medical lead on their return to pick up the progress of this work. A multi professional group is to be arranged to oversee this work. 11/01/2024- Senior Speciality Doctors is taking the lead on behalf of the Psychiatry MSC supported by the MHLD Nurse Consultant. Revised date April 2024 provided. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of April 2024.
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~~ N/K	Red	31/08/2023 - Medical Staffing Committee audit lead identified, and meeting set up for September 2023 to develop the audit framework and plan, and to discuss its implementation. MHLD directorate themed audits have also been identified which has been accepted as part of the Health Board's Clinical Audit Plan. Once implemented, outcomes of the clinical audit programme will be reported to MHLD QSE, with frequency to be determined. 12/10/2023- linked to the actions above. 10/01/2024- Updated report to be submitted to the next MHLD QSE meeting. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
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~~ N/K	Red	31/08/2023 - a meeting with colleagues from Workforce scheduled for 16th August 2023 has been deferred to 27th September (due to annual plan and financial savings work). It is noted that discussions were held in June 2023 amongst senior leadership team to address this issue and to confirm the commitment with relevant staffing groups, with plans to be finalised, implemented and embedded throughout the Directorate. It is envisaged that this will be implemented by December 2023. 11/10/2023- Meetings have taken place with Workforce colleagues who will be undertaking engagement sessions with staff. 10/01/2024- on track for March 2024 date. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
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	10/07/2023- Director of Mental Health and Learning Disabilities confirmed a Triumvirate away day on 21/06/2023 established the work going forward to enable progressing this recommendation. A time out day took place as a Triumvirate along with other key colleagues in June 2023 where we began looking at this with a further meeting now in the calendar with our relationship manager. The follow up plan is being worked up with an aim for completion by December 2023. 03/10/2023- a detailed list is being written for where service are located, with service visits to be scheduled to take place by end of December 2023. 11/10/2023- linked to the action above. 11/01/2024-to be implemented by March 2024 – the Director MHLD has begun to undertake service visits for this financial year and a rolling programme will be created for 2024/25 onwards. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of June 2024.
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~~ N/K	Red	31/08/2023 - a meeting with colleagues from Workforce scheduled for 16th August 2023 has been deferred to 27th September (due to annual plan and financial savings work). It is noted that discussions were held in June 2023 amongst senior leadership team to address this issue and to confirm the commitment with relevant staffing groups, with plans to be finalised, implemented and embedded throughout the Directorate. It is envisaged that this will be implemented by December 2023. 03/10/23- meeting took place on 27/09/23, with a plan to hold an initial two workshops in order to identify key areas to develop the Workforce and People plan. 11/10/2023- linked to the action above. 10/01/2024- on track for March 2024 date. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
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	31/08/2023 - work is currently being undertaken by the service as part of wider Health Board ask in terms of vacancies, and has allowed the opportunity to better understand the vacancy position, with an ongoing reconciliation process in place, overseen by the Directorate Workforce Group. The Directorate has also engaged with the Health Board's retention team, with focus on staff feedback in terms of new starters and leavers, providing rich information which will inform the development of the Directorate Recruitment and Retention Plan. Conversations have also commenced regarding overseas recruitment, and linking with the future workforce team. Noted that there are several service-level risks on the MHLD risk register int terms of concerns on recruitment and retention, with a view to drafting a Directorate-wide risk. However it is noted that there may be constraints given the current financial climate of the Health Board. 11/10/2023- Meeting is up and running to progress this, including engagement with Corporate teams on recruitment (e.g. NQPE directorate on nursing retention and workforce colleagues on targeted recruitment. 10/01/2024 – The Directorate have met with Work force and Organisational Development colleagues along with finance and there will be service level evaluations take place in relation to resolution of the vacancy position within the service. Revised date of July 2024 date provided considering the number of services that are involved. Director of Mental Health and Learning Disabilities believes December 2023 was in an incorrect date provided on the original action plan and a later date should have been originally provided. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of July 2024.

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	16/03/2023- To be submitted for QS&EG Meeting 21/08/23 at the latest. 11/07/2023- Head of Service (Older Adult MH) confirmed on track for end of August. 28/09/2023- Head of Service (Older Adult MH) confirmed the review has been completed (a review of 23 case-studies - inclusive of recent near-miss and serious incidents - for people experiencing functional mental ill health [including some people with mild-cognitive impairment but capacitated and able bodied] using Older Adult Mental Health Services). Additionally, the OAMH Clinical Risk Lead held case and practice discussions CR[H]T Team Leads and a range of CR[H]T clinicians within this assessment process. The report is drafted nearing completion and there needs to be more time to consult within stakeholders before the report can be finalised and submitted to BPPAG. The reason for the delay in implementing the recommendation is in part due to underestimating the scope of the work involved combined with competing high clinical risk priorities consuming the reviewers time to complete the consultation and report. Revised date of December 2023 agreed. 05/12/2023- Head of service has meeting on 08/12/2023 with the author and will provide update following this meeting. 28/12/2023-Head of service confirmed meetings have taken place and the information is in final draft, which is being checked against the crisis teams service specification that was very recently published via global. This should be ready to be tabled at to table at the next BPPAG January 25th 2024. 02/01/2024- Assurance and risk officer responded for clarity if the management response of 'Produce a report for QS&EG with any required pathway improvement/equality recommendations' has been completed or if a revised date is required. 05/02/2024- Recommendation owner confirmed this will be reported to MHLD QSEG in February 2024, after which the recommendation can be closed. 26/02/2024- recommendation owner confirmed it has been concluded by the Director of Mental Health and Learning Disabilities that the report is more suitable for being tabled at BPPAG, the next meeting of which is taking place on 28/03/2024. Paper was submitted for the BPPAG agenda however, the MH&LD Director requested further inter-service conversation and review required between Adult and Older Adult Mental Health Services before being tabled for discussion/ approval at BPPAG. Inter-service Head of Service meeting occurred 11.04.24, further meetings required before completion. 15/04/24 At the request of the MH&LD Director, the report didn't proceed via BPPAG and is being subject to further consultation between Adult Mental Health and Older Adult Mental Health Head's of Service. First meeting 11.04.24, further meetings required before returning the paper to BPPAG. Meeting 08.05.24 to progress with Kay Issac's NEW COMPLETION DATE 31.12.24
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	22/03/2023- ED departments currently under significant pressures and are unable to ring-fence identified rooms for mental health assessment only. Timescale for a full implementation for this recommendation is challenging for MH&LD service as this can only be fully implemented with the EDs support. The recommendation has been facilitated across 3 areas but remains a considerable issues in 1 area. Therefore a timescale of March 2024 is provided for full implementation for all areas. 05/12/2023- this is being progressed, however slowly during winter pressures. 05/02/2024- Recommendation owner confirmed this may be delayed.
Sep-21	2021/22	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	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	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response. 20/12/2022- All IPC issues with furniture have been addressed as all communal dining and lounge furniture has been replaced. Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed. QAST update Feb 23 Advanced for works were delayed and currently underway and due to end in May 2023. As per information above when these works are complete then painting work ban be progressed. 03/07/2023 - QAST chased for update June 23 - this is corrective work after the action above is completed. QAST update 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. 03/10/2023- Estates work has been delayed due to prioritising the WGH RAAC work, revised date of December 2023 provided. QAST update 30/10/23 actions chased, fire works approaching completion, then repaint can take place. To be confirmed once finalised. 10/01/2024- QAST Update 14/12/23 Estates advised that a start date for these works will be provided. Update 20/02/23 from AMAT- painting work will commence when all fire related work will be completed - which has been delayed until April 2024 - date will be provided once all work is completed. Update 04/03/24 from AMAT - advised to reallocate action to estates. Update 11/03/2024 Specification for multi quote 50 % complete / estimated completion and advertisement to be 25/03/2024 with an estimated start date to be mid April 2024 Update 09/05/24 Senior Nurse for the area has confirmed that decorating work is out to tender and quotes are being received. Revised timescale for completion is September 2024.
Oct-22	2022/23	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	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	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. Update Feb 23 Review completed, awaiting suitable alternative. QAST update 09/05/2023 - work underway. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 expected to be resolved by service with budget by end of September 23. 03/10/23- request for works has been submitted to Estates and this is being chased. Update 30/10/23 ward funding replacement of blinds/ curtains. Estates placed order. Update 14/12/23 The order is in with Swanmac the suppliers since October, and approval given for funding the new blinds. No update from estates since his chase email, Head of Adult inpatient to chase. Update 27/12/2023. Suppliers are due to fit Blinds on 03/01/2024 . Update 6/2/2024 via AMAT. There was an issue with the magnet fittings of the blinds despite them being anti lig and MH ward specification. Estates (SE) and ward manager are due to meet supplier to rectify the issue. Revised date end of March 2024 30/04/2024 - awaiting return costs and a lead time for modifications to the blinds from Swanmac. Although an order was placed for anti-ligature blinds the service deemed them inappropriate for installation. Update 09/05/24. Ward Manager has confirmed current update from estates to be:- there have been some delays in relation to the supplier seeking significant costs to make alterations to the blinds purchased to make them appropriate for a 136 suite and anti-ligature. We are currently ordering the relevant parts to make the modifications. This shouldn't take too much longer to get finished and in place in the suite.
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~~ N/K	Red	10/10/24- Multi disciplinary Task and Finish group established. Physical health assessment requirements formulated based on national guidance. Baseline audit planned to confirm current practices against requirements in order to inform implementation plan. Revised timescale for completion 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 19/12/23- AMAT update- Physical health checklist was discussed at the PMSC 19/12/23.

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~~ N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- AMAT update- Physical Health checklist developed for inpatient pathway and awaiting approval. Plan for implementation onpaper from Jan 24 whilst work to embed onto Care Partner is undertaken by system provider. Revised timescale 01/04/24.
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~~ N/K	Red	10/10/2023- All teams across MH/LD directorate are now engaged with Investors in Carers. A full position statement is to be presented to MH/LD QSEG in December through an Investors in Carers Agenda Item agenda item. Timescale for completion revised to 31/12/23. QAST update 30/10/23 no update received from service on action. 11/12/2023- AMAT update- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023- Multi disciplinary Task and Finish group established. Previous published work by Hywel Dda on service user perceptions and AIMS standards to be used as a reference point. Timescale revised to 31/01/24 to enable full engagement of service users and carers. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity however now impacted by long term absence in team. Revised timescale 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023- Review of Health Board Policy #370 Discharge and Transfer of Care underway however detailed input from mental health services incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore delayed. Revised timescale for completion 28/02/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Development of a training resource is incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore progress delayed. Revised timescale 01/04/24.
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~~ N/K	Red	10/10/2023-revised date of January 2024, to coincide with recommendation 6. QAST update 30/10/23 no update received from service on action. 10/10/2023- (update taken from recommendation 6) Multi disciplinary Task and Finish group established. Previous published work by Hywel Dda on service user perceptions and AIMS standards to be used as a reference point. Timescale revised to 31/01/24 to enable full engagement of service users and carers.
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	R10. The health board must ensure that adequate administrative support is available within inpatient mental health units.	Further Action: i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	~~Jan-24~~ N/K	Red	10/10/2023- Ward clerk cover in place for all wards (1 WTE admin available to all units as a minimum through a variety of roles) meeting the MH Principles for safe staffing. Band Ward PA Job Description revised on feedback from ward managers, now job matched, engagement in place with staff side in order to launch an organisational change process. Revised target date of 31/01/24 to have people in all Ward PA roles. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	10/10/2023-revised date of December 2023, to coincide with recommendation 34. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.

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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	QAST update 30/10/23 no update received from service on action.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023- Full transition to paper free clinical records incumbent on national direction. Focus of action therefore revised to: Scope digital priorities and smarter working practices to support shift to digital across MH/LD Directorate (e.g. use of digital dictation) through a digital workshop led by Innovation and Digital Transformation Team. Revised timescale 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 23/11/23 Discussion held at BPPAG with input from the HB Digital Director. Date for directorate wide workshop revised to 30/04/24.
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	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- no update yet provided on AMAT.
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	11/01/2024- AMAT has no action against this recommendation as yet. Linked to action against recommendation 19.
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	N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 The health boards policy, Calculating, Maintaining and Reporting Nurse Staffing Levels Policy Framework has been reviewed and is inclusive and reflective of processes across the MH/LD directorate. Action complete. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023- Mental Health Safe Staffing Principles and Welsh Levels of Care (version 3) remain in draft and unpublished. A review of establishment for inpatient assessment and treatment services is underway. The above draft documents are being used to inform the review. The timescale for completion has been affected by limited capacity within the finance and nurse staffing team. 31/12/23 is a current target date for completion of the review. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 22/11/23 MHLD Workforce Management Group established. Support to gain regular breakdown of workforce metrics for MHLD services to enable baseline measures and tracking approach established. Discovery focus groups underway across MHLD areas to gather feedback from staff to inform MHLD retention plan.

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	10/10/2023- Work is being led by the Assistant Director for Mental Health and Learning Disabilities. Timescale for completion revised to 31/12/23. QAST update 10/10/23 Interim MH safe staffing principles and version 3 Welsh Levels of Care reviewed and not applicable to community teams. Action completed. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- on review of AMAT this recommendation is still showing as overdue (not completed as previously stated above) therefore recommendation turned back from green to red. Last update on AMAT states- 10/10/23 Work is being led by the Assistant Director for Mental Health and Learning Disabilities. Timescale for completion revised to 31/12/23.
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	10/10/2023- ED departments currently under significant pressures and are unable to ring-fence identified rooms for mental health assessment only. This challenge has been flagged through Operational Planning and Delivery Programme (04/10/23). Solutions continue to be sought through local discussions. Overdue due to the volume of work involved in completing, alongside capacity pressures across the directorate. March 2024 set as a revised timescale for implementation. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
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	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- AMAT Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services.
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~~ N/K	Red	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Joint actions agreed by the Directorate leadership team and Culture and OD team to inform and support development of a Directorate Staff Engagement and Organisational Development plan: 1. Review of MHLD data as part of an OD and culture diagnostic to analyse and identify any trends. 2. Undertake a leadership training needs analysis to support further development and succession planning. 3. Workshops to agree the future ODRM support plan for the Directorate on a service/area basis, with a focus on sharing the culture-change vision and what it entails. 4. OD and culture team to attend bi-monthly leadership meetings to feedback and update. 5. To continue to engage and contain the 'hot' areas as they arise. 6. Explore opportunities and education for flexible/agile working and any pilots as part of retention.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- Update taken from AMAT- Medical Staffing Committee audit lead identified, and a meeting scheduled for September 2023 to develop the audit framework and plan and to discuss its implementation. MHLD directorate themed audits have also been identified and have been accepted as part of the Health Board's Clinical Audit Plan.
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	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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 y) Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Demonstration of AMaT system and its use for tracking and monitoring NICE benchmarking activity and improvement actions delivered to MH/LD directorate service and professional lead roles through training sessions on 1st and 11th August 2023. Further review of action required once clinical audit programme agreed in order to review if additional training is needed.

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~~ N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
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	R36. The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	Further Actions bb)Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	~~Mar-24~~ N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Work to develop an engagement and organisational development plan underway as per update for action MD33/1. A process for reviewing and updating mental health policies and procedures is in place through the Written Control Document Group and a full database of documents is now held which enables forward planning to avoid documents falling out of date. All documents are published and can be accessed by staff through the Health Boards sharepoint system. A plan for sharing updated documents will be agreed through the Written Control Document Group.
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	QAST update 07/09/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. A written protocol is to be developed to capture and share the process for consistent implementation. No new target date provided by service. 10/10/2023-Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. Overdue due to the volume of work involved in completing, alongside capacity pressures across the directorate. Revised timescale for completion 31/11/23. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 22/11/23 Details of existing Social Workers have been gathered and Datix accounts have been requested.
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	R40. The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	Further Action ff)Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	~~Mar-24~~ N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- Update from AMAT-Work to develop an engagement and organisational development plan underway as per update for action MD33/1. Attention to how this supports safety culture to be factored into the overarching plan as it develops. In addition to this work a Serious Incident Learning Forum has been established within the directorate to facilitate a coordinated approach to embedding lessons and the schedule for complex case review panel is being structured moving forwards to include sessions that facilitate clinical discussion around learning from incidents.
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	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	Update via AMAT - 11/03/2024 Mitie grounds and service contract has now been implemented. Site survey has been completed. waiting on Risk assessments and confirmed location for waste skips. estimated start date 25/03/2024
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	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	Mental Health & Learning Disabilities	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	14/02/2024- update from AMAT-Estates teams have been made aware of the situation and are arranging for signage to be fitted.
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	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	14/02/2024- update from AMAT- A suggested anti-ligature handrail product was submitted by clinicians to estates. Estates advised that these handrails are not suitable for the bathrooms/toilets and they will try to source alternative anti-ligature handrails. Awaiting feedback from Estates who visited the ward 29/01/24. Update 04.03.24 on AMAT- ACTION PART 1.: NB as far as I understand the HIW request, the description above is not accurate. The handrails for the bathrooms were primarily in connection to falls risk not anti-ligature risk. About 10 years ago the rails were removed due to ligature risks. Secondarily, any replacement handrail needs to be proportionately anti ligature risk. This has been followed up with estates multiple times. The clinical team agree the retractable handrails estates looked at/initially suggested are unsuitable for this space. Recommended the Ward Team speak to estates to a) dismiss the need for a retractable handrail and b) assess the feasibility to fit a fixed handrail akin to those on Enlli Ward to the three Communal Bathroom/Toilet areas. This action [Part 1.] therefore remains pending. ACTION PART 2. of this part of the action equates to reviewing the other handrails throughout the ward. A Ligature Ancho Point audit and an Action Plan [new format] has been completed therefore the requirement to review the remaining areas of the ward has been met. Additionally, a Project Feasibility Form has been completed and submitted to the Capital Team for costings (occurring 06.03.24) so that a Discretionary Capital Bid can be drafted for MH&LD Directorate approval before attempting to secure discretionary capital to go to tender to address the respective handrails. The latter part of this process can take years to complete and is not entirely suitable for an AMAT action. 15/04/24 Estates have been requested to source a suitable product and invoice the service accordingly. There is no more the OAMH service can do on this action at present. Evidence trail for this submitted to Heli Milward 11/04/24

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	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~~ 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	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	11/01/2024- Membership identified for the task and finish group and dates for initial meeting are being scoped. 29/02/2024- Update from AMAT system 09/02/24- Task and finish group met 08.02.24 with contributions from MCA team, MHA team, Resus Officer, Professional Leads, QAPD, Nursing and Medical colleagues. Feedback from the HIW report was examined and considered alongside relevant sections of the MHA and MCA Codes of Practice for Wales. Outcome was that attempts should be made to seek further clarification from HIW inspectorate team regarding the specific practice issues raised as based on review of feedback by internal experts, no breaches in practice against All Wales guidance (including DNA CPR) or codes of practice for Wales could be identified. Request made to Patient Safety and Assurance Manager to reach out to HIW for further clarification. Update 04.03.24 from AMAT- Awaiting feedback and clarification from HIW to determine if further action needed. Update 04.03.24 Awaiting feedback and clarification from HIW to determine if further action needed. Update 08/05/24 Further feedback provided by HIW to confirm an inaccuracy in wording in the report and acknowledgement of this causing confusion. Clarification provided on areas of practice to strengthen:- - A recorded consideration of the patient's concordance with medication during the first 3 month period. Plan to instigate a means to ensure this is picked up through MDT discussions at ward round to ensure consideration and documentation of patient's concordance, their level of understanding and how their treatment is being authorised (i.e. with their consent or through the authority of the MHA). - Evidence in the record of consultation regarding DNACPR orders, whether that consultation is with the patient or, where such a conversation is felt likely to cause harm, with their family/friends. Consideration to be given to whether this could be recorded on the form itself or in the clinical record. Task and finish group to be reconvened on 13th June 2024 to finalise and agree further actions for implementation. Revised timescale for completion July 2024.
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	Update 04.03.24 from AMAT- Awaiting feedback and clarification from HIW to determine if further action needed. Update 08/05/24 Further feedback provided by HIW to confirm an inaccuracy in wording in the report and acknowledgement of this causing confusion. Clarification provided on areas of practice to strengthen:- - A recorded consideration of the patient's concordance with medication during the first 3 month period. Plan to instigate a means to ensure this is picked up through MDT discussions at ward round to ensure consideration and documentation of patient's concordance, their level of understanding and how their treatment is being authorised (i.e. with their consent or through the authority of the MHA). - Evidence in the record of consultation regarding DNACPR orders, whether that consultation is with the patient or, where such a conversation is felt likely to cause harm, with their family/friends. Consideration to be given to whether this could be recorded on the form itself or in the clinical record. Task and finish group to be reconvened on 13th June 2024 to finalise and agree further actions for implementation. Revised timescale for completion July 2024.
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	R18. The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the CTO might be more suitable option in accordance with paragraph 27.8 -27.9. This must be recorded in patients notes.	A review of the content and layout of the section 17 leave form to be undertaken as part of planned 3 yearly policy review to incorporate prompts for Responsible Clinicians about considering CTO when leave is being granted for more than 7 days.	Oct-24	Oct-24	Amber	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. Update 08/05/24 Review of section 17 leave policy remains ongoing and due for sign off at MH Legislation committee in June. Revised completion date 30/06/24.
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~~ 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	R1. The HB should review access pathways and processes to ensure they are equitable for ASD and ADHD.	Review existing diagnostic/ management, transition and treatment pathways	Jun-24	Jun-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	R2. The HB should review processes to facilitate the delivery of dual ADHD and ASD assessments.	Explore opportunities for integrated joint working to deliver dual ADHD and ASD assessments.	Jun-24	Jun-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	R3. The HB should review how children accessing ASD assessment can receive physical health screening as part of the assessment process.	To review existing ASD diagnostic pathways and explore opportunities with Child Health colleagues for integrated working	Jun-24	Jun-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	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	24/04/2024-Demand and Capacity has been undertaken. Training with NHS Executive to be rescheduled. Revised date of June 2024.
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	24/04/2024- good progress being made.

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	24/04/2024- good progress being made.
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	R8. The HB may wish to consider ways to expand use of information technology to support timeliness and efficiency of information gathering and signposting at referral and along the patient pathway.	The ADHD/ASD Service will explore ways to expand the use of information technology to support timeliness & efficiency of information gathering and appropriate sharing	Jun-24	Jun-24	Amber	22/02/2024- discussions to explore technology is taking place with Digital services.
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	R8. The HB may wish to consider ways to expand use of information technology to support timeliness and efficiency of information gathering and signposting at referral and along the patient pathway.	To explore the use of information technology to support the management of referrals and patient pathways.	Jun-24	Jun-24	Amber	22/02/2024- Further discussions taking place. Service Delivery Manager for Community Paediatrics and Service Delivery Manager Neurodevelopmental Services to meet to go through the evidence for the action.
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.	Explore necessary adaptations that may be required for diagnostic assessments for CYP with sensory sensitivities and physical impairments.	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	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	24/04/2024- in progress with draft being considered.
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	24/04/2024- in progress
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	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 current pathways to S-CAMHS from Paediatric Psychology and initiate improvements where possible.	Apr-24	~~Apr-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	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	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.	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	24/04/2024- in progress.
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.	Complete remaining CTP training sessions for S-CAMHS workforce	Apr-24	~~Apr-24~~ N/K	Red	24/04/2024- in progress and should be completed by end of April 2024.
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~~ N/K	Red	24/04/2024- in progress and should be completed by end of April 2024.
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.	CTP monitoring group to continue - bimonthly basis to ensure continued compliance & quality	Apr-24	~~Apr-24~~ N/K	Red	24/04/2024- in progress and should be completed by end of April 2024.
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	24/04/2024-Demand and Capacity has been undertaken. Training with NHS Executive to be rescheduled. Revised date of June 2024.
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	24/04/2024- in progress with VBHC colleague invited to be involved in the development.
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	11/01/2024- There was a meeting in December 2022 with the Associate Service Group Director for MH and LD and Head of Nursing for LD in Swansea Bay University Health Board to explore the potential of an arrangement with them but this did not yield a solution. A meeting with Deputy Director for Operations and Planning and the Director and Assistant Director of Mental Health and Learning Disability has been arranged to progress this. Meeting 09.11.23 with Head of Strategic Commissioning, copy of SUHB Epilepsy Care Pathway emailed. Head of Strategic Commissioning to explore the commissioning of a medical expert in this field.
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	N/K	Red	11/01/2024- Pathway needs to provide clarity on how gaps are mitigated and that it is the medical staff in CTLDs who are responsible for determining and making the onward referrals to neurology or return to primary care. Update 24/01/24 AMAT- Responsible person updated, who has attending Written Control Group and leading a working group to progress.
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	11/01/2024- Contact has been made with Public Health Wales and a request has been made for information from across Wales. No revised date provided on AMAT. Update Jan 2024 AMAT- Feedback awaited from PHW.
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	Update 24/01/24 AMAT- PHW contacted and feedback awaited. Update 25/2/24 AMAT- Step Together has not been adapted in Wales, Need to confirm that we are registered with and use the SUDEP Action safety list please so that this action can be closed.
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	11/01/2024- The epilepsy nursing service is managed by the Strategic Head Community and Chronic Conditions and therefore the review will need engagement with this team. 26/10/2023 Email sent to progress 16/11/2023 AMAT update- staff away from work, forwarded to epilepsy nurse who is not in a position to assist. To seek advice on the cover arrangements for Strategic Head Community and Chronic Conditions.

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	11/01/2024 AMAT update- Service lead emailed Epilepsy Wales for guidance on emergency guidelines and protocols on 26.10.23.
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	Update 24/01/24 AMAT- review of 2 patients has been completed and 2 carers have been approached with an offer to share review. A review of the complaints received at the time has been requested from complaints team in order to update holding letter. Easy Read memo has been written, establishing the completeness of final aspect.
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 epilepsy.	Mar-24	~~Mar-24~~ N/K	Red	Update 04/03/24 on AMAT- All options explored and there have been no applicants for the NHS Locum and Substantive LD Consultant posts. The meeting with an interested party did not result in a formal job application. This action is unable to complete because we are unable to identify / secure a LD Consultant into one of our vacant posts with a special interest in Epilepsy care
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	

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)	Progress update/Reason overdue
Nov-22	2022/23	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	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~~ N/K	Red	28/11/2022 - Parking on all hospital sites remains a challenge. Alternative ways to support patients access is being continually considered by Director of estates and Facilities 31/05/2023- Business & Governance Manager (central ops) confirmed the Gwili Railway scheme is nearing completion. Confirmation still required from Carms Countil that they will support a change in planning permission prior to finalisation of the remaining enablement works. There will be a 6 week lead time from confirmation of planning consent to commencement of this scheme due to the need to finalise enablement works. Unfortunately no indication has been provided on how long this consent may take. We now estimate that the earliest date for commencement of this scheme will be August 2023. An additional 40 parking spaces are due for completion on the GGH site at the end of June 2023 associated with the W&C phase 2 development 11/09/2023- development have been delayed due to the development and signing of the legal agreements taking longer than anticipated. We expect the development to be completed within three weeks of the legal agreements being approved by both parties. 25/10/2023-Signing of the legal agreements are expecting very soon once some final details have been addressed. Once the date of signature is known the UHB will be confident in reporting a revised timeline. If all goes to plan construction is expected to commence from 06/11/2023 with the car park opening on 01/12/2023. However, this is entirely dependent on the agreement timescales. 02/11/2023- The GRC have completed all the lighting on site and are currently working on the car park barriers. They are still planning to commence their ground works on the 6th Nov 2023 for 2/3 weeks to complete the access ramp. Based on this timeframe and leave commitments etc, a revised date of 05/01/2024 has been provided. 28/12/2023- All aspects of the legal requirements have been completed by our lawyers and similarly by the lawyers representing the GRC. The GRC have financial backing for the numerous changes to the facility via their lenders and they require their approval before completing the legal process. The lenders have approved the partnership with HDUHB verbally but this has yet to be confirmed formally in writing. This has been delayed due to the festive period and is expected to be received early in the new year. Once received the GRC can complete the final enablement works which include, sewerage connection, lighting, walkway construction, fencing to the hospital site etc. Enablement works to be completed on the hospital site to meet H&S recommendations with widening of pavements, road marking, groundworks etc to be undertaken. These have all the relevant capital expenditure finances in place and have been through the contractor tender process. Again, once the legal formalities are complete these should be completed within a matter of weeks. Revised date of February 2024 provided.
Nov-22	2022/23	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	N/A	R7. The Health Board to have better communication by keeping patients regularly informed of waiting times.	Funding agreed via WG for digital communication screens in waiting area, once purchased will have information on waiting times.	Mar-23	~~Mar-23~~ ~~Dec-23~~ ~~Apr-24~~ N/K	Red	28/11/2022 - Funding agreed awaiting screens. 11/07/2023- to be checked with Heads of Nursing if this has been implemented. 15/09/2023- Deputy HON (PPH) confirmed there are no communication screen in MIU in PPH. 06/10/2023- emailed Digital Director (cc'd Director of NQPE) for progress on digital screens and revised date of implementation. 09/10/2023- Digital Director confirmed •The networking for GGH and PPH has been completed and over the next 2 weeks we will the testing the CCTV and Digital Signage before handing over to the service. • The networking team will be starting onsite in WGH and BGH in the next 2 weeks, with an anticipated completion of 6 weeks before a further 2 weeks of resting before handing over to the service. 06/02/2024 - Interim Assistant Director of Nursing has confirmed that all screens are in place but are still not connected due to ongoing difficulties with security/compatibility between screens and resource issues.
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~~ N/K	Red	18/05/23 - Actions considered by the TUEC programme Director, further discussion taking place to determine timescales for implementation and congruence with priorities as determined by NHS Executive and delivery of Ministerial Objectives (Urgent Primary Care, SDEC, Discharge Planning Coordination, D2RA and DPOC). Update to be provided in June 2023 07/07/2023 - Falls strategy work in progress - meeting of the next falls strategy group to be held in July/August 2023 to review strategy progress to date. Draft strategy circulated to members of the work group. 13/09/2023- falls strategy meeting held 05/09/2023cand strategy reviewed to date. Task and Finish/working group established to fine tune the details of the strategy - next meeting due to be held in October. It is anticipated that this group will need to meet on a number of occasions to add more detail to the strategy. UHB anticipate a realistic timescale of March 2024 for a completed strategy. 12/10/2023-the strategy group met in September and reviewed the draft strategy. As a result a working group has now been established to fine tune the detail, before returning back to the main strategy group with actions. The first meeting of the working group is scheduled for 19/10/2023. 28/12/2023- meeting in the diary for January 2024 with a few key stakeholders from the strategy group. PHW making current amendments to the strategy. Once amendments have been finalised, a strategy group meeting will be held to review. 07/03/2024 - Falls Strategy Work is currently on hold following discussions with the new Director of Therapies and Director of Nursing. It is anticipated that the strategy may form part of a frailty strategy. Work remains ongoing. 08/04/2024 - The Quality Improvement Practitioner has advised that the proposed training plan is being presented to the CEGG panel on 28th May for approval. Internal Audit have advised that following the submission of the proposal, they will review and confirm whether or not it addresses the recommendation for closure.
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	18/05/23 - Actions considered by the TUEC programme Director, further discussion taking place to determine timescales for implementation and congruence with priorities as determined by NHS Executive and delivery of Ministerial Objectives (Urgent Primary Care, SDEC, Discharge Planning Coordination, D2RA and DPOC). Update to be provided in June 2023 07/07/2023 - E-learning package awaiting All Wales rollout. QI practitioners attended simulation training 25/26 May 2023 with a view to incorporating simulation into a practical falls training package for the Health Board. 13/09/2023- UHB have been asked by 4 Nations Falls Group to scope what we currently have in relation to falls training in our Health Board, this is on the agenda for discussion at the Health Board falls group in September 2023. Awaiting 4 Nations/National position on guidance for falls training. Awaiting results of the scoping exercise to identify how we move this forward. 12/10/2023-As part of falls awareness week (w/c 18/09/23) falls training was held on two of the acute sites with excellent feedback. Education programme has been developed to include input from manual handling, pharmacy, therapies, podiatry and practice and professional development with support from QI. A working group will then be set to organise how this will be run on a Health Board basis. All Wales inpatient falls network are looking into mandating an e-learning falls training programme for All Wales. ESR falls package was commenced in Betsi and it is anticipated that this could potentially be the model to adopt. A sub group of the All Wales inpatient falls network is being established to action this which the Quality Improvement Practitioner will be a member of. 28/12/2023- Training day programme set and powerpoints completed with input from therapies, pharmacy, podiatry, PPDN, manual handling and quality improvement. Pilot of training session being run in Ty Nant on 18th January 2024 for a limited number of staff before submitting finalised study day plans to EAGLE panel for approval.
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	Update Dec 2023 - To discuss and clarify the access to privileged information and the audit trail that is available at the network meeting. 06/03/2024 - No new update from AMAT.
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	18/01/2023 AMAT update- Availability of national training to be confirmed. AMAT system confirms original timescale for action is December 2024, not Dececmber 2023 as originally noted on the tracker. Tracker corrected and RAG status changed back from red to amber. 06/03/2024 - AMAT update - National training for staff is due to be held on how to assess level of potential damages.
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	18/01/2023- No update currently on AMAT. 04/03/2024 - A SOP has been drafted and submitted with the papers for the Listening & Learning Sub Committee on 6th March.
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	R6. HDUHB should consider the introduction of naming convention for files related to claims management. This will ease record identification issues.	This will be developed and in place by the end of March 2023.	Mar-24	~~Mar-24~~ N/K	Red	18/01/2023- No update currently on AMAT. 06/03/2024 - No new update from AMAT.
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	R6. HDUHB should consider the introduction of naming convention for files related to claims management. This will ease record identification issues.	Consideration of document/ correspondence management system for legal case files.	Mar-24	~~Mar-24~~ N/K	Red	18/01/2023- No update currently on AMAT. 06/03/2024 - No new update from AMAT.
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	R7. HDUHB to review the process for the managing PTR responses to ensure the requirements of the Regulation are adhered to and that complaint responses include the necessary information.	A revised process will be produced outlining management of concerns, where a patient requests a verbal response only (local resolution and PTR). This will be incorporated into the toolkit.	Dec-23	~~Dec-23~~ N/K	Red	18/01/2023- No update currently on AMAT. 06/03/2024 - No update currently on AMAT.

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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	08/04/2024- management responses and completion dates due to be provided to ARAC at its meeting in April 2024. The tracker will be updated to reflect the management response and completion dates. 26/04/2024- Under discussion with paper to Board in March 2024. Timescales aligning with Clinical Services Plan anticipating completion March 2025.
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	08/04/2024- management responses and completion dates due to be provided to ARAC at its meeting in April 2024. The tracker will be updated to reflect the management response and completion dates. 26/04/2024- Primary Care workforce planner included as part of the Strategic Programme for Primary Care (SPPC) bid to work alongside the Primary Care Academy for 2 years. (No completion date provided in the management response presented at ARAC for this recommendation).
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	08/04/2024- budget setting
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	08/04/2024- management responses and completion dates due to be provided to ARAC at its meeting in April 2024. The tracker will be updated to reflect the management response and completion dates. 26/04/2024- to be confirmed following timescale of Strategy (No completion date provided in the management response presented at ARAC for this recommendation).
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	08/04/2024- management responses and completion dates due to be provided to ARAC at its meeting in April 2024. The tracker will be updated to reflect the management response and completion dates. 26/04/2024- A review of the CDS PROMS and PREMS will be considered by the Dental QSE meeting by October 2024.
Mar-19	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open	N/A	Primary Care, Community and Long Term 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	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments. 28/02/2023- there is no further update on the above. 27/06/2023- confirmed at Primary Care QSE meeting that there is no further progress on this. 04/12/2023 - No further update received from Welsh Government. 28/02/2024 - No further update received from Welsh Government. 27/03/2024- recommendation owner confirmed there is no further progress. 07/05/2024 - No further update received from Welsh Government about the development of a national system to note the language skills of Primary Care staff. In HDdUHB, the language skills of all health board staff. The health board does NOT collect the language skills of the primary care independent contractor workforce.

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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	Update 23/11/23: Due to RISP project the development of new leaflets needs to be delayed until the new RIS system installed (early 2025). However all leaflets have been reviewed and only printed not photocopied copies are used to improve quality to patients (example uploaded)
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	QAST update 09/05/2023 chased, awaiting progress. 03/07/2023 - QAST chased for update June 23 no update received. QAST update 30/10/23 actions chased, no update received from service. 10/01/2024 - Update from QAST = "Update 23/11/23 added to risk register". No revised date provided. 08/03/2024 - Requirement escalated in exception report to OQSEC 09/01/2024
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.	Disseminate audit template widely across Radiology sites within the Health Board and at the Clinical Audit Meeting.	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	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	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	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	
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	Due 23/07/24.

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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	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update when HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found. 14/10/2022 - Update from Joao Martin: LHBs have not yet received the OpenEyes UAT for testing. Believed to be pending on CRNs duplicates issues and last Monday's test was unsuccessful. Unknown when this will be resolved nationally. We do meet with the National Team every Monday and I expect clarification on some of the issues next week. Further guidance may be provided at the National Programme Board at the end of month. 18/05/2023 - Update from Head of Digital Programmes: At national level the governance of the EyeCare project is transitioning from Cardiff and Vale to DHCW, this raises some uncertainty around the national plan during the transition, discussions are ongoing to clarify. At local level some concerns have been identified with the DPIA for version 6 of OpenEyes, but work continues with Information Governance, the national project team and Ophthalmology to address the concerns in readiness for when the transition at national level is complete, which is expected in Q3 this year 06/06/2023 - (Taken from DITS Response Pack June 2023) - This continues to be delayed and we are awaiting a "Go Live" date. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = The implementation of the National Electronic patient record (EPR) was awarded to Cardiff and Vale. This project was not delivered due to concerns around governance. Digital Health and Care Wales (DHCW) have now commenced a review of how the EPR can be delivered across Wales. PROGRESS TO DATE = 1) The DHCW have undertaken a review of the delivery and time lines for the 'Open Eyes' project with a view to re-start in April 2024. 2) Funding has been awarded from the DHCW for the recruitment of a Band 7 project manager to support the 'Open Eyes' project. 3) An applications support manager is in post for the 'Open Eyes' project. 4) A regional approach to roll for the 'Open eyes' project with Swansea Bay has been agreed and a plan of delivery has been finalised. NEXT STEPS = 1) Confirm how DHCW are going to deliver this project. 01/02/2024 - Update from DHCW. Nationel Eyecare Digiitilisation Programme transition Board meeting held on 22/01/24 with proposed options analysis: 1 - Cardiff & Vale retain the contract with Delivery partner 2 - A new procurement 3 - In-house development of digital eyecare solution for Wales 4 - Commission NHS Education Scotland to develop solution for Wales 5 - Hybrid procurement to cloud host plus in-house development team Timescale revised to reflect minimum 18 month turnaround, depending on option chosen.

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	08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Positive progress being achieved in the delivery of Ministerial measures for the 52/104 week waiters. Further work underway to deliver additional weekend clinics to reduce the backlog of people awaiting appointments. This will continue until approximately June 2023 at present. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Template and job plan redesign has been completed to ensure outpatient activity is protected whilst allowing emergency eye services to continue. Positive progress being achieved in delivery of Ministerial Measures requirements for the 52/104-week pathway measures. Balancing the Ministerial Measures with the Eye Care Measures due to the backlog continues to be a challenge, however, through close micro-management of all available clinics and capacity we anticipate further improvement into 2023. 12/09/2023 - Current focus on 2 high risk areas: Intravitreal Therapy service - additional lists undertaken and whole pathway being reviewed (15 week breach has been reduced to 6 week breach) and an SBAR for this service is currently in draft. Glaucoma - Recent ARCH meeting with Swansea Bay UHB identified areas for improvement. Alongside GIRFT review, several additional actions identified. Several actions identified - Eye Care steering group due to meet November 2023. 2) To employ the Band 7 project manager. 3) To continue to develop the platforms for Glaucoma delivery to align with Swansea Bay HB. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Balancing the Ministerial Measures with the Eye Care Measures continues to be challenging. PROGRESS TO DATE = 1) The Glaucoma service is developing further capacity with the introduction of 1.0 WTE Glaucoma consultants, additional virtual review clinics for SAS doctors and 13 optometrist providers supporting virtual clinics to increase capacity. 2) Additional IVT lists have been introduced to reduce waiting times within this sub-specialty. 3) The Diabetic Retinopathy (DR) pathway has successfully reduced the pressure on secondary care services by sending patients to Optometrists in primary care for their yearly review. NEXT STEPS = 1) Secondary care technician clinics to be introduced to provide data capture for virtual review in secondary care as an interim support to the current ODTC pathway. 2) Glaucoma C patient pathway to be developed for general clinics to increase capacity for this cohort of patients. 3) A review of infrastructure for the IVT service to be undertaken to potentially identify further capacity for delivery. 4) Introduction of treat and extend protocol for IVT to be rolled out HB wide to assist with the development of further capacity. 5) To further develop delivery of DR pathways in Ceredigion ensuring delivery of care close to home for all HB patients 01/02/2024 - 2 additional virtual Glaucoma clinics identified for potential start date April 2024. IVT service: displaced by RAAC is being transferred to Manchester Square, Milford Haven on 19.02.24 which will provide an IVT service back in Pembrokeshire and gain 20 further injections per week. New Biologic pathway launched on 15.01.24 alongside a treat and extend pathway to gain future capacity. Ongoing review of service to increase capacity.

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	08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Investment into Amman Valley has supported the repurpose of OPD for wAMD to allow the DSU to undertake high volume Cataract lists. Sustainable monies have been invested in the Glaucoma and Cataract Plans, however, there still remains other areas of the service (AMD, Paediatrics, VR, plastics) that require investment. On Demand Training Centre (ODTC) Contracts have been awarded to two providers Carmarthenshire and Pembrokeshire. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. Pan-Wales clinical view that central investment in estate, infrastructure and workforce is required to develop a sustainable long- term Ophthalmology Service model. 12/09/2023 - wAMD workshop identified several areas of improvement. Ophthalmology team has reviewed demand and capacity for this service. We have also reviewed the biologic and biosimilar pathways with a view to the introduction of a virtual process to reduce pressure on this service. Regional discusssions around a workforce development plan which will inform the 3-year service development plan. Further ODTCs to be scoped once contracts/funding have been confirmed. 12/12/2023 - (From ARAC Dec 2023 Ophthalmology Deep Dive Paper): CHALLENGES = The current Ophthalmology service is delivered out of 9 sites which presents a challenge when staffing all 9 sites across 3 counties. PROGRESS TO DATE = 1) The delivery of data capture from 13 optometrist's providers ensures all Glaucoma A patients can access services closer to home. 2) The Diabetic Retinopathy (DR) pathway has successfully been introduced ensuring patients can access care closer to home as this is delivered in primary care with a small secondary care element. 3) Phase 1 of the National Optometrist contract reform commenced in October 2023 which ensures that patients with red eyes no longer need to attend RACE and can access care with specialist trained optometrists locally. NEXT STEPS = 1) With further roll out of the National Optometrist contract reform, the ODTC pathway will potentially be delivered in primary care ensure all Glaucoma B patients can access services closer to home. 2) The introduction of DR pathway to Ceredigion will ensure delivery of care closer to home for this cohort of patients. 3) A review of infrastructure for IVT service to ensure delivery of this service in all three counties, currently scoping delivery in Pembrokeshire after the service was moved due to the RAAC issues in WGH. 01/02/2024 - Met with ODTCs on 09/01/2024 with SBUHB Glaucoma consultant to review ODTC pathway and associated documentation in preparation for the contract reform for further ODTC development. Displaced IVT service to move back to Pembrokeshire 19.02.2024.
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	13/10/2022 - Update from Primary Care: Optometric Advisor as the Diagnostic Treatment Centre (ODTC) contracts have been awarded to two Providers, one in Haverfordwest and the other in Llanelli. The internal process is being finalised between PC and secondary care colleagues and it is anticipated that clinics will start in November 2022. 10/01/2023 - Update from Primary Care: The internal processes have been agreed. ODTCs to use Consultant Connect to save and be able to share the findings with colleagues in HES. Prior to setting this up, the HB Information Governance (IG) team must agree/sign off a Data Processor Data Protection Impact Assessment (DPIA). HES submitted the DPIA to IG in October and despite them requesting an update on multiple occasions, they still do not have a timescale from IG. Unable to provide revised timescale. 16/01/2023 - Update from Rachel Absalom: We are awaiting confirmation from IG that we can progress and, despite repeated emails, have not received this as yet. Revised timescale is therefore unknown. Will continue to chase/raise as an issue. 22/02/2023 - Update from Rachel Absalom: Informed by IG that they would be meeting to discuss on 06/02/2023 but no response received to their requested for an update. Until IG respond, no timescale can be given. 21/03/2023 - Update from Rachel Absalom: No further progress. Still awaiting sign off of/support with a DPIA, which will allow the use of Consultant Connect in the Glaucoma pathway. Without this, we cannot share patient information and therefore, the pathway cannot commence – despite having contractors ready to go. This sign off/support needs to come from our Information Governance Team. We still have not had any correspondence from colleagues in IG, despite multiple emails from various members of the PC and Ophthalmology teams requesting it. 18/04/2023 - SBAR presented at ARAC: No expressions of interest received from providers in Ceredigion – Primary Care Optometry Team liaising with practices in this area. 16/05/2023 - Assurance and Risk Officer contacted Head of IG to ascertain progress and confirm level of input on this recommendation. No response received to date. 08/06/2023 - The DPIA was signed off in March 2023 and the contract went live from 1st June 2023. DITS Response pack June 2023: *ODTC Pathway for Glaucoma patients has last week begun to invite patients to attend an appointment with an optometric practice within primary care* . 23/06/2023 - Awaiting clarification from Head of Optometric Services on the remaining steps to progress this recommendation towards closure. 27/09/2023 - National Optometric implementation is commencing in October 2023. This will take some time to implement fully. Contracts expected to be in place December 2024. Risk to be added to Optometry risk register (Primary Care) around the risk to patient safety. 12/12/2023 - (From ARAC Paper Dec 2023):

															MAIN CHALLENGES = no expressions of interest received from providers in Ceredigion. Limited interest from other providers in the Carmarthenshire and Pembrokeshire areas. PROGRESS TO DATE: 1) Optometric Diagnostic and Treatment Centres (ODTC) continue in Carmarthenshire and Pembrokeshire on a limited basis allowing HB patients to be monitored in the community and referred to secondary care only if further support is needed. 2) The national Optometrist Contract reform is on a phased implementation with phase 1 rolled out in October 2023 ensuring Optometrists can support secondary care with emergency eye care in the community. The ODTC pathway is identified in phase 2 which is expected in spring 2024 to further support secondary care with its Glaucoma B patients. 3) Additional virtual sessions have been introduced with Glaucoma consultants from SBUHB to review the Glaucoma B patients processed through the ODTC pathway. NEXT STEPS: 1) Scope Glaucoma B patients to attend Friday afternoon screening sessions with technicians to be reviewed virtually in secondary care to deliver an interim process whilst awaiting the ODTC pathway to be further developed. 2) 3 virtual sessions built into SAS doctor's job plans to increase delivery to the Glaucoma pathway by 40 patients per week. 01/02/2024 - Met with ODTCs on 09/01/2024 with SBUHB Glaucoma consultant to review ODTC pathway and associated documentation in preparation for the contract reform for further ODTC development.

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	13/05/2022- SDM provided revised date of March 2024. This will be depending on the regionalisation with Swansea Bay (ARCH), in principle this should cover the whole of UHB. Ceredigion discussions on Mid Wales Collaborative with Powys and Betsi- discussions taking place on Mid Wales lead for Ophthalmology to be advertised, difficulties in recruiting in Ceredigion area. 07/07/2022- Risk stratification of Glaucoma patients now complete. Work continues on outpatient templates to ensure capacity to review patient backlog. Current difficulties with staff capacity March 2023, as per Ministerial measures for addressing backlog. Meeting to take place with WG which will hopefully provide clarity on targets. 30/09/2022- Revised completion date to be kept as March 2023. A discussion has taken place with WG, they want eye care measures and MD to be implemented; the service are micro-managing capacity and booking to ensure both targets are prioritised. 9/1/2023- Meeting with team planned this month (capacity, model for delivery etc). 02/03/2023 - Planned expansion of the glaucoma service is expected to improve review response times throughout 2023. Clinical job plans to be completed by April 2023 to maximise clinic capacity. 18/04/2023 - SBAR presented to ARAC: Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. Planned expansion of the Glaucoma service is expected to improve review response times through 2023. 27/09/2023 - Investment in Glaucoma as we are now linked with SBUHB. There is continued capacity challenges between R1, routine patients and access to IVT. Revised date based on GIRFT programme. 12/12/2023 - (From ARAC Paper Dec 2023): MAIN CHALLENGES = Demand currently outweighs capacity. PROGRESS TO DATE = 1) A Risk stratification process has been implemented and patients have been risk stratified on the waiting list into category Glaucoma A, B C & D (with A being the least risk and D being the most risk). 2) 1 WTE Glaucoma consultants commenced in regional post 20th November 2023 gaining 2 additional clinic session per week for delivery to the Glaucoma D patient cohort. 3) 150 Glaucoma A patients sent to Optometrists for data capture to support virtual review clinics in secondary care and reduce the length of wait for this cohort of patients. NEXT STEPS: 1) Further risk stratification process agreed with new Glaucoma consultants to clinically validate any patient on the waiting lists with no code assigned to their record. 2) 100% delayed FU patients to be focus booked in line with priority. 3) 42 Stage 4 Glaucoma patients being clinically validated by consultant and will be prioritised for theatre following validation in line with urgency 01/02/2024 - 200 patients have been removed from 100% delayed cohort through virtual Glaucoma pathway. Validation of stage 4 GLaucoma patients is now complete.
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	30/09/2022- No official response from IMTP. The UHB has a funded Glaucoma plan and diabetic retinopathy plan, which are both in place. The overarching plan for the whole service is outlined in the IMTP. To clarify with Director of Operations if this recommendation to be closed. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm that this recommendation can now be closed. 9/1/2023 - Dependent on outcome of IMTP - no response yet. 02/03/2023 - Outcome of regional clinical workshop (being held early 2023) will influence long-term model. 18/04/2023 - SBAR presented at ARAC: Further review of Glaucoma plan is scheduled due to lower than anticipated contractual interest from community-based optometrists. Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - The GIRFT requires us to form an Executive-led implementation board that is expected due to the volume of actions for GIRFT, the majority of this will be included (IVT and diabetic retinopathy are not included but are covered in the Corporate risk). There needs to be consideration of the regional model including the mid-Wales collaborative model ad this needs to be assessed for not only clinical impact, but financial surety. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Delivery of Glaucoma plan restricted by contractual interest from community based optometrists. Delivery of cataract plan restricted by availability of AVH theatre. Challenges around Regional delivery of cataract plan. PROGRESS TO DATE = 1) The Integrated Medium Term Plan (IMTP) was agreed and resourced with medium term plan for Glaucoma and Cataract delivery. 2) A Getting it Right First Time (GIRFT) review undertaken for Glaucoma and Cataract delivery with recommendations made for service improvement. 3) Cataract lists in Amman Valley Hospital (AVH) increased to 7 patients per list to provide more capacity for cataract patients. 4) Complex cataract list in GGH introduced weekly to provide more capacity for complex cases. 5) Additional cataract list introduced on a Friday p.m. bi-weekly to provide more capacity for cataract patients. NEXT STEPS = 1) To continue the delivery of the GIRFT recommendations to assist delivery and increase capacity within the HB. 2) To introduce a treat and extend pathway to the IVT service which will give further capacity to reduce the length of wait. 3) To review current delivery in AVH theatre to potentially release capacity for further cataract operations. 4) To review RACE follow up capacity and introduce SOS/PIFU for suitable patients to further reduce pressure on emergency eye services. 5) To produce a detailed delivery plan for other sub-specialties within the service to ensure all sub-specialities within Ophthalmology have a focus for improvement. 01/02/2024 - Paper on GIRFT progress submitted to SDODC Feb 2024. 12 recommendations are now completed with 18 recs progressing. Treat and extend pathway has now been launched 15.01.2024. AVH review to be undertaken when IVT service transferred to Manchester Square. Demand and Capacity review undertaken 25.01.2024 with further work needed to review sub-speciality data.

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	30/09/2022- No official response from IMTP. Sustainable monies have been invested into Glaucoma plan and cataracts, however there are still other areas of the service (such as AMD, plastics, paeds, VR, etc.) that require investment. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm current position of this recommendation and revised date. 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 18/04/2023 - Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There is currently a financial gap, in particular to deliver the required activity for IVT and there is a concern which could be addressed by regional working as to the reliance on high-cost locum support in the HB, therefore a further regional meeting is to be held to look primarily on-call and also on joint working. 12/12/2023 - (From ARAC Paper Dec 2023): CHALLENGES = To work within agreed financial budgets. PROGRESS TO DATE = 1) Sustainable monies have been invested in the Glaucoma, Diabetic retinopathy (DR) and cataract sub-specialties which has improved the DR delivery and has ensured the Glaucoma pathway has made steps towards improvement. 2) Funding has been agreed for the changes to infrastructure needed to accommodate the IVT service back to Pembrokeshire to improve travel for patients and staff and potentially free up AVH theatre for further cataract surgery. 3) Short term funding has been agreed for the delivery of additional IVT lists whilst the sustainable capacity is developed. 4) Short term funding has been agreed for outsourcing to reduce waiting times, whilst a sustainable solution is worked through NEXT STEPS: 1) To secure permanent positions for clerical staff (sustainable funding has been identified within budget) to continue the delivery of the DR and Glaucoma pathways, where significant clerical input is required. 2) To secure further Glaucoma practitioners (sustainable funding has been identified within budget) to expand the Glaucoma service and 'grow your own' specialist practitioners for future service delivery. 3) To introduce the new biologic pathway across the HB and introduce treat and extend, which will reduce costs. A proportion of these savings could be used to secure longer term funding for IVT service development. 4) To agree outsource providers for the delivery of additional cataract operations. 01/02/2024 - IVT: new Biologic pathway introduced on 15.01.2024 and outsourcing for cataract operations due to commence Feb 2024.
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	13/05/2022- Honorary contract in plan, and substantive Consultant Ophthalmologist to start in March 2023 (from New Zealand) . No further progression on the collaboration with Shrewsbury & Telford . Mid Wales clinical lead to be readvertised. 30/09/2022- We have successfully recruited 2 speciality doctors and 2 locum consultants. A second honorary annual contract with Swansea Bay glaucoma consultants is in progress via ARCH. The midwales (Powys and Betsi) clinical lead was readvertised with no applicants. SDM to meet with the County Director Ceredigion for next course of action. 02/03/2023 - Regional clinical view is that without central prioritised investment, it would be difficult to attract appropriately qualified skilled individuals who are able to be recruited into centres of excellent elsewhere across the UK. 18/04/2023 - Update from SBAR presented at ARAC: Between September – November 2022 the service has successfully recruited two locum consultants and four speciality doctors. A second consultant with an interest in glaucoma has been awarded an honorary contract to continue to support this service. Specific action on risk 1664 in terms of holding regional discussion to be aranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There has been further successful recruitment at consultant level, however further recruitment needs to be considered at joint regional posts. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Recruitment of substantive consultants with currently 4 substantive consultants within the HB. Recruitment of nursing staff with Ophthalmic experience. Recruitment of Nurse injectors for IVT service. Recruitment of Optometrists with experience for delivery of ODTC pathway. PROGRESS TO DATE = 1) Ophthalmology has successfully recruited a fourth substantive consultant with an interest in plastic surgery strengthening the substantive team. 2) The substantive consultant team is supported currently by 1 WTE locum Glaucoma Consultants from SBUHB, 4 locum consultants across the HB and 1 agency consultant which supports the current substantive posts with service delivery. 3) Tysul ward in GGH have recently successfully recruited another 3 WTE nurses which will ensure a more robust nursing model in Ophthalmology. NEXT STEPS = 1) To review current consultant job description and release to advert. 2) To continue development of ophthalmic training programme for nursing staff to make ophthalmology nursing jobs more appealing. 3) To develop the IVT nurses skills and identify a career progression for this cohort of nurses to make the job role more attractive. 4) To scope the introduction of a training pathway for outpatient nurses supporting ophthalmology clinics. 01/02/2024 - Consultant job description is under review.

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	9/1/2023 - Prioritisation still happening (e.g. longest waits). Still don't have capacity to deliver (outweighed by demand). 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. 02/03/2023 - Improvements in follow-up waiting times will be based mainly around extended roles for optometrists which will be possible through contract reform (no date agreed as yet). Planned extension of the glaucoma service is expected to improve response times throughout 2023. 18/04/2023 - Risk stratification of glaucoma patients complete, including those on a follow-up pathway. See on Symptom and Patient Initiated Follow-up is not considered a suitable pathway for Ophthalmology patients; therefore, improvements will be based around extended roles for optometrists which will be possible through contract reform. Planned expansion of the Glaucoma service is expected to improve review response times through 2023. This is reflected in the risk action plan for 1664 in terms of reviewing the Glaucoma plan by July 2023 06/06/2023 - (Taken from DITS Response Pack June 2023) The service remains fragile and links to the request to formally merge with SB to form a regional service to strengthen the workforce and provision of patient care. 27/09/2023 - This is superseded by the R1 Eye Care Measures that were introduced (in 2019). WG have encouraged SOS of PIFU use in follow-ups and collaborating with Primary Care/Optometrists to create further new capacity. Focus on 100% delays. The HB are undertaking a full review of the workforce required internally to deliver the required capacity (multidisciplinary training). The Directorate plan to review all current Audit and Inspection tracked reports as there are concerns that a large proportion are out of date and have been superseded by Eye Care Measures and the recent GIRFT review. We accept that IVT is not formerly included in these new reports and would welcome a discussion how improvements can be captured. The Directorate have added a comprehensive Corporate level risk to Datix that encompasses all sub-specialities within Ophthalmology. 12/12/2023 - (From ARAC minutes Dec 2023) - Director of Secondary Care: The HIW recommendations pose a challenge to the Health Board; whilst the position has been improved, they have not yet been fulfilled. It will only be possible to close these HIW recommendations when patient access to the Glaucoma pathway is occurring on a consistent basis, without delays. This has strategic ramifications as well as operational and will be difficult to resolve. (From ARAC Paper Dec 2023): CHALLENGE = Demand currently outweighs capacity. PROGRESS TO DATE = 1) Additional Glaucoma clinics have been introduced with start of new consultants increasing capacity for FU patients. 2) Additional Intravitreal injection (IVT) sessions have been delivered through WLI to reduce the length of wait for this cohort of patients. 3) RACE clinic capacity has been increased to reduce the length of wait for emergency patients. 4) Phase 1 of contract reform went live in October 2023 for community optometrists trained as Independent prescribers (IP) to support Rapid Access Casualty for eyes (RACE). NEXT STEPS = 1) To commence 3 additional Glaucoma virtual clinics with SAS doctors to increase capacity for the FU cohort of patients. 2) To introduce treat and extend to IVT service to assist recovery and reduce the length of wait for patients. 3) To undertake a review of the infrastructure within the HB for IVT delivery across the HB to ensure efficient delivery of service. 4) To review RACE follow up capacity with introduction of SOS/PIFU for suitable patients to further reduce pressure on the RACE clinic 01/02/2024 - Secured 2 additional virtual clinics for Glaucoma. Treat and Extend has been completed 15.01.2024. Review of infrastructure is currently ongoing.
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~~ N/K	Red	30/04/2024 - No update received from service since follow-up IA issued in Feb 2024.
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	30/04/2024 - No update received from service since follow-up IA issued in Feb 2024.

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	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. 09/06/2023 - The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7). The Orthoapedic Portfolio Management team and CL are fully supportive of such expansions. 25/09/2023 - Orthopaedics has a clear understanding about the demand within the service currently and data reports have been developed in conjunction with Informatics and Performance teams to assist with the management of patient referral to Treatment pathways and improve efficiencies across the stages. The service monitors and reports on RTT data, KPI's and governance in order to reduce duplication and avoid pathway variation, with the aim of improving standardisation of care. Work to increase activity across the Health Board continues with scrutiny around addressing inefficiencies and maximising the use of resources. Weekly Health Board wide theatre scheduling meetings have been established and are used to review and challenge utilisation of lists. A focussed Trauma & Orthopaedic specific theatre utilisation meeting is also held to discuss and review the ability to increase sessions across sites on an ongoing basis. BGH currently has an allocation of 5 main theatre sessions per week which is in line with pre-covid capacity. WGH currently has an allocation of 7 main theatre and 3 day case theatre sessions per week which is 4 main theatre sessions below the pre-covid allocation. PPH currently has an allocation of 12 main theatre sessions per week which is 8 sessions below the pre-covid allocation. However we also have 7 day case sessions available to us through the Demountable Day Unit which we did not have pre-covid. Delivery is directly impacted by the Health Board's current financial position and the lack of recovery money that has been made available. Andrew Carruthers, Director of Operations, is the lead for the Health Board on the South West Wales Regional Orthopaedics work between HDUHB and SBUHB. Some progress has been achieved in recruitment of theatre staffing and Consultant Anaesthetists but levels have not increased enough to allow an increase in elective theatre sessions. Scheduled Care Risk 1657 highlights the risk around non-delivery of ministerial priority expectations of planned care recovery ambitions due to uncertain resource, availability of workforce and UEC pressures which continue to impact on available capacity. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. 15/01/2024 - Further addditional in patient capacity has been created from the 18th January 2024 at PPH main theatres at which there will be 16 theatre sessions per week allocated to Orthopaedics. This additional capacity has arisen following relocation of some theatre staff from WGH and from DSU PPH. The pre-Covid funded theatre allocation was 20 session per week. The further lift and shift of theatre and anaesthetic staff from DSU PPH is planned with staff requiring enhanced training which is ongoing. 26/02/2024 - During March 2024, the Orthopaedic service will be undertaking a "perfect month" supported by the NHS Executive (though this has now reduced to 3 weeks due to planned industrial action during the final week of March) during which time it will return to 20 theatre sessions per week. This has been achieved with the above actions (lift and shift etc) and some specialties have been relocated to other sites during this time. During the "perfect month" theatre/patient throughput efficiencies will be monitored against national targets and GIRFT recommendations with a view to enhance overall efficiency within the service. It has been confirmed that from 1st April, there will be 18 theatre sessions per week at PPH. BGH remains at 5 sessions per week, its original pre-Covid theatre template and WGH will remain as a Day-Case facility during March. It is anticipated that during April a dedicated Scheduled Care overnight stay facility on which Orthopaedics will have beds, will increase the patient case mix that can be treated on this site. However theatre sessions per week will remain at 11. Expansion towards 3 day sessions and 6 day working is dependent on additional funding and, thereafter, workforce recruitment. Regional working with SBUHB has resulted in theatre capacity being offered to HDDUHB at Neath Port Talbot Hospital, however, due to the complexity of patients on the HDDUHB waiting list currently waiting more than 156 weeks, it has been difficult to identify appropriate patients to utilise this facility. 13/05/2024 - Issue is being progressed and further highlighted via the Clinical Services Plan. Regular meetings have been taking place for many months. This increase in service provision is totally reliant upon receipt of additional funds above and beyond core capacity to achieve.
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.	May-22	~~Oct-23~~ ~~Dec-23~~ ~~Feb-24~~ ~~Apr-24~~ Mar-25	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7) 09/06/2023 - Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services. 25/09/2023 - A number of actions are replicated within recommentation 12. An EQIiP (Enabling Quality Improvement in Practice) project is currently being run by Pre-assesment and focusses on streamlining processes Health Board wide due to a lack of consistency. There continues to be discharge delays for medically fit patients due to delays in social services assessments. Work is being undertaken through NHFD groups around early mobilisation and is captured through NHFD reported KPI's. This work also advises on the reasons for being unable to mobilise patients. Updates to be obtained from NHFD groups and Pre-assessment EQIiP project. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. A Task and Finish Group has been established to standardise the Pre-assessment process across the Health Board - increasing efficiency and the flow of patients across the HB to where theatre and surgical staff capacity exist, thereby utilising resources more effectively. An all Wales group is also being established to assist facilitation of Regional work 26/03/2024 - Data around multiple pre-assessments prior to surgery and pre-assessment timeliness is being collected as part of the "perfect month" in March 2023 to futher support improvements within the pre-assessment service. 13/05/2024 - General Manager for Scheduled Care is overseeing a complete review of the caapacity and demand associated with pre-admission services required as activity increases to bring in line with best practice and meet operational requirements of services in list-loading theatre sessions.
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	30/06/2022 - Pre-operative assessment pathways subject to current review in line with NHS Wales IP&C guidance 09/06/2023 - Pre-operative assessment pathways are subject to current review in line with NHS Wales IP&C guidance and is being undertaken through an EQuIP project. This is not a rate limiter for Orthopaedics. 25/09/2023 - EQIiP project in pilot phase, with the aim of standardising all documention across the Health Board. The pilot commenced at BGH on 11/9/2023 and rollout will continue at PPH & GGH week beginning 9/10/2023, then finally at WGH the week beginning 16/10/2023. 3 month pilot. Feedback will be expected through the Scheduled Care QSESC directorate meetings. 15/01/2024 - As part of the regional Orthopaedic work with SBUHB there is a group looking at pre-assessment across the region. 13/05/2024 - General Manager for Scheduled Care is overseeing a complete review of the caapacity and demand associated with pre-admission services required as activity increases to bring in line with best practice and meet operational requirements of services in list-loading theatre sessions.

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	Red	01/06/2023 - Communication underway with Clinical Coding Team and Gareth Beynon 06/09/2023 - Data received, to be analysed and discussed in the joint business meeting on 05/10/2023 20/11/2023 - Meeting has had to be rescheduled due to availability (date to be confirmed). 20/01/2024 - Clinical lead is analysing data to simplify coding methods in our specialties, follow up meeting to take place in February to agree on final list of clinical codes. Clinical Coding team have access to a weekly catch up with service management and the clinical lead, for any issues that arise in relation to coding. 12/03/2024 - Clinical lead now has list and is working on breaking down the codes into useable list. A meeting is to be scheduled in April 2024.
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	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, SCP to lead on the Audit at WGH and has started. Andrew Burns and Dawn Davies are collecting the data. 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint buisness meeting on 25/01/2024. Audits are to be ongoing. 12/03/2024 - Findings have been presented by Mr Harries and Andrew Burns. The completed review gives a baseline from which improvements can be made (NELA audit). Clinical input will be needed to address some of the details in the improvement planning to address the 2nd part of this recommendation. Measurements for clinical audits will be required. Improvements are generally made following the presentation given every 3 month. Clarify in next business meeting next steps with these audits.
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	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, ANP's to lead on the Audit at GGH and have started collecting the data. 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint buisness meeting on 25/01/2024 12/03/2024 - Clarify in next business meeting next steps with these audits.
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	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, Mr Soare to lead on the Audit at BGH 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - This has been delayed. Audit data is being collected by the team but it has been rejected by the clinical audit team. This has been escalated to the clinical director for scheduled care. 12/03/2024 - Clarify in next business meeting next steps with these audits.
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	Red	01/06/2023 - Meeting being arranged with the Glangwili General Hospital site triumverate, Scheduled Care triumverate team and the General Surgery Clinical Lead/Management team 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint buisness meeting on 25/01/2024. Audit will be ongoing. 12/03/2024 - Clarify in next business meeting next steps with these audits.
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	06/09/2023 - Meeting being arranged with the Glangwili General Hospital site triumverate, scheduled care triumverate team and the General Surgery Clinical Lead/Management team. Due to conflicting pressures, this meeting has been difficult to arrange and we will pursue this for September. It is high on our agenda as an action. Meeting was planned for September but has been delayed, due to the WGH position. 20/11/2023 - Delayed due to RAAC/bed issues in WGH. 20/01/2024- Meetings have commenced between clinical leads, scheduled care management and unscheduled care management at GGH. Two meeting have taken place in December 2023. Unscheduled care pressures and industrial action have delayed further meetings. Further meeting to be arranged for February 2024. 12/03/2024 - Due to emergency pressures, there are currently not sufficient beds. Meeting with site leads to implement this and included in annual plan.
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	01/06/2023 - Conversations are underway - meeting with SBUHB to look at regional pathway 06/09/2023 - Hywel Dda has a health board IBD and functional LGI lead. Meeting with SBUHB to look at regional pathway in September, after summer holidays 20/11/2023- Initial meeting with Bladder and Bowel Service held. The meeting has shown this to be a complex pathway that requires a longer timescale for completion. 12/03/2024 - Identified certain surgeons to carry out procedures but pathway yet to be developed. Clinical input is required to develop this in various stages. Referral guidelines/route to be developed as next stage.
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	01/06/2023 - Meeting being arranged with relevant Portfolio teams to discuss Day Surgery criteria / Pre-Assessment 06/09/2023 - First meeting has taken place with relevant Portfolio teams to discuss Day Surgery criteria / Pre-Assessment. A follow up meeting needs to be arranged once we have had the discussion in our joint business meeting on 05/10/2023. 20/11/2023 - Ongoing work which is quite complex due to multiple factors (e.g. number of people involved across multiple disciplines) 12/03/2024 - Task and finish group in place to review the pre-assessment process and Anaesthetic criteria.
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	01/06/2023 - Picked up alongside reccomendations 14,15 & 16 20/11/2023 - Recs 15 and 16 now completed. See update for Rec 14.
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	01/06/2023 - Picked up alongside reccomendations 14,15 & 16 20/11/2023 - Recs 15 and 16 now completed. See update for Rec 14.
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	Red	01/06/2023 - Strategic Group underway to discuss additional capacity on the Glangwili Hospital site for the complex upper GI patients 06/09/2023 - Strategic Group underway to discuss additional theatre and bed capacity on the Glangwili Hospital site for the complex upper GI patients. This is dependent on unscheduled care patient flow pressures. 20/11/2023 - Delayed due to RAAC plank/bed issues. 12/03/2024 - Operating capacity has increased in colorectal to above pre-covid level. In General Surgery this is not yet the case, although other improvements have been made to make the sessions that are happening more efficient. These efficiencies may gradually offset this reduced number of sessions. The backlog is gradually be reduced in this way.
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	01/06/2023 - Conversations underway within the Health Board and Welsh Government in relation to E-Consent 06/09/2023 - There is a national programme underway in relation to E-Consent 18/01/2024 - Recommendation is currently outside the gift of the Health Board as it is reliant on the rollout of a national E-consent programme.

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 Senioer Nurse Manager 2) Workforce development plan to be written and implemetnted.	Apr-24	Nov-24	Red	16/11/2023 - New Ophthalmology management structure inclusive of Nursing representation will work closely with Clinical teams to review theatre delivery. Workforce development plan to be developed with Swansea Bay HB. 30/04/2024 - action still in progress
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	16/11/2023 - JD for Clinical lead to be circulated to all elegible staff within the service as an expression of interest for this role. 30/04/2024- JD for Clinical Lead reviewed and awaiting approval.
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	27/09/23 Preliminary meeting held with Optometrists. 02/01/2024 - Updated decision making tool currently being reviewed and agreed.
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~~ N/K	Red	27/09/23 Pre-operative assessment documentation currently being reviewed. 02/01/2024 - EQIiP programme to look at delivery of pre-opreative assessment (starting 7th November 2023). 30/04/2024- 30/04/2024 - Pre-operative assessment documentation has been updated and approved by the Nursing documentation Group. The One-Stop Pre-Operative assessment pathway for cataract patients is being developed as part of the EQIiP programme- SOP documentation needs to be finalised and approved in SC Working control documentation group, as well as disseminated to staff.
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~~ N/K	Red	Clinic area identified for potential one stop cataract clinics with access to the required equipment for assessment. Staffing and processes to be scoped. Enabling Quality Improvement in Practice (EQIIP) programme successful bid starts in November 30/04/2024 - The process has been mapped and redesigned; the one stop pathway has been developed and requires finalisation and approval of procedure documentation to allow implementation. Potential dates to start process identified.
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 undertakenby head of Nursing and Senior Nurse Manager 2) Workforce development plan to be written.	Apr-24	Nov-24	Red	27/09/23 - HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days. 30/04/2024 - action continues in progress
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	27/09/23 Review of consent process currently being explored with HB consent lead. 30/04/2024 - Consent discussion and documentation to be undertaken at the one-stop pre-op assessment stage. Consultant carried out training with the relevant doctors on 05/04/2024, to include undertaking consent for bilateral cataracts. Further training scheduled for the whole medical team with the consent team.
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	Documentation being developed and to be discussed at upcoming QSE meeting. All documentation will need to go through Scheduled Care Working Controlled Documentation group (WCDG). 30/04/2024 - All documentation has been developed and is awaiting approval by the Working Control Documentation group, which is due in May 2024.
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	16/11/2023 - Any change to documentation will need to go through WCDG 30/04/2024 - Priority ratings discussed with Primary Care Lead to be adhered to strcitly. One-Stop Pre-Op process should support operating in priority order. Cataract listing card currently under review.
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	Red	27/09/23 Pre-assessment process and documentation currently being reviewed. 30/04/2024 - Telephone screening included as part of the new pre-assessment process. Risk stratification tool included in the new pre-assessment pathway document to allow for easier identification of patients with co-morbidities and better planning.
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	Work undertaken to increase to high volume lists in AVH. Patient lists have been increased from 5 to 6 and now from 6 to 7 patients per list. Review of processes would need to be undertaken to introduce high volume lists on other sites as recommended. 30/04/2024 - BGH theatre visit not yet completed to assess current flow, but BGH have moved the Ophthalmology lists to a different theatre recently and will need to assess when stable. GGH has room for improvement; meeting with theatre colleagues required to discuss recommendations following visit (unable to set up a date when attempted). The theatre is too far away from admission/discharge area and increasing volume may require investment in staff and equipment. AVH has been optimised as much as possible under the current process, but should be better utilised upon implementation of bilateral cataracts and new one-stop pathway.
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	We currently have mixed lists mainly GA however LA patients added to fill the lists rather than lists go under utilised. 02/01/2024 - To meet with main pre-assessment lead to discuss streamlining process for GA patients. 30/04/2024 - Mixed lists remain in main sites (GGH and BGH) due to other procedures only being able to be carried out at these sites, and cataracts being used to maximise theatre potential.
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	27/09/23 Workforce development plan commenced. 30/04/2024 - still in development, not applicable to current cataract process but will be beneficial once new process is established and will be explored then.
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	Red	27/02/23 Pre-operative processes currently being reviewed. 30/04/2024 - Pre-assessment process developed to consent patient in Outpatients on the day of One-stop assessment as part of their preparation for theatre. This will work better than consenting in the anaesthetic room and will apply to all sites. Patients will be optimised to ensure the consultant does not need to carry out an extensive review on the day. Patients will have been seen approximately 6 weeks prior in clinic by a suitably trained clinician (training delivered 05/04/2024) . Process due implementation soon.
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	27/09/23 SNN to review theatre processes with theatre team. Theatre review days are booked. 30/04/2024 - process redesigned to allow for consent to be undertaken at pre-assessment.

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	SNM to review theatre processes with theatre team. 30/04/2024: AVH - no anaesthetic room, process works well currently with patients climbing on/off. GGH - suggested team to trial using two trolleys, no updates BGH - no assessment carried out yet
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	Experienced Consultant who has undertaken Cataractathon now employed in a substantive post to support and advise. 30/04/2024 - a number of cataracts have been Outsourced between February and March 2024. Further options continuously being scoped.
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	Red	16/11/2023 - SNM to review theatre processes with theatre team. Theatre start and finish times. Theatre attendance at QSE. 30/04/2024 - Theatres have started and maintained a dashboard of theatre times to allow transparency and visibility. Finish times remain a problem in GGH theatres as staff are required to support late shift work in other theatres. Theatre times should improve after implementation of the one-stop pre-assessment process as this will remove the need to ward rounds. Will need to be reassessed after the one-stop process is implemented.
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	Review of IVT service in AVH to clinic rooms to create further capacity being scoped. 30/04/2024 - IVT moved out of AVH OPD back to Pembrokeshire in March 2024. Due to various staffing constraints, unable to progress further.
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	27/09/23 - Regional post secured for Glaucoma patients. Exploring further regional options with Swansea Bay. 01/02/2024 - Exploring further regional options with Swansea Bay. 30/04/2024 - Remains in progress.
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	27/09/23 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days. 30/04/2024 - after discussion with theatre teams, this is not a factor that is currently affecting the theatre flow and training the staff on these actions may not be of any benefit at this point.
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	27/09/23 - HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days. 30/04/2024 - remains in progress
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	27/09/23 - Workforce planning in line with the RCOphth will be undertaken alongside the workforce development plan discussed with Swansea Bay. 30/04/2024 - Workforce planning remains in progress. HV lists have been increased in the number of patients up to 7 patients per list. Upon introduction of ISBCS process and One-stop Pre-Op, reassess possibility to increase lists further.
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	Red	27/09/23 Senior Nurse Manager for Ophthalmology shadowing all theatre processes to discuss changes required with theatre Sisters. 30/04/2024 - Theatre electronic records need to remain in place for compliance with theatre processes. Cataract paperwork has been streamlined and is only awaiting implementation.
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	Red	02/01/2024 - Discussed at QSE meeting and audit timetable to be agreed. 30/04/2024 - remains in progress
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	27/09/23 Senior Nurse Manager for Ophthalmology has observational dates booked to review all theatre processes. 30/04/2024 - initial observation carried out at AVH and GGH in October/November but not at BGH yet. BGH visit to be organised, repeat visits to GGH and AVH to be organised.
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	27/09/23 - Preliminary discussion held with ward Sister. 30/04/2024 - Action to be reviewed once the One-stop process is in place and working appropriately. As the current process stands, this option is not viable as it will force the surgeon to come out of theatre in between patients to consent the next ones, which will impact the lists negatively.
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	Red	27/09/23 - Preliminary discussion held with ward Sister, next steps, to be explored with pharmacy. 30/04/2024 - Action to be reviewed following implementation of One Stop to see how this can be implemented as it will have impact on pre-assessment.
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	Red	27/09/23 - Review of consent process started with Head of Consent for the HB. 30/04/2024 - Discussions have led to the decision that the current consent form is very adequate and supported/in line with Welsh Risk Pool, which needs to remain the case. Nurse-led consent to be explored after other urgent changes to pre-assessment and cataract process have been implemented and optimised.
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	Red	16/11/2023 - Work has commenced on coding and data analysis. 30/04/2024. Meeting undertaken with coding team and draft document has been drawn up to be reviewed by management team.
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	Red	Currently 8 Optometrists hold a higher certificate with another 15 Optomotrists currently being developed in the HB. 30/04/2024 WGOS 4 being implemented with desk top exercise of all Glaucoma A patients to be undertaken in May and June with potential to discharge patients to community optometry pathway.
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	Red	27/09/23 - Review of data collection and referral management has commenced.

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	Risk stratification has been applied with E and F category almost eliminated from the New pathway. Plan to validate whole FU waiting list with plans to eliminate uncoded patients and the E and F catgories in the the FU cohort. 30/04/2024 Validation of Glaucoma A category will commence as part of the WGOS 4.
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	Red	27/09/23 - Review of Ophthalmic delivery and infrastructure has commenced.
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	Red	27/09/23 - Delivery of further virtual sessions has been job planned for new Glaucoma consultants and tech support for these sessions is currently being scoped.
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	Review of all sites delivering care and maximise footprint where possible. Also scoping space in Pentre Awel and in the primary care hub in Carmarthen to expand infrastructure. 30/04/2024 Clinical services plan reviewing over all delivery of service and potential options for centralising services.
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	Red	27/09/23 Review of Ophthalmic delivery and infrastructure commenced.
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	Red	Discussion with Swansea Bay to develop a regional workforce development plan have been commenced.
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	27/09/23 The use of a mobile centre will be scoped as part of the infrastructure review.
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	27/09/23 - Regional Glaucoma Consultants secured. Regional EPR system being scoped and workforce development plan to include regional support from Swansea Bay. 02/01/2024 - Funding secured for 1.0 WTE Band 7 digital project manager and 0.5 Band 5 application support manager. 30/04/2024 - Open Eyes project on hold centrally (not HB dependent). Work with Glaucoma consultants continues. SB have no capacity to take HD cataract patients but alternatives are currently being scoped.
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	27/09/23 - Funding available for further Glaucoma Practitioners. Regional workforce development plan will need to be implemented to support the development of these nurses.
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	Red	27/09/23 - The OPT competency framework is being utilised in the development of the nurse practitioners and one of the middle grade doctors is atteding the OCT training to support as training lead.
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	27/09/23 - Review of workforce commenced.
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	Red	27/09/23 - In-depth Demand and Capacity planning undertaken, recovery plan to be developed in line with proposed increase in capacity as workforce and infrastructure developed.
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	02/01/2024 - 100% delayed patients in high risk categories being reviewed with plans to increase virtual sessions to review lower risk patients to free F2F appointments for the Glaucoma C&D categories. 30/04/2024 WGOS 4 introduction will release suitable patients back to primary care giving additional capacity to high risk patients.
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	Further work being scoped to increase patient utilising ODTC style clinics both in primary and secondary care supported via virtual platforms. 02/01/2024 - Contract reform will give further opportunities to develop this pathway.
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	03/05/2024- Compliance evidence sent to PSOW 25/03/24, awaiting further contact from PSOW
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	03/05/2024- Offer was evidenced to PSOW 25/03/24, awaiting further contact from PSOW
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	03/05/2024- Compliance evidence sent to PSOW 11/04/24, awaiting further contact from PSOW
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	03/05/2024- Compliance evidence sent to PSOW 11/04/24, awaiting further contact from PSOW
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	03/05/2024- Compliance evidence sent to PSOW 03/04/24, awaiting further contact from PSOW
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	

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)	Progress update/Reason overdue
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	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - Update to ARAC -The review has now been complete. However, only a draft version has been sent to date with the recommendations omitted. The Health Board has responded to the factual accuracy and overall content relating to the body of the report. Unfortunately, at this stage (31 May 2023), the final report is yet to be received. 11/01/2024-Deputy Director of Operational Planning and Commissioning confirmed recommendation is completed, with report provided to the Targeted Intervention meeting January 2024. 09/02/2024: Audit Wales Report of November 2023 has documented that this recommendation is in progress. 22/04/2024: The UHB is committed to embedding the requirements of the updated maturity matrix and Targeted Intervention (TI) framework into its day-to-day plans and processes, ensuring that the outcomes and outputs of both are integrated into the revised organisational structure. This structure, consisting of three reporting groups and sub-groups, will be the foundation for a continuous planning process that aligns with the UHB's strategy and focused set of 10 planning objectives, which are closely linked to the reporting groups and Welsh Government's Ministerial Priorities/Measures. This targeted approach will enable the UHB to effectively address the challenges in 2024/25. By involving various Directorates in supporting the TI effort, the UHB will develop planning resilience, enabling early identification of issues and a coordinated response to challenges through the robust monitoring of the Directorate annual and saving plans. The UHB aims to drive systemic change from within by leveraging the TI framework as a catalyst for improvement, aligning with its strategy and planning objectives.
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	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - Update to ARAC -The current position remains extant to the summary update provided as at the 9 February 2023. However, there has been changes to the planning cycle and overall process. Equally, a greater understanding of the roles and responsibilities the planning function may undertake has increased through the planning cycles aligned to the Annual Plan (submitted to WG on the 31 March 2023) and the Annual Plan supplementary (submitted to WG on the 31 May 2023) document. Therefore, subject to the final report being received from Welsh Government, a planning directorate structure inclusive of the proposed roles and responsibilities will be produced. 11/01/2024-Deputy Director of Operational Planning and Commissioning confirmed whilst the original intention was for to expand the Corporate Planning and Commissioning team; this has been superseded due to the financial position. Moreover, the Transformation Programme Office now sits under the Deputy Director of Operational Planning and Commissioning and as such, the resources within the TPO are supporting both the Annual Plan and the Medium Term direction through the Clinical Service Plan. Therefore, this improves both the capacity and capabilities in the interim. To be clarified with the Director of Strategy and Planning if this recommendation can be closed. 09/02/2024: Audit Wales report of November 2023 has documented that this recommendation remains in progress. 22/04/2024: The UHB is focusing on building organisational capacity in the interim to address the identified challenges. The UHB will leverage expertise and resources across various Directorates to support the TI effort and internally any escalated Directorates, enhancing its ability to drive systemic change and improvement. The integration of the commissioning function into the Planning Directorate in January 2023 has provided additional resilience, and the Transformation Programme Office, now under the Deputy Director of Operational Planning and Commissioning, supported both the Annual Planning process and the Medium-Term direction through the Clinical Service Plan. By aligning appropriate skills and experience from different Directorates, the UHB aims to strengthen its capacity and capabilities in the interim, while embedding TI into the new reporting groups to ensure all changes are sustainable and in line with the Health Boards direction of travel.
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	24/02/2023- Under suggested timescale the Internal Audit report states 'To be considered in advance of the Outline Business Case stage'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 20/06/2023 & 19/07/2023- Capital Planning Project Manager confirmed there is Executive Team discussion around future governance of the programme, awaiting outcome. 05/09/2023- Further work on this will be undertaken following the Gateway Review of the Strategic outline case (SOC) in October 2023. 08/01/2024 - This work will be completed following SOC completion and submission to Welsh Government. RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	24/02/2023- Under suggested timescale the Internal Audit report states 'As required'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 08/01/2024 - This work will be completed following SOC completion and submission to WG. RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 -RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
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	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).

Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Strategic Development and Operational Planning	High	R2. Strategic programmes should be managed as such from the outset, with appropriate programme management resource and a formal programme plan demonstrating alignment with the organisations objectives and setting out the aims, milestones and anticipated outcomes.	The strategic programmes of change within the Health Board are described by the Planning Objectives agreed annually by the Board. The Executive team will establish a formal process to assess the resource requirements for each and align corporate resources accordingly.	Jul-23	~~Jul-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 The Core Delivery Group was established in August 2023 as a sub-group of the Executive Team. As per the Terms of Reference, responsibilities include overseeing delivery of the Health Board's savings plan, including ensuring that clear processes are in place for capturing project plans consistently and ensuring that support is provided for each scheme from corporate functions as necessary. The savings process document provides guidance on the approach that should be followed within each stage of the framework, including a resource allocation review in the Discover phase to identify resources required to bring an idea into fruition, and a detailed project plan as part of the Design stage outlining clear milestones, deliverables and performance indicators. The Project Initiation Document template has been developed to ensure this detail is determined and captured as part of the planning process, including: • Project scope and drivers • Project team • Anticipated benefits and risks • Key milestones and tasks • Monitoring arrangements We were advised that to date, no additional strategic change programmes have been identified following the full audit undertaken in spring 2023. Internal Aduit Conclusion: Action Taken – further review required to assess compliance and effectiveness 22/04/2024 - Confirmation from service leads that report to be transferred from Finance to Strat ops
Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Strategic Development and Operational Planning	High	R3. The programme plan should form the basis of monitoring programme delivery against milestones and achievement of identified aims and outcomes. This would encourage transparency, consistency and completeness in assurance reporting to the Board.	Linked to the ongoing Targeted Intervention work the Health Board will review its processes and documentation for managing programmes	Aug-23	~~Aug-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 As noted above, scheme delivery will be monitored through the Core Delivery Group. Arrangements for reporting delivery of anticipated savings are clear – via the savings tracker template with a Power BI dashboard to facilitate monitoring and reporting both within the organisation and externally (e.g. to Welsh Government). Arrangements for monitoring and reporting achievement of non-financial benefits (for example quality, safety and experience improvements) are more ambiguous at this stage – the PID template should facilitate this if completed and used as intended, although as no additional strategic change programmes have been identified following the full audit undertaken in spring 2023 we have been unable to assess this. Internal Audit Conclusion: Action Taken – further review required to assess compliance and effectiveness 22/04/2024 - Confirmation from service leads that report to be transferred from Finance to Strat ops
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~~ N/K	Red	12/03/2024 - Principal Programme Manager Transformation (SH) has advised that this recommendation is on the agenda for the Decarb Meeting Thursday 21st March, following which a Task & Finish Group is likely to be formed to take this forward.
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	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	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.	TBC	TBC	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	
Mar-23	2022/23	Peer Review	Planning Arrangements in Hywel Dda University Health Board	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Shaun Ayres	Director of Strategic Development and Operational Planning	N/A	R1. Establish its operating model for managing and delivering change - paragraph 81 provides a blueprint.	Management responses to be presented at August 2023 SDODC. 08/12/2023: The Health Board has integrated learning from the annual recovery work phases one and two into ongoing planning activities. This integration is a core part of the operational planning framework, ensuring a seamless transition of insights and strategies into future plans. The operational framework is underpinned by the integrated planning process, which serves as the cornerstone of the approach to managing and implementing change. This process is more than a strategic document; it is a live operational tool that brings together all aspects of the organisation. It enables us to align our efforts with the Board's overall objectives, ensuring that operational initiatives are in sync with our risk appetite and strategic goals. The savings process, integral to the operational planning, ensures continuity and sustainability. It is a cyclical ongoing process where lessons learned and efficiencies identified in one cycle will feed in to the planning of the next, allowing us to maintain a dynamic and responsive operational planning approach. This cycle not only addresses financial efficiencies but also reinforces our commitment to quality care and service improvement.	Dec-23	~~Mar-24~~ N/K	Red	Management responses to be presented at August 2023 SDODC. 12/09/2023- Paper to August 2023 SDODC confirms a thematic approach that consolidates the UHB response to the Maturity Matrix; Peer Review and the internal planning Master Actions emanating from the original Targeted Intervention expectations. December 2023 timescale provided by Deputy Director of Operational Planning and Commissioning. 11/01/2024-Deputy Director of Operational Planning and Commissioning update- the UHB has integrated learning from our annual recovery work phases one and two into our ongoing planning activities. This integration is a core part of our operational planning framework, ensuring a seamless transition of insights and strategies into future plans. Our operational framework is underpinned by the integrated planning process, which serves as the cornerstone of our approach to managing and implementing change. The savings process, integral to our operational planning, ensures continuity and sustainability. It's a cyclical on-going process where lessons learned and efficiencies identified in one cycle will feed into the planning of the next, allowing us to maintain a dynamic and responsive operational planning approaches. Revised timescale of Macrh 2024 provided to coincide with the plan being submitted to WG.
Mar-23	2022/23	Peer Review	Planning Arrangements in Hywel Dda University Health Board	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Shaun Ayres	Director of Strategic Development and Operational Planning	N/A	R2. Develop effective means for strengthening and supporting planning by operational teams, ensuring that there are clear pathways for turning strategy into implementation plans. A clear route map for delivering the strategy is needed to support this.	Management responses to be presented at August 2023 SDODC. 08/12/2023: The Health Board has focused on enhancing the Integrated Planning Process as the key driver for transforming strategic and planning objectives into actionable implementation plans. This process is at the heart of our operational planning, effectively bringing together diverse strands such as financial management, service delivery, workforce planning, and recovery requirement to the heart of the planning process. Through the Integrated Planning Process, we will ensure there is a clear coherent approach for operational teams to develop and execute plans. This process is informed by insights from our Annual Recovery Plans, which provide valuable lessons and strategies for service improvement and risk management. Additionally, it incorporates elements from our Clinical Services Plan, ensuring that our planning objectives are aligned with patient care priorities and broader Health Board wide service fragility issues and concerns. The savings process, integral to our planning, follows a structured approach from enquiry to delivery, ensuring that every potential efficiency is explored and implemented within the broader operational context. This systematic approach aids in strengthening our planning capabilities, supporting teams to identify, design, and implement effective changes. The inclusion of detailed reports, such as the 'Planning Objective 6a Highlight Report' and the '6a Planning Objective Deep Dive Report,' further illustrates the depth and comprehensiveness of our planning process. These reports demonstrate our commitment to continuous improvement, governance, and documentation clarity, ensuring that every step from strategy to implementation is well-defined and effectively executed. In summary, our Integrated Planning Process is the cornerstone of our response to this recommendation, providing a robust, adaptable, and comprehensive approach for operational teams to turn planning objectives into both deliverable and implementable operational plans.	Dec-23	~~Mar-24~~ N/K	Red	Management responses to be presented at August 2023 SDODC. 12/09/2023- Paper to August 2023 SDODC confirms a thematic approach that consolidates the UHB response to the Maturity Matrix; Peer Review and the internal planning Master Actions emanating from the original Targeted Intervention expectations. December 2023 timescale provided by Deputy Director of Operational Planning and Commissioning. 11/01/2024-Deputy Director of Operational Planning and Commissioning update- the UHB has focused on enhancing our Integrated Planning Process as the key driver for transforming strategic and planning objectives into actionable implementation plans. Through the Integrated Planning Process, we will ensure there is a clear coherent approach for operational teams to develop and execute plans. This process is informed by insights from our Annual Recovery Plans, which provide valuable lessons and strategies for service improvement and risk management. In summary, our Integrated Planning Process is the cornerstone of our response to this recommendation, providing a robust, adaptable, and comprehensive approach for operational teams to turn planning objectives into both deliverable and implementable operational plans. Revised timescale of Macrh 2024 provided to coincide with the plan being submitted to WG.

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)	Progress update/Reason overdue
Feb-24	2023/24	Public Service Ombudsman (Wales)	202108316	Open	N/A	Therapies	Therapies	Lance Reed	Director of Therapies and Health Science	N/A	R1. Apologise to the complainant (Miss A) for the failings identified in this report.	Reflect on the Ombudsman's report and draft a suitable apology letter	Mar-24	~~Mar-24~~ N/K	Red	Copy of apology letter 03/05/2024- Compliance evidence sent to PSOW 19/03/24, awaiting further contact from PSOW
Feb-24	2023/24	Public Service Ombudsman (Wales)	202108316	Open	N/A	Therapies	Therapies	Lance Reed	Director of Therapies and Health Science	N/A	R2. Pay the patient's (Mr B) estate financial redress in the sum of £350 in recognition of the failure to appropriately explore and document Mr B's long standing urinary dysfunction and the uncertainty caused by this.	Include the offer of financial redress in the apology letter. If accepted, ask Finance for evidence when paid.	Mar-24	~~Mar-24~~ N/K	Red	Copy of apology letter and evidence from Finance 03/05/2024- Offer included in apology letter of 19/03/24 and further email sent 09/04/24. Unable to pay until we are contacted by complainant with payee details. PSOW updated 02/05/24
Feb-24	2023/24	Public Service Ombudsman (Wales)	202108316	Open	N/A	Therapies	Therapies	Lance Reed	Director of Therapies and Health Science	N/A	R3. Provide the Ombudsman with evidence to support the measures it has referred to in paragraph 43 including putting in place a cauda equina pathway, reviewing and standardising its letters and delivering training for MSK physiotherapists across the First Health Board to improve the clinical screening of CES. If these actions have not been carried out, the First Health Board should put in place an action plan to ensure that these learning points and improvements are implemented.	[The Health Board] said since the complaint was received, it had put in place a cauda equina pathway, standardised letters and delivered a significant volume of training for MSK physiotherapists across the Health Board to improve the clinical screening of CES and associated documentation. It said the service would continue with a rolling program of training for all physiotherapists working across the MSK pathway.	May-24	May-24	Amber	Documentary evidence of measures put in place.

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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	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	Red	09/02/2024- this recommendation supersedes the previous recommendation on the original report (HDUHB-2324-03) - 5.1. Previous Matter Arising 5: Incidents Management 01/05/2024- Work is underway to reduce the number of open incidents and the length of time waiting for them to be closed. 275 incidents were closed in the last quarter; extraordinary meetings in addition to the monthly scrutiny meeting arranged to look at closing historic cases. 660 remain open over 120 days. A revised date will be provided once improvement trajectories have been analysed.

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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~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update received. QAST update 30/10/23 Awaiting quotation from Estates for refurbishment of staff facilities and seeking Charitable Funds support to fund the refurbishment. Update 20/12/23 partial refub taken place, awaiting painting of room and chartable funds for lockers. 25/01/2024- this action will be implemented by March 2024, as discussed at the GGH Quality, Safety and Assurance meeting in January 2024. Update 23/2/24 The repair of the wall has been undertaken in the staff toilet awaiting all other planned maintenance to be done Linked with estates today and will meet in the department next week to confirm date to complete all works needed. Colour scheme and paint have already been decided. We are also in the process of ordering new lockers for staff through charitable funds. To instigate a refurbishment of staff facilities is complete though understanding the works may take up to 3 months to complete

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Jun-23	2023/24	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Mental Health & Learning Disabilities	Senior Nurse Manager	Director of Operations	N/A	R20. The health board must consider its approach to community engagement and communication at a corporate level regarding the 'front door' services available at Prince Philip Hospital and accessing the right service according to need.	Review of current MIU scope and criteria documents and development of redirection protocols underway.	Dec-23	~~Dec-23~~ ~~Jan-24~~ N/K	Red	Update 20/12/23 meeting / strategic work underway re scope of MIU service, to inc MH service and delivery. Expected to go to Committee January 2024. 01/02/2024: AMaT updated on 17/01/2024 - meetings and strategic work remains in progress - being presented to CDG on 24th January 2024. Update 22/03/2023 AMAT- meetings and strategic work remains in progress - being presented to next OPDP meeting
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.	Jun-16	N/K	Red	10/02/2022 - Recommendation owner amended to reflect recent changes in SDM role. 10/01/2023- Weekly meetings continue between the Clinical Lead and SDM. Recruitment remains a challenge within Respiratory with Consultants and Middle Grades supporting services, this continues to put huge stress on the respiratory system . The plan to train-up known junior doctors remains ongoing but this is a medium term plan. Realistic and operational short term plans are now in place to release specialist physicians from work that other physicians can undertake (acute on call, General ward rounds), in order to free up specialist time providing input on a health board wide basis. . This of particular relevance to Lung cancer where Dr Robin Ghosal has taken responsibility as Lung Cancer lead running the Lung Cancer service single handed. This interim service provision will continue until we can recruit. We do currently have a locum consultant working remotely managing the general chest waiting lists across the sites to alleviate pressure on sub speciality work Following our Away Day an IMTP is currently being drafted which includes the succession plan for the Lung Cancer Service and this involves the planning and recruitment of one of our existing Middle Grade Doctor to become a Consultant to support the robust provision of lung cancer. Cancer Services continue to work alongside the service management team monitoring cancer waiting times in their weekly lung cancer MDT tracker meetings. 16/03/2023- Funding sources have been obtained from establishment across Carmarthenshire and sites to provide lung cancer services across the UHB footprint, the barrier now facing the service is the difficulty in recruiting the middle grade doctor. At present the Hospital Director is lone working as the only consultant for the lung cancer service. A succession plan is in place but recruitment remains difficult. This has been reflected in risk 1655 (Fragility of Lung Cancer Service). To be raised with Director of Operations if he is happy for this recommendation to now be closed, as this is reflected in risk 1655. 27/10/2023- The strategic review has taken place and we have recruited a locum consultant to support the previous lone working consultant. Recommendation to be discussed with Director of Operations for closure. 08/04/2024: Director of Operations has requested assurance that the report has been sent to him or that it has been presented/submitted to a committee or forum and that there is an action plan in place. Once confirmation has been received, the report can then be closed. Awaiting information from Service Delivery Manager, Respiratory & Diabetes.

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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	R1. Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	The Stroke Steering Group (SSG) will review the need to engage with GP practices and localities GP engagement and for the stroke medical team to develop relationships.	Dec-24	Dec-24	Amber	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- The Clinical Lead for Stroke has contacted the Deputy Medical Director for Primary Care and a response is awaited.
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	R2. Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Hywel Dda University Health Board will work collaboratively with Public Health Wales to support the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign.	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system. 11/04/24 Update on Amat - FAST evidence uploaded. Complete.
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	R3. Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Hywel Dda University Health Boards to work collaboratively with Public Health Wales and with black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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	R9. Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	The Health Board has commissioned a partner to review any opportunities there may be relating to predictive methodology for demand. This development work is scheduled to continue through Q3 & Q4 2023/24.	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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	R12. Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	The issues paper will be ready by March 2024. There will be further work and planning required in relation to the stroke service whereby the information gathered from the patient survey will be pivotal in the re design of Stroke care in HDdUHB	Apr-24	~~Apr-24~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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	R12. Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Part of the clinical service programme the Health Board are surveying the population during October 2023 via the CIVICA system. This is part of a patient survey as part of the early engagement assisted by the Stroke association. The national stroke board is also supporting an All Wales patient Survey.	Apr-24	~~Apr-24~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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	R16. Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	The Health Board stroke CNS to develop a training package for the receptionist team. This will be available on line.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- one to one training has been delivered to receptionist team on all sites, the training package awaits development. 05/03/24 Amat update- and confirmed 11/04/24 one to one training has been delivered to receptionist team on all sites, the training package is not to be developed it has been decided. Partially complete.
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	R21. Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	A summary report of finding and recommendations will be shared with operational site teams in March 2024	Apr-24	~~Apr-24~~ N/K	Red	
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	R22. Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	The Health Board will review any recommendations arising from the NHS Executive review the stoke pathway through the self-presenting patient's perspective. The report is yet to be released.	Nov-23	~~Nov-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- The NHS Executive review of stroke pathway has yet to be released. Actions that require all Wales work raised with WG Oct 2023. 11/04/24 Amat update- Stroke team to chase the review of pathway report.
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	R24. Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.	ED Senior sisters to keep an up to date training record and to inform the Stroke team of any new staff starting in their departments	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system. 11/04/24 Amat Update- ED senior sisters / CNSs on each site keep a training record. Update from BGH CNS training list held on site.
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)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R37. Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	1)Neuropsychologist post out to recruit for second time. Reviewing potential of regional service model with SBUHB cover if recruitment remains problematic 2)Neuropsychology Assistant Practitioner posts currently being recruited to with aim of delivering a stepped care model to support the Stroke pathway by end March 2024	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system. 11/04/24 update on Amat. 1)Lead confirmed that the Neuropsychologist role has been recruited to and starts on 22/04/24 Complete. 11/04/24 update on Amat 2) from Lead, Neuropsychology Assistant Practitioner posts recruited to.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R38. Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Therapy 7 day staffing, including ESD reviewed as part of Stroke Services Redesign Program, Regional CRSC Programme, Clinical Services Plan (CSP) and factual assessment of staffing profile. CSP issues paper to be reviewed by Board March 24	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system. 11/04/24 update on Amat- Clinical Services Plan Issues paper attached.Partially Complete.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R39. Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Majority of stroke rehabilitation environments across the Health Board are appropriate and adequate to meet the patients' needs. There are currently significant short to medium term operational challenges in : 1)WGH site due to impact of RAAC - local mitigation in place to provide acute in-pt rehab WGH and in SPH. ESD to support split pathway	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system. 11/04/24 Update on Amat- the position remains a challenge, on WGH report attached detailing issues re RAAC; BGH no rehabilitation nor room to create one, this has been added to the risk register; GGH and PPH position awaited.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R39. Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Majority of stroke rehabilitation environments across the Health Board are appropriate and adequate to meet the patients' needs. There are currently significant short to medium term operational challenges in : 2)Stroke rehab on the BGH site is considered as part of BGH strategy. Interim arrangements include ward& bed based rehab, with longer term inpatient rehabilitation provision being scoped as part of CDU / Leri Day business case, due to be developed by December 2024.	Dec-24	Dec-24	Amber	10/01/2024 - No update via the AMaT system. 10/04/24 update on Amat- QIA for WGH site position re reopening of ward 11.
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~~ N/K	Red	10/01/2024 - No update via the AMaT system. 30/01/2024- Update via AMAT system - 30/01/2024 Roof covering requires major capital expenditure. surveys underway, business case to be developed. Expected April 2024 Temporary water collection system and drain divert created to enable full use of the space. Completed October 2023 Update 15/02/24 issues escalated, capital investment required to resolve, warranty being explored, and remedial actions and IPC being monitored in the meantime. Update 11/03/2024 AMAT Site inspection held with responsible contractor holding roof warranty, waiting on outcome report. Additional site inspections and costings for electronic leak detection system order to be placed on receipt of roof report. ETA April 2024
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R16. The health board must ensure that where oxygen is required that it is prescribed as appropriate	Memo to remind all staff that oxygen must only be administered if prescribed other than an in an emergency.	Nov-23	~~Nov-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Memo to remind staff to complete the Manchester triage tool pain assessment.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Retrospective baseline audit to be completed to determine compliance of use of Manchester triage tool pain assessment.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Spot checks to be completed weekly for 6 weeks to monitor compliance	Mar-24	~~Mar-24~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Quality Improvement team to complete pain RA audit to monitor compliance	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.

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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	To engage with clinical colleagues and specialist team to ensure that assessments & prescribing of analgesia is carried out in a timely manner.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R18. The health board must ensure that the sluice room and the area of the ED used by WAST colleagues is safe, secure and free of hazards at all times.	Memo to remind staff not to overfill Sharps box and poster to be displayed.	Oct-23	~~Oct-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
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)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R21. The health board must ensure that there is a system in place to identify to staff patients who require assistance eating or any dietary/allergen requirements.	Remind staff that allergen requirements are to be discussed with hotel services selection of daily menu choices.	Oct-23	~~Oct-23~~ N/K	Red	10/01/2024 - No update via the AMaT system
Nov-23	2023/24	Public Service Ombudsman (Wales)	202202950	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Louise O'Connor/ Luke Lenton	Director of Nursing, Quality and Patient Experience	N/A	R3. Should provide the Ombudsman's office with a copy of its complaints handling toolkit.		Apr-24	~~Apr-24~~ N/K	Red	Copy of the complaint handling toolkit. Due 10/04/24 03/05/2024- Compliance evidence sent to PSOW on 10/04/24, awaiting further contact from PSOW

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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	11/01/2024 - QAST Update = None 22/02/2024 - No further updates on AMaT 01/03/2024 - No further updates on AMaT
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	11/01/2024 - QAST Update = None 22/02/2024 - No further updates on AMaT 01/03/2024 - No further updates on AMaT
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	Recommendation not on AMaT
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	11/01/2024 - QAST Update = None. 01/03/2024 - No updates currently on AMaT
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	11/01/2024 - QAST Update = None. 22/02/2024 - Update taken from AMaT = Unable to complete. Midwives HEIW funded places secured - due to commence in Jan 2025
Feb-23	2022/23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	Low	R3. Management should undertake a lessons learnt review of the project following completion.	An interim lessons learnt exercise was undertaken in 2021. A Capital Governance Review was also undertaken in 2021 which has picked up on learnings from previous audit reports on the scheme. A lessons learnt exercise will be carried out 6-12 months after scheme completion in line with best practice.	Dec-24	Dec-24	Amber	16/03/2023- Lessons learnt review will take place when construction activity is complete. Target date December 2024. 08/01/2024 - Work has commenced on this exercise and a report will be presented to the Capital Sub-Committee in March 2024.
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	review complete with following findings: Outpatient waits have decreased, we currently have no one waiting longer than 52 weeks. Work is ongoing to achieve no patients longer than 32 weeks, which is almost achieved Access to ring-fenced beds remains unavailable on Picton ward GGH, Rhiannon Ward BGH and Ward 9 WGH due to wider system pressures outside of the service - involvement in working group for restablishment of elective baed pathway in WGH providing some solution, treatment room on picton currently protected from wider system pressures to preserve path way We have returned to pre COVID levels of main theatre allocation with the return of lost session in WGH, we continue to pick up around 2 – 6 sessions of backfill per week to facilitate our treatment back log and ongoing demand. The loss of 2 day theatre sessions in PPH has now been somewhat mitigated by the acess to 2 day case sessions in WGH day theatre unit on a temporary basis, the service is hoping that this can be retained going forward. 08/05/2024 - this is constrained by the ability to perform certain procedure that can be performed in the setting provided. full review of clinicians outpatient procedure basket that can be performed in out patients and will be performed, so that patients can be stream appropriately. review of equipment available in the out patient setting to ensure equity can be delivered across all sites. need to take the piton ward request to the wider system with a view to ring fence at least 4 beds. BGH currently no ring fence arrangements, will require further discussion with the wider system - completion aim date 12/2024 (Rec turned back Red at service's request)
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	We have a well established Endometriosis specialist nurse and have recently on boarded a Urogynaecology specialist nurse, both managing a caseload and will delivering weekly clinics in both specialities. We had funding agreed for a menopause specialist nurse/ Allied healthcare specialist, due to current financial pressures this has been frozen and will be out for recruitment should funds be released. The service is scoping the possibility for a Fertility specialist nurse and how this role would look. The service is currently scoping the pathway and funding for the nurse hysteroscopist role, with discussions with McMillan around supporting the funding of the role. discussion are ongoing with Aberystwyth university around providing a nurse hysteroscopy training programme within wales. Currently only offered in Bradford. 08/05/24 update - meeting as part of national task and finish group for nurse hysteroscopist training to look at national solution - 15/05/2024. review date set 09/2024 - aimed completion date -6/2026.
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	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	Sep-22	N/K	Red	Internal service demand and capacity review complete and updated weekly to understand performance against prediction. Work streams underway for complex endometriosis pathway with SBUHB, to develop clearly defined pathways for HDUHB patients with Complex Endometriosis. Bevan Exemplar project underway to develop one stop clinic and treatment pathway for patients with post HRT PMB. With working groups established for this plus pelvic mass one stop clinic and modelling gynae hubs for each acute sites. Work streams underway to further develop the pathway for complex menopause patients between primary care and secondary care services. And the development of a more sustainable menopause service.
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	Work has commenced to implement recent review of theatre list and session capacity, and changes to theatre operating list have began acordingly to ensure maximum utilisation in line with the GIRFT reconmendations. SBAR completed on impact of lack of ring fenced surgical beds across the health board is having on theatre capacity for patients requiring OVN stay post op, and how the lack of access to these beds is driving theatre session delays and patient cancellation, which as highlighted in the previous reconmendation response work is underway across the HB for solutions for this. Bevan Exemplar project underway to develop one stop clinic and treatment pathway for patients with post HRT PMB. With a view to providing a direct and intervention to test pathway for the patients identified on this pathway. Work to commence on further development of acute gynaecology services engagement in developing pathways which has led to generation of a one stop see and treat clinic for the longest wait cohort of urgent and routine patients. 08/05/24 update - continues as above, further development of one stop shop cancer diagnostic clinic implementation underway - review date 09/24 - aimed completion date 12/25
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	Endometriosis specialist nurse in post providing pathway for these patients, Also providing fertility support for patients on this pathway. Currently exploring issues with care of complex endometriosis patients with SBUHB. There is also currently a review underway in to demand and the possibility of expanding the endometriosis and fertility teams. Urogynaecology' specialist nurse appointed. Reintroduction of Urodynamic clinics across the health board to reintroduce this pathway fully for these patients. project underway to develop one stop clinic and treatment pathway for patients with post HRT PMB. With a view to providing a direct and intervention to test pathway for the patients identified on this pathway. Working groups in place to develop same model for pelvic mass and Gynae hubs across acute sites. update 08/05/24 - referral pathways no available in online directory for primary care, updated regularly. menopause service review and referal updates underway. aimed completion date 12/24

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	Currently limited engagement between service and existing pelvic health and existing women's health hub work streams. Acute gynaecology work streams to be taken and presented at next working group. Further development of menopause and PMB pathways to embed these services within the women's health hub and develop stronger links between primary and secondary care has begun. 08/05/24 - collective work in other recommendations around HVLC and nurse led services, with new clinic streams to steer and form potential health hub models - review date 12/204 - targeted completion date 06/26
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	SBAR complete on loss and lack of day case capacity, business case plan and engagement for funding underway to access this loss plus develop extra day case and L/A capacity, The speciality continues to back filling between 2 and 8 sessions per week where possible across the health board demonstrating we have capacity and demand to merit an uplift in allocated sessions. we now have provisional access to extra day case in WGH, Review of ambulatory and day case capacity complete in relation to cancer pathway performance and shortfalls in diagnostic procedure to ensure maximum utilisation is achieved to close the current gap. 08/05/24 update - work in to list utilisation complete, delivered at local meetings to re-, addition of local case to end of list to mitigate for anaesthetic cancellation. (No implementation date provided on AMaT)
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	Improved Utilisation of Aberglassney suite GGH to improve utilisation of ambulatory diagnostic and treatment procedure. To ensure capacity is maximised. As in recommendation 9 - business case plan and engagement for funding underway to access this loss plus develop extra day case and L/A capacity, cu A one stop clinic and treatment pathway for patients with post HRT PMB has commenced. In Cardigan integrated health centre. With a view to potentially accessing community treatment space in the Carmarthenshire hub which is due for completion summer 2024. 08/05/25 update - carmarthenshire hub now for completion 12/26, as outlined in previous recommendations work ongoing in patient clinic per condition - for review 09/24 - aimed completion 12/25
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	The loss of 2 day theatre sessions in PPH has left the service with only 2 day theatre sessions per week in GGH. As outlined in previous Recommendations we have received an uplift in equptment and have access to extra day case proivision and have began to map and implement extra sessions of activity. 08/05/24 update - review of last 12 months of activity to pull day case rates to ascertain current performance, requires engagement with clinical coding partners - review date 09/24 - aimed completion 03/25
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	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	Task and finish group has developed a work stream with clinical coding partners, to pilot streaming coding for procedures, work underway with common themes picked out. review of clinic return and patient outcome documentation, with a view to improving efficiency. This will make data extracted around diagnostics and procedure more streamlined an accurate, by eliminating duplication and mitigating potential error. beging a trail of changes to clinic outcome and returns sheet to improve data quality. 08/05/24 update - working group with clinical coding set up with aim to pilot new return forms and coding proceedure cleanse (no implementation date provided by service on AMaT)
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	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	Task and finish group has developed a work stream with clinical coding partners, to pilot streaming coding for procedures, work underway with common themes picked out. review of clinic return and patient outcome documentation, with a view to improving efficiency. This will make data extracted around diagnostics and procedure more streamlined an accurate, by eliminating duplication and mitigating potential error. beging a trail of changes to clinic outcome and returns sheet to improve data quality. 08/05/24 update - review of last 12 months of activity to pull day case rates to ascertain current performance, requires engagement with clinical coding partners - review date 09/24 - aimed completion 03/25
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	A Full review of lengths of stay related to the procedures outlined is required to further progress with this recommendation. Discussion with Clinical lead and medical workforce to be scheduled around the elements outlined in the recommendation in order to begin implementation. 08/05/24 update - review of previous 12 months of data to ascertain if within recommended 25% tolerance, if not targeted interventions to be put in place based on findings - aimed completion 12/24
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	Recommencing the 5day EPAU unit in WGH following a reduction in service during COVID, to begin 15/01/2023. Further development of nurse ultrasound scanning and prescribing underway, 1 fully qualified in both another in scanning and commencing nurse prescribing training. Wales Ultrasound Faculty lead in post with in the service, plans around further training to be developed further training for ultrasound scanning being provided for nursing workforce in BGH to develop a more sustainable emergency gynae and EPA service 08/05/24 - 2 new EPA nurses now in post, EPA clinical lead session post to be created and advertised to support, currently 7 day model not feasible, this is to be scoped further - targeted completion date - 03/2025
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	Job plan review	Mar-22	Jul-24	Red	Centre's Comments - PEC cover maintained for all cardiac centres. All PECs undertake sufficent clinical duties to meet the 20% desired contribution to CHD activity. All PECs participate in network activity. Review notes and actions 2023 - Aiming to move to green (see A15) Local database supports clinic's activity and helps provide evidence for monitoring/job plan development. 08/02/2024 - PEC cover maintained for all cardiac centres. All PECs undertake sufficent clinical duties to meet the 20% desired contribution to CHD activity. All PECs participate in network activity. By July 2024 PECS to have visits to tertiary centres.

											from a CSSC, for referrals to local services and for communication between health professionals.					
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	03/07/2023 - (Taken from DITS response pack June 2023): Peer review revisited in June 2023- updated position to be submitted to HB formally in next few weeks. CHD Network have advised that there is no HB action required at this time although we are mitigating the risk with the following actions: Transferring patients all have a detailed letter. There is no template currently in place. Health Board still awaiting receipt of the standardised national template. Unable to progress the recommendation until received, therefore status amended to External. In addition, access to "Cardiobase" for Cardiff- based cases has now been formally secured for all HD PECs to allow them to review care plans for CYP across the HB's. Follow-up report noted: Do join MDTs if appropriate. Related to all children. To note there is a Communication of Patient Information T&F Group.
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	June 2023 - Centre's comments: Unable to secure dedicated individual due to capacity issues within the adult team- however, one individual with interest continues to work closely to support PEC. Funding would be required to make this a directorate dedicated role. Review notes and actions 2023: x2 physiologists identified within adult department with interest in peadiatric physiology. In early stage of ECHO training. Action: (SC/LH) To investigate ECHO tec support available (underway). 07/02/2024 - Discuss with network, explore sources of funding and support from Adult cardiology services. Risk to be considered. Arrange meeting with Adult service SDM (Nick to do by July 2024). Overall rec = November 2024
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	A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group. There is an ambition to deliver psychology services from a local service perspective. There has recently been some successful recruitment to the psychology team -but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. NB: Pathway to UHW psychology provision is in place to support tertiary patients- and remains intact. 08/02/2024 - Cardiff have new psychologist in place, waiting list being addressed for tertiary pathways (most seriously unwell have access to the services). Complete for tertiary care. HB have commissioned psychology review from NHS Executive received Nov 2023. There is a gap in service. Health Psychology requirements are being considered as part of the review. SDM taking part in HB review. Pathway to UHW psychology provision is in place to support tertiary patients- and remains intact.
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	Review notes and actions 2023: Centre to await outcome of dental review and confirm rating. 07/02/2024 - Awaiting response from Dental service in Primary Care. Pathways do exist into Swansea/Cardiff for at-risk patients/needing surgical intervention. Local provision still awaiting response. Primary Care to be noted as supporting service - Associate Medical Director for Dental to provide update.
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	June 2023 - Work is underway across the Network to look into this issue. New Action: Network to link up audit evidence to include Helen Wallis' audit from 2019 patient lists.
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	Action: Service to link with transition nurse and map out how to reach full compliance within the next 9 months. 08/02/2024 - New consultant starts April 2024. Participation of adult cardiologist being explored. Risk of referrals for transition being lost now mitigated.

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)	Progress update/Reason overdue
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	High	R1. We found that there is no clear, overall implementation plan to support the Health Board's 10-year workforce strategy. The Health Board should ensure its refreshed workforce strategy is supported by a resourced implementation plan, which is clear about delivery priorities. There should be a Page 31 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health Board clear programme approach to delivery with outcomes set out so that progress and the impact of the plan's delivery can be effectively monitored.	The 10-year workforce strategy was developed in 2018-19 and is due to be refreshed to take account of the changing strategic context and challenges faced by NHS Wales i.e. Post COVID, Cost of Living Crisis etc and actions related to workforce shifted focus. There was an implementation plan aligned to our 10 Year Strategy covering the first 3 years, however, the development of people aligned to strategic intent is an iterative process, we evolved our approach as we matured and integrated workforce planning within our structures and built capability. The Strategic Workforce Implementation Plan was adapted through subsequent iterations of our Workforce Planning process/Annual Plan as we began to focus on the most critical gaps in our workforce i.e. Nursing Workforce Implementation Plan. The Nursing Workforce Plan has demonstrated progress and impact as per the metrics developed and monitored as part of our Performance Dashboard. We will continue to build on the work noted above and we will continue to define the shape of the workforce we feel is best placed to meet the agreed demands faced within the financial envelope available to the Health Board, as needed seeking efficient and effective resource utilisations in the short medium and long term. Multiple scenarios may be required.	Apr-24	~~Apr-24~~ N/K	Red	
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	
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	R3. We found that service leads generally understood their role in workforce planning but operational pressures did not allow them sufficient time to 'think strategically' to develop solutions. The Workforce Planning Team should develop a process to ensure services Page 32 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health Boardroutinely receive support with workforce planning, for example through adopting a workforce planning business partnering model.	WOD does not have a Business Partnering Model we have 3 distinct teams which deliver on supporting cultural development (ODRM's); our operational workforce colleagues who facilitate change (OCP processes) and the workforce planning team. We are working collaboratively across WOD and with service leads to test our approaches to supporting services in the short, medium and long term. An evaluation will be undertaken and a paper on value of approaches in March 2024.	Apr-24	~~Apr-24~~ N/K	Red	
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	R4. We found that the Health Board is strengthening workforce planning capability through a range of training initiatives, some of which are still in development. Training is central to ensuring staff have the capability to support good workforce planning, as such the Health Board should develop an evaluation framework to measure the success of its training programme.	The approach to evaluation is in progress and a report reflecting the approach and outcomes will be undertaken in line with recommendation and actions under R3 above	Apr-24	~~Apr-24~~ N/K	Red	
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	High	R5. We found that in the absence of a clear implementation plan supporting the 10-year workforce strategy, it is difficult to gauge the progress and impact of its delivery. We recognise that the Health Page 33 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health BoardBoard is refreshing its workforce strategy. But in the interim it should update the People Organisational Development and Culture Committee twice a year on: A. progress against the key outcomes for success outlined in the workforce strategy; and B. how actions are having an impact on reducing workforce risks, specifically by developing a set of measurable impact measures for the Workforce Strategy.	Please note commentary in relation to R1 above and references to gauging progress and impact. In the interim, specifically in relation to A: we will be appraising the PODCC committee and introducing SPPEG to the requirements of the workforce plans in progress and developing, which align to our current and evolving strategic approach and implementation plans. Specifically in relation to B, again this is in progress through a number of pieces of work on Workforce Risk Assessment & Intervention Framework; Development of Intelligence and Metrics linked to Workforce Performance and further organisational alignment to the HB's Benefit's Realisation Tool will be sought to ensure an integrated strategic & operational approach to workforce planning and measurement of impact.	Apr-24	~~Apr-24~~ N/K	Red	
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	High	R6. The Health Board benchmarks its workforce performance metrics with other health bodies in Wales, but there is potential to benchmark with similar bodies outside of Wales. The Health Board should look to other health organisations with similar demographics, geography, and challenges, both to benchmark performance and seek good practice.	The Health Board has undertaken scoping to assess relevant health organisations on a local and international scale, this is referenced in a number of HB documents. Further work is ongoing as part of continuous improvement to our approach to workforce planning.	Apr-24	~~Apr-24~~ N/K	Red	
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 April 2024

Report name	Lead Executive/Director	Number of recommendations	Final report received at
HIW IRMER- Diagnostic Imaging x-ray department Withybush Hospital January 2024	Director of Operations	9	
Internal Audit- Agency & Rostering March 2024	Director of Workforce & OD	3	Audit and Risk Assurance Committee
Internal Audit- Follow-up: Consultant Job Planning	Medical Director	3	Audit and Risk Assurance Committee
Internal Audit - Transforming Urgent & Emergency Care – Discharge Management Final Report	Director of Operations	6	Audit and Risk Assurance Committee
Internal Audit - RAAC Internal Major Incident Final Report	Director of Operations	1	Audit and Risk Assurance Committee
Internal Audit - Transforming Urgent & Emergency Care (TUEC) Final Report	Director of Operations	4	Audit and Risk Assurance Committee
Internal Audit - Cross Hands Health & Wellbeing Centre Final Report	Director of Strategy and Planning	10	Audit and Risk Assurance Committee
Internal Audit - Elective Waiting List Management: Single Cancer Pathway Final Report	Director of Operations	3	Audit and Risk Assurance Committee
Internal Audit - Glangwili General Hospital - Fire Precautions Phase 1 Final Report	Director of Operations	12	Audit and Risk Assurance Committee
Internal Audit - Standards of Cleanliness Final Report	Director of Operations	10	Audit and Risk Assurance Committee
MWWFRS- Letter of Fire Safety Matters Premises: Theatres Block 5 & Block 6. Second floor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Director of Operations	8	Health and Safety Committee

MWWFRS- Letter of Fire Safety Matters Premises: Template 17, (Pathology First Floor), Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Director of Operations	4	Health and Safety Committee
MWWFRS- Letter of Fire Safety Matters: Cardigan Integrated Care Centre, Rhodfa'r Felin, Cardigan, Ceredigion, SA43 1JX	Director of Operations	8	Health and Safety Committee
MWWFRS- Letter of Fire Safety Matters Premises: Block 5 FF, Library, Secretaries offices & Chapel, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	5	Health and Safety Committee
MWWFRS- Letter of Fire Safety Matters Premises: Block 5 GF, EBME, Physiotherapy, & CT Scanner, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	5	Health and Safety Committee
Peer Review- Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	Director of Operations	17	Quality, Safety and Experience Committee
PSOW- 202207759	Director of Operations	8	Listening and Learning Committee
PSOW- 202203963	Director of Operations	4	Listening and Learning Committee
Total: 18			

Reports closed on the Audit Tracker since ARAC April 2024

Report name	Lead Executive/Director
Audit Wales- Audit Wales ISA 260 and Letter of Representation 2022/23	Director of Finance
HIW- Clinical Review into the Death of a Service User in HMP Parc	Director of Operations
Internal Audit - Discharge Processes	Director of Operations/Director of Primary Care, Community & Long-Term Care
Internal Audit - Records Digitisation	Deputy Director of Operations
Internal Audit - Job Planning	Medical Director
Internal Audit - Follow-up: Records Digitisation Final Report March 2024	Deputy Director of Operations
Independent Review- Savings Governance Review	Director of Operations
Llais- West Wales Region Engagement Report (South Pembs Hospital report)	Director of Operations
Peer Review- Hywel Dda UHB Lung Report, issued January 2020	Director of Operations
PSOW- 202101889	Director of Nursing, Quality and Patient Experience
PSOW- 202203842	Director of Nursing, Quality and Patient Experience
PSOW- 202103161	Director of Operations
Total: 12	

Appendix 5

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales- Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	2	April 2024	2 - Awaiting service update via AMaT	Mental Health & Learning Disabilities	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Audit Wales- Review of Workforce Planning Arrangements	5	April 2024	5 - Awaiting service update via AMaT	Workforce & OD	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Primary Care Follow-up Review – Hywel Dda University Health Board	1	April 2024	1 - Original completion dates lapsed since previous meeting	Primary Care	A revised timescale for this recommendation, which pertains to setting a budget for Primary and Community Care for the year 2024/25, will be requested in readiness for the next report to ARAC in August 2024.
Community Health Council- Accident & Emergency Departments in the Hywel Dda Health Board area	2	April 2024	2 - Awaiting service update via AMaT from Estates	NQPE	Both recommendations are reliant on actions to be completed by Estates & Facilities and Procurement in order to progress with implementation. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.

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Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Community Health Council - Palliative End of Life Care	3	September 2023	Awaiting service update via AMaT	Ceredigion	Although this report is aligned to Ceredigion on AMaT, it is noted that actions are system-wide, with responsibility spanning the 3 Counties. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Delivery Unit- All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	1	March 2024	1 - Original completion dates lapsed since previous meeting	Mental Health & Learning Disabilities	This recommendation has now been noted as 'Fully Complete – Awaiting Approval' on AMaT. The Assurance and Risk Team are awaiting confirmation from Internal Audit as to whether this recommendation can be closed. Further updates to be reflected to ARAC in August 2024.
HEIW- Surgical Specialties Glangwili General Hospital	1 External	April 2024	1- External	Medical Director	This recommendation has been noted as 'external', as an action assigned to Health Education and Improvement Wales (HEIW) must be completed first before this recommendation can be progressed. Further progress updates will be reflected in the next report to ARAC in August 2024.

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Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW- Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022	1	March 2024	Awaiting service update via AMaT from Estates	Unscheduled Care (GGH)	This recommendation is currently awaiting completion of outstanding works by Estates & Facilities before it can be progressed. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
HIW - Mental Health Discharge Review	33	April 2024	33 - Awaiting service update via AMaT	Mental Health & Learning Disabilities	Since the data for this report was extracted, revised dates have been added against recommendations on AMaT, and will be reflected to ARAC in August 2024.
HIW- Prince Philip Hospital Minor Injuries Unit	1	January 2024	Awaiting service update via AMaT	Unscheduled Care (PPH)	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
HIW - Bronglais Hospital Maternity Unit	3	January 2024	Awaiting service update via AMaT	Women and Children's Services	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.

Appendix 5

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - National Review of Patient Flow – a journey through the stroke pathway	11	March 2024	11 - Awaiting service update via AMaT	Unscheduled Care (WGH)	The service rely on support from 5 other services in order to implement recommendations as raised within the report - Acute Services, Public Health, Therapies & Health Sciences, Strategic Performance Improvement, and Unscheduled Care - Stroke Services. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
HIW- St Non, St Caradog, Canolfan Bro Cerwyn WGH	4	April 2024	4 - Awaiting service update via AMaT	Mental Health & Learning Disabilities	Further progress updates are obtained from the service on AMaT, with updates to be reflected to ARAC in August 2024.
HIW - Emergency Department, Withybush General Hospital, Hywel Dda Healthboard.	5	March 2024	1 – Revised date lapsed 4 - Awaiting service update via AMaT	Unscheduled Care (WGH)	Progress updates and revised timescales are obtained from the service on AMaT, with updates to be reflected to ARAC in August 2024.
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November	1	September 2023	1 - Awaiting service update via AMaT	Radiology	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.

Appendix 5

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	2 – Revised dates lapsed 6 – Original completion dates lapsed since previous meeting	Strategic Development and Operational Planning	These recommendations are noted as 'external' as the service are unable to complete their actions until Welsh Government have made a decision on the submitted Strategic Outline Case (as agreed with Internal Audit). Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Internal Audit - Falls Prevention and Management	2 (1 External)	March 2024	1 – Revised date lapsed 1 – External	NQPE	1 recommendation relating to the development of a delivery plan for the Falls Strategy is being presented to the Clinical Education Governance Group (CEGG) Panel on 28 May 2024 for approval. IA have confirmed that following the submission of the proposal, they will review and advise whether it addresses the recommendation for closure. 1 recommendation has been noted as 'external', as the Health Board 'Falls Lead' (Quality Improvement Practitioner) is working with the 'All-Wales National Falls Task Force' to identify an e-learning training package. Once training package is ratified then it will be aligned to the internal Falls Strategy.

					Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Report	**Number of N/K Recs**	**Date rec became N/K**	**Reason rec is N/K**	**Service Area**	**Progress Update**
Internal Audit – Deprivation of Liberty Safeguards (DoLS) (August 2023)	2	March 2024	2 – Original completion dates lapsed	Long Term Care	The Assurance and Risk Team are awaiting confirmation from IA as to whether these recommendations can be closed. Progress updates will be reflected in the next report to ARAC in August 2024.
Internal Audit – Follow-up: Strategic Programme Governance	2	August 2023	2 – Original timescales lapsed	Strategic Development and Operational Planning	Ownership of recommendation was transferred to the Strategic Development and Operational Planning Directorate from Finance in April 2024 as agreed with the Director of Finance and Director of Strategy and Planning. Progress updates and revised timescales are currently being sought from the service, with updates to be reflected to ARAC in August 2024.
Internal Audit- Follow-up: Theatre Loan Trays & Consumables	1	March 2024	1 – revised completion date lapsed	Scheduled Care	The recommendation relating to the adoption of an alternative patient traceability solution has now surpassed the proposed timescale of March 2024 for completion.

					The Assurance and Risk Team will continue to seek updates and revised timescales for this report in readiness for the report to ARAC in August 2024.
Report	**Number of N/K Recs**	**Date rec became N/K**	**Reason rec is N/K**	**Service Area**	**Progress Update**
Internal Audit- Decarbonisation	1	March 2024	1 – revised completion date lapsed	Strategic Development and Operational Planning	This recommendation was included on the agenda for the Decarbonisation Taskforce Group (DTFG) meeting in March 2024. Progress update and revised timescale are currently being sought from the service, with updates to be reflected to ARAC in August 2024.
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.
Internal Audit- Transforming Urgent & Emergency Care (TUEC)	2	April 2024	2 – Awaiting timescales from service	Acute Services	The Head of Assurance and Risk is liaising with the Director of Secondary Care to obtain progress updates and completion dates for this report which was added to the tracker in April 2024, and will be reflected to ARAC in August 2024.

Internal Audit- Transforming Urgent & Emergency Care – Discharge Management	1	April 2024	1 – Awaiting timescale from service	Acute Services	The Head of Assurance and Risk is liaising with the Director of Secondary Care to obtain progress updates and completion dates for this report which was added to the tracker in April 2024, and will be reflected to ARAC in August 2024.
Report	**Number of N/K Recs**	**Date rec became N/K**	**Reason rec is N/K**	**Service Area**	**Progress Update**
Internal Audit- Waste Management	1 External	April 2024	1 – Original timescale lapsed	Estates	This recommendation is noted as 'external' as the service are unable to complete their actions until Waste Policy guidance (HTM 07 01) is updated at an All-Wales level.
NHS Wales Executive- Children and Young Person's Neurodevelopmental Services All Wales Review	1	April 2024	1 - Awaiting service update via AMaT	Mental Health & Learning Disabilities	The recommendation was discussed at a meeting in April 2024 where it was agreed that the Service Delivery Manager for Community Paediatrics and the Service Delivery Manager for Neurodevelopmental Services would work with the service to complete the actions. Progress update and revised timescale are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.

NHS Wales Cyber Resilience Unit- Cyber Assessment Framework Report	2 External	March 2024	2 - External	Digital	2 recommendations on this report cannot currently be progressed as the service is awaiting further input from NHS Wales Shared Services Partnership (NWSSP). It is anticipated that this report will be superseded by a more recent audit before the next ARAC in August 2024.
Report	**Number of N/K Recs**	**Date rec became N/K**	**Reason rec is N/K**	**Service Area**	**Progress Update**
Peer Review- Respiratory Cancer Review, issued June 2016	1	July 2016	1 – revised completion date lapsed	Unscheduled Care (PPH)	This recommendation will be closed on receipt of evidence from the Lead Officer that a strategic review has been undertaken, with relevant action plans in place if necessary. Risk 1655 - Risk of patient harm due to fragility of Lung Cancer Service is currently noted on the services' risk register which is associated with this recommendation, and has a current risk score of 6.
Peer Review- Colorectal Cancer (Third Cycle), issued January 2022	1	March 2024	1 – revised completion date lapsed	Cancer Services	The service are unable to provide a revised completion date for this recommendation as they are awaiting an update related to the A Regional Collaboration for Health (ARCH) programme to proceed. The Assurance and Risk Team will be seeking further progress updates and a revised completion date, to be reflected in the report to ARAC in August 2024.

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 for this recommendation 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.
Report	**Number of N/K Recs**	**Date rec became N/K**	**Reason rec is N/K**	**Service Area**	**Progress Update**
Peer Review - GIRFT - Gynaecology Review - September 2022	3	September 2022	3 – Awaiting service update via AMaT	Women and Children's Services	The report was originally received by the service in September 2022, but only recently added to the tracker in April 2024 (and therefore noted as a new report in Appendix 3). 3 recommendations are currently being progressed however have no timescales assigned and relate to a demand and capacity assessment to develop standardised pathways, an audit of theatre utilisation, and establishing procedures for data capture. The Assurance and Risk Team will be seeking further progress updates and revised completion dates where necessary, which will be reflected in the report to ARAC in August 2024.

Peer Review - Planning Arrangements in Hywel Dda University Health Board	2	March 2024	2 – original completion dates lapsed since previous meeting	Strategic Development and Operational Planning	The recommendations are in regard to the establishment of an operating model for managing and delivering change and the development of an effective means for strengthening and supporting planning by operational teams. Further updates and revised completion dates will be sought from the Lead Officer, to be reflected in the report to ARAC in August 2024.
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 awaiting receipt of 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 will be seeking further progress updates and revised completion dates, to be reflected in the report to ARAC in August 2024.

Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	7	April 2024	7 - Awaiting service update via AMaT	Mental Health & Learning Disabilities	Progress updates and revised timescales are required from the service on AMaT, with any updates to be reflected to ARAC in August 2024.

Appendix 5

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	1 External	December 2023	1 – revised timescale lapsed	Scheduled Care	The implementation of this recommendation is currently outside the gift of the Health as the service await the rollout of a national E-consent programme. Any further updates received will be reflected in the report to ARAC in August 2024.
Peer Review- GIRFT Ophthalmology Review	8	April 2024	7 – original completion dates lapsed 1 – revised completion date lapsed	Scheduled Care	Revised documentation and pathways are nearing completion for 6 of these recommendations, with potential completion dates discussed with several processes now awaiting review. 2 recommendations are unable to progress further at present. The action to separate theatre lists into cataract-only and glaucoma-only is not possible as some procedures can only be carried out at specific sites and cataract surgery is carried out to maximise theatre potential. The action to rationalise cataract surgery to high flow sites cannot be completed due to staffing constraints. Further progress and revised timescales will be sought by the Assurance and Risk Team to be reflected in the report to ARAC in August 2024.
PSOW- 202202950	1	April 2024	1 – original completion dates lapsed	Unscheduled Care (WGH)	Evidence of compliance was submitted by the service in May 2024, and currently awaiting confirmation from PSOW that this recommendation can be noted as complete.

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Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
PSOW- 202108316	2	March 2024	2 – original completion dates lapsed	Therapies	Evidence of compliance has been submitted to the Ombudsman in March 2024, and currently awaiting confirmation from PSOW that recommendations can be noted as complete.
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 in readiness for ARAC in August 2024.
Public Health Wales- Llwynhendy Tuberculosis Outbreak External Review	6 External	July 2023	6 - external	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 continue to request updates on this recommendation and will report any updates to ARAC in August 2024.

Appendix 5

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	5 (1 External)	March 2024	1 – External 4 – Revised completion dates lapsed	Director of Operations	The Head of Assurance and Risk is due to meet with the Head of Consent and Mental Capacity in order to obtain progress updates, which will be updated In the paper to ARAC in August 2024.
Welsh Risk Pool- Concerns Assessment	4	March 2024	4 - Awaiting service update via AMaT	NQPE	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in August 2024.
Total number of N/K Recs	**150**				