Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 June 2023
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

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Asesiad / Assessment

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

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

Improving Together sessions with directorates commenced in January 2023, which include reviewing progress against audit and inspection recommendations with Directorate leads. Updates are provided by way of table of actions generated from Improving Together sessions and via existing governance arrangements within Directorates.

HIW inspection activity, and the corresponding follow up to determine progress of recommendations raised, is undertaken and managed by the Quality Assurance and Safety Team with progress provided to the Assurance and Risk team for the Audit and Inspection Tracker.

Since the previous report, 12 reports have been closed or superseded on the Audit Tracker, and 18 new reports have been received by the Health Board, as detailed in Appendix 2.

As of 17 May 2023, the number of open reports has increased from 89 to 95. 32 of these reports have recommendations that have exceeded their original completion date, a slight decrease from the 33 reports previously reported in April 2023. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

Of the 156 recommendations noted as overdue, 26 of these relate to reports where formal management responses and timescales are due to be presented to the appropriate Board sub-committee in June 2023 (these are RAG rated red until timescales for implementation are known). There is an increase in the number of recommendations where the original implementation date has passed, from 115 to 126. The number of recommendations that have gone beyond six months of their original completion date has decreased from 56 to 42, as reported in April 2023. Details on these movements 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.

	Open reports at ARAC April 23	New reports since April 23	Closed reports since April 23	Open reports at ARAC June 23	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	4	1	0	5	3	5	2
CHC	4	0	0	4	3	8	2
CHC / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
Counter Fraud Authority	1	0	1	0	0	0	0
DU	6	1	1	6	2	6	5
HEIW	0	2	0	2	0	19	0
HSE	0	0	0	0	0	0	0
HIW	12	1	3	10	5	49	8
HTA	0	0	0	0	0	0	0
Independent Review	1	0	0	1	1	2	0
IA	23	8	3	28	11	28	13
Internal Review	0	0	0	0	0	0	0
MHRA	1	0	0	1	1	1	1
MWWFRS	23	0	0	23	1	0	0
NHS Wales Cyber Resilience Unit[3]	1	0	0	1	0	8	0
Peer Reviews	5	2	1	6	2	18	8
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	5	2	3	4	1	1	0
PHW	1	0	0	1	0	0	0
Royal Colleges	1	0	0	1	1	3	3
Other (External Consultant)	0	0	0	0	0	0	0
WLC	1	0	0	1	1	0	0
Welsh Risk Pool	0	1	0	1	0	4	0
TOTAL	**89**	**18**	**12**	**95**	**32**	**152**	**42**

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 These recommendations are not included on Appendix 1 due to the sensitive nature of the information.

There are currently **405 open recommendations** (an increase from 327 reported in April 2023) on the audit tracker. Appendix 2 details reports which have been added to the Audit and Inspection tracker since April 2023. Appendix 1 includes the 25 recommendations that are considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement. These recommendations are marked as 'External' in the RAG status column.

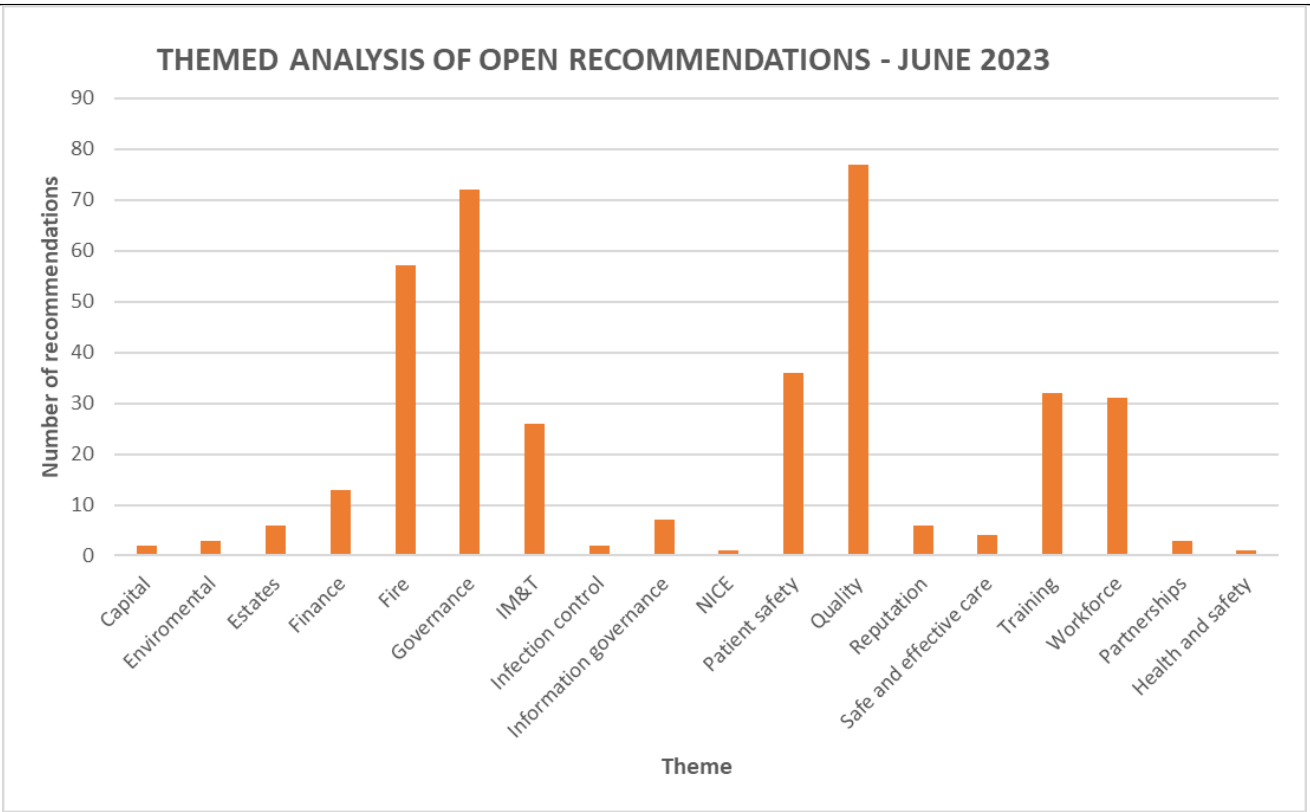
Appendix 1 does not include recommendations from HIW and CHC reports relating to inspections of independent contractors (i.e. GP and dental practices not managed by the Health Board). The practices remain directly accountable for implementing these recommendations.

There are 69 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported), an increase from the 47 previously reported. The increase is primarily driven by:

- 19 recommendations from 2 new HEIW reports that are awaiting management responses and timescales, which are to be presented at the People, Organisational Development & Culture Committee (PODCC) in June 2023;
- 7 recommendations from the Getting It Right First Time (GIRFT) Orthopaedic and that are awaiting management responses and timescales, which are to be presented at ARAC June 2023 respectively;
- 22 recommendations which have recently lapsed to N/K status since April 2023.

The individual recommendations are included in Appendix 3, which details the date at which recommendations became N/K, and the reason why they are N/K.

Below is a chart providing a thematic analysis for all open recommendations on the Audit and Inspection Tracker as at June 2023, and that the majority of recommendations relate to the themes of quality, governance and fire :



Audit Tracker Summary Per Service / Directorate

Below is a snapshot of the audit tracker activity split by service/directorate as at 17 May 2023, including trends since the last report to ARAC in April 2023. Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager.

The arrows included in the table below are as follows:

↑	Increase in number of recommendations / reports
↓	Decrease in number of recommendations / reports
↔	No change in number of recommendations / reports

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

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

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
Acute Services	2 ↑	1 →	11 ↑	4 →	3 →	• 1 New IA report on Service Reset and Recovery - 1 recommendation with a completion date of August 2023. • 1 HIW National Review on WAST - 4 overdue recommendations, 3 of which are overdue by more than 6 months. Revised timescales are being requested via the Quality Safety and Assurance Team. 6 recommendations with an 'External' status.
Cancer Services	1 →	1 →	2 ↓	2 ↓	2 ↓	• 1 Peer Review on Colorectal Cancer – 2 outstanding recommendations which are overdue by more than 6 months with revised completion dates of March 2024.
Cardiology	0 ↓	0 ↓	0 ↓	0 ↓	0 ↓	• 1 DU report closed on All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review.
CEO Office (Welsh Language)	1 →	1 →	2 →	2 →	2 →	• 1 follow-up IA report on Welsh Language Standards - 2 recommendations overdue by more than 6 months, with revised completion dates of July and September 2023.The Assurance and Risk Team are currently working with the Welsh Language service to support progression of this report, with an emphasis on developing action plans for the services to tackle non-compliance with Welsh Language standards.
Community – Carmarthen-shire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Community – Ceredigion (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Community - Pembrokeshire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Central Operations	2 →	1 ↓	19 ↑	4 ↓	3 ↓	• 1 new Peer Review on Out Of Hours – 1 recommendation where completion date has recently lapsed, and 15 recommendations on schedule with completion dates ranging to December 2023. Report supersedes the previous 2019 Out of Hours Peer Review, which has been closed. • 1 IA report on Records Management – 3 recommendations overdue by more than 6 months with revised completion dates of May 2023 and March 2024. A further IA review is due to take place for Records Management in 2023/24. This will be confirmed in the IA Plan 2023/24.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
Digital and Performance	5 ↑	1 →	33 ↑	15 ↑	0 →	• 1 new IA report on Fitness for Digital – Use of Digital Technology with 9 recommendations – 2 recommendations are overdue with no revised completion dates. • 1 new IA report on Records Digitisation – 4 recommendations with completion dates between July and December 2023. • 1 report by NHS Wales Cyber Resilience Unit on Cyber Assessment Framework - 12 recommendations (all of which are split into sub-recommendations), 8 of which are overdue with revised completion dates between June 2023 and July 2024. 1 recommendation noted as 'external'. Progress of these recommendations are monitored via SRC In-Committee bi-monthly. • 1 IA report on IT Infrastructure - 6 recommendations, 3 of which are overdue, with revised completion dates of June and December 2023. 1 recommendation noted as 'external'. The Assurance and Risk Team are working closely with the Head of Digital Business & Engagement to coordinate responses from the Digital service leads with the aim of progressing these reports and setting realistic revised timescales ahead of the next ARAC. • 1 IA report on Cyber Security - 2 recommendations noted as complete, and awaiting confirmation from IA to close the report.
Director of Operations	2 ↑	1 →	11 ↑	5 ↑	0 ↑	• 1 new WRP report (A National Review of Consent to Examination & Treatment Standards in NHS Wales) – 9 recommendations of which 1 is overdue, 3 are awaiting timescales to be confirmed by the Head of Consent and Mental Capacity, and 5 on schedule with varying timescales to October 2023. • 1 AW Review of Quality Governance Arrangements – This has been reassigned to Director of Operations due to nature of outstanding recommendations and their ownership - 2 recommendations remain outstanding, 1 of which has an 'External' status.
Estates	28 ↑	2 ↓	74 ↓	2 ↓	1 ↓	• The number of recommendations has decreased slightly from 75 to 74 (20 of these recommendations are from 5 IA reports, with remainder from the 5 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)). • The number of overdue recommendations has reduced from 8 to 2, due to 4 recommendations relating to fire management plans from LOFSMs being implemented, and 2 recommendations from the IA WGH Fire Precautions Works: Phase 1 August 2022 report being implemented. • 1 new IA Withybush General Hospital - Fire Precautions Phase 1 report with 10 recommendations with varying timescales to February 2024. All MWWFRS recommendations overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
Finance	1 →	0 →	2 ↑	0 ↓	0 →	• 1 new IA report on Regional Integration Fund – 2 recommendations with completion dates of June and July 2023. • 1 Counter Fraud Authority report closed on Covid-19 Post Event Assurance Report.
Governance	2 →	1 ↑	6 ↓	4 ↑	0 →	• 1 Independent Review on Governance and Decision Making in relation to Bluestone Field Hospital – 2 open recommendations with revised completion dates ranging to November 2023. • 1 AW report on Structured Assessment 2022 - 4 open recommendations, with two on schedule for completion by December 2023 and March 2024. 2 recommendations are overdue, and currently awaiting progress update from a supporting service to determine revised timescales.
Medical	3 ↑	0 →	14 ↑	0 →	0 →	• 1 new IA report on Job Planning - 7 recommendations with completion dates between July and December 2023. • 1 PHW report on Llwynhendy Tuberculosis Outbreak External Review - 7 recommendations, 1 of which is owned by the Health Board and has a completion date of June 2023, and 6 'external' recommendations being led by PHW. • 1 IA report on Individual Patient Funding Requests - 1 recommendation noted as complete and awaiting confirmation from IA to close the report.
Medicines Management	1 →	1 →	1 ↓	0 ↓	0 ↓	• 1 AW report on Medicines Management in Acute Hospitals - 1 'external' recommendation.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
MH&LD	11 ➔	6 ➔	76 ➔	14 ➔	6 ➔	• 1 New DU report on Review of Psychological Therapies in Wales - 7 recommendations with varying timescales to December 2023. • 1 new HIW report on Mental Health Discharge Review - 38 recommendations with varying timescales to March 2024. • Total number of recommendations which have passed their original completion date has reduced from 19 to 14. • The details of recommendations that have passed their original completion dates are below: ○ CHC report on S-CAMHS – 2 recommendations, 1 of which is overdue with a revised completion date of June 2023. ○ IA on Prevention of Self Harm (Follow up report) – 2 recommendations overdue by more than 6 months, with revised completion dates of June 2023. ○ DU report on All Wales Assurance Review of Crisis and Liaison Psychiatry Services for Adults – 1 overdue recommendation. Since the numbers were run off for this report this overdue recommendation has been implemented, which will be reflected in the next Audit tracker paper in August 2023. ○ HIW National Review of Mental Health Crisis Prevention in the Community – 4 recommendations overdue, of which 2 by more than 6 months. ○ HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months. Revised completion dates of May 2023 have recently passed, and updates will be requested via the QAST team, which will be reflected in the next Audit tracker paper in August 2023. ○ HIW Bryngofal Ward – Prince Phillip Hospital, Issued October 2022 - 4 recommendations have passed their original completion dates, with revised dates of June and July 2023. • AW report on Review of Mental Health and Learning Disabilities Directorate Governance Arrangements – 6 recommendations with completion dates ranging from June 2023 to March 2024. • 1 DU report on All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults - 4 recommendations with completion dates ranging from May 2023 to March 2024. • 1 DU report on All Wales Review of Primary & Secondary Mental Health Services for Children & Young People - 5 recommendations with completion dates ranging from July to December 2023.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
NQPE	8 ↑	2 ↑	19 ↑	10 ↑	0 →	• 2 new IA reports: o Patient Experience - 3 recommendations on schedule with completion dates to July 2023. o Safety Indicators – Pressure Damage and Medication Errors – 4 recommendations, 2 of which have recently become overdue, and 2 on schedule with completion dates to July 2023. • 1 new PSOW report – 202101488 - 2 recommendations on schedule, with completion dates of June and August 2023. • 1 CHC report on Accident & Emergency Departments - 5 recommendations, of which 3 are overdue (Assurance and Risk Team are clarifying with the service if these recommendations have been implemented) and 2 on schedule with completion dates to June 2023. • 1 IA report on Falls Management – 4 overdue recommendations with revised completion dates ranging from June to July 2023. • 1 IA report on Quality and Safety Governance - all recommendations confirmed by the service as implemented, and currently awaiting IA approval for closure of the report. • 2 PSOW reports: o 202002558 – 4 complete recommendations. Evidence has been submitted to PSOW and currently awaiting confirmation to close. o 202003189 – 1 overdue recommendation and awaiting ratification from PSOW.
Pathology	1 →	1 →	1 →	1 →	1 →	• 1 MHRA report for WGH - 1 outstanding recommendation overdue by more than 6 months, with a revised completion of September 2023.
Primary Care, Community and Long Term Care	4 ↑	3 →	14 ↑	6 →	5 →	• 1 new PSOW report with 5 recommendations with timescales ranging to August 2023. • 1 IA report on Continuing Healthcare and Funded Nursing Care - 1 overdue recommendation with a revised completion date of June 2023. • 1 IA Discharge Processes report - 2 'external' recommendations and 5 overdue by more than 6 months. IA will be undertaking a review of discharge processes by the end of Quarter 3 2023/24, which will follow up on the recommendations made in this report. In the interim, the Assurance and Risk Team will seek clarity on the current status of the recommendations. • 1 WLC report – 1 'external' recommendation.
Public Health (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present* .
Radiology	1 ↓	0 ↓	17 ↓	12 ↑	0 →	• 1 HIW IRMER report GGH – 17 outstanding recommendations, 12 of which are overdue with revised timescales of June 2023. • 1 HIW IRMER report WGH closed.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
Scheduled Care	5 ↓	2 →	16 ↓	15 ↓	9 ↑	• 1 Peer Review on Getting It Right First Time (GIRFT) Orthopaedic Review – 7 outstanding recommendations with management responses being presented to ARAC in June 2023, after which the tracker will be updated. The RAG status of these recommendations will remain red until management responses, recommendation owners and timescales are confirmed. • 1 CHC report – 3 recommendations overdue by more than 6 months, 2 of which have revised timescales of June 2023 and 1 with an unknown timescale, and noted as 'external'. • 2 DU reports – 5 recommendations overdue by more than 6 months, with no revised completion dates. • 1 HIW report - 1 recommendation which is overdue by more than 6 months with a revised completion date of June 2023. • 1 PSOW report 202102801 closed.
Strategic Development & Operational Planning	4 →	2 →	24 →	2 →	2 →	• 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangements - 2 recommendations overdue by more than 6 months (reopened in December 2022 following AW Structured Assessment 2022), with revised completion dates of March 2024. • 1 IA report on A Healthier Mid & West Wales Programme - 16 recommendations, with completion dates ranging from May 2023 to January 2024. • 1 IA report on Decarbonisation - 2 recommendations on schedule with completion dates of January and March 2025, and 3 'external' recommendations. • 1 IA report on Glangwili Hospital Women & Children's Development - 1 recommendation with a completion date of July 2023.
Therapies (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
USC BGH	2 ↑	1 →	15 ↑	15 ↑	3 →	• 1 new HEIW report on General Internal Medicine Bronglais Hospital - 12 recommendations for which management responses are being presented to People, Organisational Development and Culture Committee (PODCC) in June 2023, after which the tracker will be updated. The RAG status of these recommendations will remain red until management responses, recommendation owners and timescales are confirmed. • 1 RCP report - 3 recommendations overdue by more than 6 months. 1 recommendation with revised completion date of March 2024 and 2 with no revised completion dates. • A meeting took place in April 2023 between the Assurance & Risk Team, General Manager and Hospital Services Manager regarding the RCP report and it has been confirmed that a report on the Postgraduate education centre will be presented to the Director of Operations to establish if the recommendations can be closed.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
USC GGH	2 →	1 →	16 →	15 ↑	0 →	• 1 HIW report on the Emergency Unit at GGH – 1 recommendation on schedule for completion by September 2023 and 14 recommendations have recently become overdue with no revised completion dates. Awaiting clarification from the service, via the Quality Assurance and Safety Team, that these recommendations have been implemented. • 1 IA report on GGH Directorate Governance review - 1 overdue recommendation, with evidence to be submitted to Internal Audit which will demonstrate implementation of the recommendation and close this report. Until confirmation received from IA that they are satisfied, the recommendation timescale is currently noted as not known (N/K).
USC PPH	2 ↑	0 →	2 ↑	2 ↑	2 ↑	• 1 Peer Review Lung Report, issued January 2020, has been added to the audit tracker - 1 recommendation overdue by more than 6 months without a revised timescale (N/K). The Assurance and Risk Team are liaising with the service to obtain a revised timescale. • 1 Peer Review on Respiratory Cancer – 1 recommendation overdue by more than 6 months, with the revised timescale currently not known (N/K). • A risk regarding the fragility of service has been added to Datix which reflects the challenges in implementing the recommendations above.
USC WGH (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Women & Children	7 →	4 →	30 →	24 ↑	3 ↓	• 1 new HEIW report on Obstetrics and Gynaecology Glangwili Hospital – 7 recommendations for which management responses are being presented to People, Organisational Development and Culture Committee (PODCC) in June 2023, after which the tracker will be updated along with recommendation owners and timescales. • 1 CHC report on Babies and Births in Hywel Dda – 4 recommendations, 2 of which are overdue with revised completion dates of June and July 2023. • 1 IA report on Glangwili Hospital - Women & Children's Development – 1 overdue recommendation currently awaiting a revised completion date, and 1 recommendation on schedule for completion in December 2024. • 1 IA report on Glangwili Hospital Women & Children's Development, issued April 2022 - 1 recommendation classified as 'external'. • 1 HIW report on Glangwili – Maternity Services – 7 overdue recommendations, 2 with no revised completion dates. The QAST team are obtaining updates from the service via AMAT. • 1 HIW report on Angharad Ward, Bronglais Hospital – 1 overdue recommendation with no revised timescale, which is being requested by the QAST team, and 1 recommendation which is on schedule for completion in June 2023. • 1 Peer Review – 7 recommendations, 6 of which are overdue by more than 6 months with revised completion dates of October 2023. 1 'external' recommendation. • 1 PSOW report 202100614 closed since the previous meeting.

Service	Open reports as at May 23	Overdue reports As at May 23	Total number open recs May 23*	Total overdue (red) recs May 23	Of which overdue by more than 6 months	Comments
Workforce & OD	0 ↓	0 →	0 →	0 →	0 →	• 3 IA reports closed on Medical Staff Recruitment, Non-Clinical Temporary Staffing and Overpayment of Salaries.
Total	**95**	**32**	**405**	**152**	**42**	

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

Services with improved performance

Mental Health and Learning Disabilities

There has been an improved performance within the Directorate since April 2023, with the total number of recommendations overdue reducing from 19 to 14, of which those overdue by more than 6 months also reducing from 9 to 6. In addition, 2 HIW reports have been closed since the previous meeting.

Women and Children

While the total number of overdue recommendations has increased from 17 to 24 since the previous meeting, it is noted that this is due to the new HEIW report on Obstetrics and Gynaecology Glangwili Hospital, where the 7 recommendations as raised in the report will have management responses presented to PODCC in June 2023. The RAG status of these recommendations will be amended once management responses and timescales are confirmed. The total number of recommendations overdue by more than 6 months has decreased from 6 to 3 since April 2023.

Argymhelliad / Recommendation

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

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

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

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
AW_295A2015	Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Jenny Pugh-Jones	Director of Primary Care, Community & Long Term Care	AW_295A2015_002	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	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.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	AW_2360A2021-22_001	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	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 - 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.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	AW_2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	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	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 as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - 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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b3	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could 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	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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b4	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~~ N/K	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
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_004	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 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.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_002	High	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 associatedgovernance arrangements progresses as a matter of urgency.	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	Amber	
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_004	High	The Health Board has not set out expected outcomes for all its planning objectives set out in its Annual Plan. In revising its planning objectives for 2023-26, the Health Board needs to clearly articulate the expected outcomes for its streamlined set of planning objectives.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Mar-23	~~Mar-23~~ N/K	Red	01/06/2023 - This has been completed. There has been a revised approach to the overall Planning Process and a streamlining in the Planning Objectives (POs) from circa 80> to 23 POs. Currently awaiting clarification if all POs have expected outcomes prior to formally closing the recommendation on the tracker.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_005	High	Implementation plans to support corporate enabling strategies did not always exist or include clear milestones, targets, and outcomes. The Health Board needs to ensure: • existing implementation plans include clear milestones, targets, and outcomes; and • implementation plans are developed for enabling strategies that currently do not have one. Alongside the monitoring of relevant individual planning objectives, this will enable periodic review of overall progress of delivery of the enabling strategies.	This is being incorporated into the annual plan for 2023-34 and a revised planning cycle approach.	Mar-23	~~Mar-23~~ N/K	Red	01/06/2023 - The Annual Plan followed a revised planning cycle approach. The key principles were set out congruent to the R5 recommendation. Moreover, this approach was consistent with the expectations from WG, namely, the format of the Ministerial templates required trajectories, which were underpinned with milestones and actions. Currently awaiting clarification in terms of implementation plans prior to formally closing the recommendation on the tracker.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_006	High	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	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
AW_3507A2023	Feb-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	AW_3507A2023_001a1	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a)Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b)Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	To undertake a review of the BPPAG Terms of Reference (TOR), and establish sub-groups where appropriate, who will provide Exception Reports to BPPAG, ensuring the relevant escalation of key operational matters to be discussed within the forum.	Sep-23	Sep-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_001a2	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a)Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b)Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	To undertake annual reviews of the planned BPPAG agendas, ensuring that strategic and operational plans are discussed and monitored at the appropriate time.	Sep-23	Sep-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_001a3	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a)Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b)Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	To ensure that updates to the Table of Actions (TOAs) arising from previous BPPAG meetings are provided in writing in advance of the meeting to ensure appropriate time management of meetings.	Sep-23	Sep-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_001b	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a)Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b)Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	Matters of concern raised in BPPAG are escalated to the Director of Operations' Senior Operational Business (SOB) meetings, which are held monthly. Matters requiring the attention of Board or its committees can be discussed in this forum, and advised on the appropriate escalation route required. Matters of concern are also discussed via the recently implemented Improving Together sessions, which are attended by Executives and Directorate Senior Management.	Sep-23	Sep-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_002a	N/A	R2. There is uncertainty within the Directorate of the thresholds for escalation of risks and issues, which could affect the ability of the Board to be assured. The Health Board should work with the Directorate to improve its understanding of the escalation and deescalation of risks.	The Directorate is supported by the Assurance and Risk Team in the formal processes and procedures in terms of the escalation and de-escalation of risks by providing training to relevant staff within the Directorate, and providing regular risk updates to both BPPAG and QSE meetings. Directorate to define thresholds and/or performance metrics in order to assist in the escalation and de-escalation of risks.	Sep-23	Sep-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_002b	N/A	R2. There is uncertainty within the Directorate of the thresholds for escalation of risks and issues, which could affect the ability of the Board to be assured. The Health Board should work with the Directorate to improve its understanding of the escalation and deescalation of risks.	Directorate to implement the defined thresholds and/or performance metrics in order to assist in the escalation and de-escalation of risks, with training to be provided to relevant staff, supported by the Assurance and Risk Team.	Dec-23	Dec-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_003	N/A	R3. The Directorate has acted upon previous reviews and made progress in improving its risk management arrangements, however, the quality of information contained on the risk register needs improving. The Directorate should ensure the Directorate risk register contains clear mitigating actions, milestones and expected outcomes.	Risks are reviewed monthly by Heads of Service within the Directorate, supported by their Business Managers, and are reported at every BPPAG and QSE meeting within the Directorate. Risks are also discussed and challenged by the recently-implemented Improving Together sessions, which are attended by Executives and Directorate Senior Management. Directorate to hold a "risk workshop" in order to review and challenge where necessary the existing risks on the risk register to ensure mitigating actions, milestones and expected outcomes are clearly articulated.	Jul-23	Jul-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_004a	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	Dec-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_004b	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.	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	Dec-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_004c	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 plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_004d	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	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_005a1	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.	The Health Board routinely conducts staff surveys. The Directorate to undertake Directorate-specific surveys in order to inform future staff engagement plans, and to highlight any concerns which staff may have requiring the attention of Directorate senior management.	Dec-23	Dec-23	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_005a2	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	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_005b	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-23	Amber	

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AW_3507A2023	Feb-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	AW_3507A2023_005c	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	Amber	
AW_3507A2023	Feb-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	AW_3507A2023_006	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	Dec-23	Amber	
CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Digital and Performance	Carly Hill	Director of Operations	CHC_ECSIW0320_005	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~~ N/K	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 25/08/2020 update- still awaiting national roll out as part of national work stream. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 08/10/21- further national delays to the roll out of EPR due to network concerns. 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.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_001	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~~ June-23	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 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.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Carly Hill	Director of Operations	CHC_ECSIW0320_002	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	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 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.
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_003c	N/A	R3. The Health Board to look at the waiting areas and to provide comfortable seating for patients who have to wait hours. To provide water coolers, cups and vending machines.	WG have provided capital funds to enhance the experience in A&E. Progress on this is to be through Capital Monitoring Group	Mar-23	~~Mar-23~~ N/K	Red	28/11/2022 - Capital finds have been agreed actions being taken forward through General Managers through each site. All General Managers aware of bids will oversee progress against actions. 21/04/2023 - This recommendation has been implemented in GGH; BGH in processs to be completed
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_004b	N/A	R4. Toilet cleanliness needs addressing with regular cleaning schedules	Spot check audits of schedules and time cleaned	Dec-22	~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ N/K	Red	28/11/2022 - To be considered as part of core audits. 10/03/23 - Ad Hoc assurance check to be undertaken led by the IPC team and reported back by 31/03/23
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_005a	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	Amber	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
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_005b	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	There are patient designated parking areas which are patrolled by car parking attendants. Staff parking in these areas are issued with a parking fine.	Jun-23	Jun-23	Amber	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
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_006b	N/A	R6. Ensure patients are made aware at reception they can discuss their need in private and not in front of a waiting room of people.	WG funding has been agreed and booths are being considered in reception area on the BGH site.	May-23	May-23	Amber	28/11/2022 - This work will be overseen by the capital monitoring group.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
CHC_AEDHDHBA1122	Nov-22	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	CHC_AEDHDHBA1122_007b	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~~ N/K	Red	28/11/2022 - Funding agreed awaiting screens.
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_001f	N/A	R1. Provide much more post-natal support for mums on the ward. Whilst mums who have had babies before or who have had normal deliveries may feel well supported, other mums with different kinds of births want more help to recover from their delivery. This includes managing to care for their new-born and in establishing breastfeeding. Aparticular focus needs to be given to first time mums, those with caesarean or unexpected types of deliveries.	Birth rate Plus Ward acuity tool to be commenced in January 2023 – one month bedding in phase to support understanding levels of acuity to ensure appropriately staffed to the level of activity.	Jan-23	~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ Jul-23	Red	15/03/2023 - Delay start for the tool due to training requirements of staff new date April 30th if Birthrate plus can deliver the training in the agreed timescales. We are dependent on the external company for this. 16/05/2023 - Notification from Welsh Government regarding a delay in ward based acuity tool due to Birthrate Plus upgrade, therefore a revised completion date provided of July 2023.
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_002b	N/A	R2. Use feedback from mums and families in discussions with staff, as these provide specific instances of good and bad communication. There were many examples of good communication on CHC's findings but also times when there was a lack of empathy and compassion.	We actively seek our women and families feedback through the use of surveys to inform and improve services. We publish and you said we heard response to these.	Apr-23	~~Apr-23~~ ~~N/K~~ Jun-23	Red	Surveys – Antenatal, Labour, Postnatal and Induction of Labour have been completed – 2 have been shared with the public the final 2 anticipated Spring 2023 16/05/2023 - awaiting new presentation date at the Listening and Learning Committee as this had been previously missed, therefore revised completion date provided of June 2023
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_002c	N/A	R2. Use feedback from mums and families in discussions with staff, as these provide specific instances of good and bad communication. There were many examples of good communication on CHC's findings but also times when there was a lack of empathy and compassion.	Scope the availability of Emotional Intelligence training and education.	Jun-23	Jun-23	Amber	HB Culture and People Team are scoping this for our service.
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_003a	N/A	R3. Review the communication and advice given to mums during their pregnancy, delivery and after delivery, to provide better consistency. Whilst written information may be available on the wards and should continue to be available, potentially an 'app' that mums can access on their phones or devices will avoid the need to look for information on the wards, when staff appear to be busy. Information on an app can also be updated quickly and added to as women share their experiences about using maternity services. Alternatively, being able to access short videos, explaining what to expect on the ward could be helpful and might reduce the need to read lots of paper based information.	Public Health Wales are reviewing the Baby Bump and Beyond Book issued in pregnancy in conjunction with the 7 Health Boards in Wales. This is anticipated to be available in the Summer of 2023.	Aug-23	Aug-23	Amber	
CHC_BBHD_1222	Dec-22	CHC	Babies and births in Hywel Dda	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	CHC_BBHD_1222_004c	N/A	R4. Many mums want to breastfeed their babies but need more help on the ward and after discharge home. A further investment in breastfeeding support could help mums establish breastfeeding, continue with breastfeeding when they go home and receive support that could allow them to extend the length of time that they breastfeed.	Recruitment of 3 community based Public Health Care Assistants	Aug-23	Mar-24	Amber	In progress, compliance expected March 2024 – rolling programme throughout 2023 – 2024.Compliant with annual mandatory Infant Feeding updates for all maternity staff. Options to employ Band 4 NNEB (5.69wte) for the postnatal ward considered
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004a	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	S-CAMHS will ensure all GP Clusters are provided with the S-CAMHS Service Specification to ensure awareness of service function and referral pathways.	Mar-23	~~Mar-23~~ Jun-23	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed revised implementation date of June 2023.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004b	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	The S-CAMHS website will be updated and available to provide additional information and advise.	Mar-23	~~Mar-23~~ Jun-23	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed revised implementation date of June 2023, due to dely in updating the website.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_004c	N/A	R4. Better information and knowledge of the support available from CAMHS to be displayed by primary care and other healthcare providers	The PMH Service Manager will attend monthly GP Cluster meetings where service developments and any key issues can be raised and addressed. We have shared new innovations and service developments via these meetings and will consider developing new literature to share information.	Mar-23	~~Mar-23~~ Jun-23	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed revised implementation date of June 2023.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005a	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will ensure Implementation of the Code of Practice for Autism.	Jun-23	Jun-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track for June 2023 implementation.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005b	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will contribute and implement further service support ,interventions and developments in line with the Welsh Government Neurodivergence Improvement Plan	Jun-23	Jun-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track for June 2023 implementation.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005c	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will continue to support the Regional Partnership Board in the delivery of improved services.	Jun-23	Jun-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track for June 2023 implementation.
CHC_SCAMHS_0123	Jan-23	CHC	S-CAMHS	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	CHC_SCAMHS_0123_005d	N/A	R5. Improvement in the services, support, and interventions offered to neurodivergent children and young people and their parents or carers.	S-CAMHS will ensure the workforce receives specific training on ASD and related Neurodevelopmental disorders.	Jun-23	Jun-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track for June 2023 implementation.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_007	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	N/K	~~Apr-22~~ ~~Oct-22~~ ~~Nov-22~~ N/K	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.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_FOAR0116_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	~~Mar-23~~ ~~Apr-23~~ N/K	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
DU_AWRPTDECM 0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM 0919_002	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~~ N/K	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.
DU_AWRPTDECM 0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM 0919_004	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~~ N/K	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.
DU_AWRPTDECM 0919	Sep-19	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	DU_AWRPTDECM 0919_006	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~~ N/K	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.
DU_AWARCLPSA 0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0 322_005a	N/A	R5a. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	The Health Board is currently developing a new assessment form, which will incorporate a section on risk, and safety, to ensure this, is completed at point of assessment.	Dec-22	~~Mar-23~~ May-23	Red	03/05/2022 - PAS team are assisting the Directorate with providing management responses to these recommendations, and corresponding timescales. Tracker to be updated on receipt of information 20/05/2022 - confirmation received from the PAS team that they are continuing to support the directorate in formulating responses and they are currently in draft and awaiting sign off. 02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- Patient Safety and Assurance Team confirmed revised completion date of 30/05/2023.The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 16/02/2023- Lead Officer confirmed the introduction and implementation of the new assessment document has been delayed. Revised date of May 2023 provided. 04/04/2023- Head of Service (Adult Mental Health) confirmed recommendation on track for revised May 2023 date.
DU_AWARCLPSA 0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0 322_005b	N/A	R5b. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clear process to be identified in both Liaison and CMHC SOP about recording of risk and safety plan.	Dec-22	May-23	Red	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023. 04/04/2023- Head of Service (Adult Mental Health) confirmed recommendation on track for revised May 2023 date.
DU_AWARCLPSA 0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0 322_005c	N/A	R5c. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	6 Monthly audit of patient risk assessments to be completed by team managers to review quality.	Dec-22	May-23	Red	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023. 04/04/2023- Head of Service (Adult Mental Health) confirmed recommendation on track for revised May 2023 date.
DU_AWARCLPSA 0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0 322_005d	N/A	R5d. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Clinician to attend WARN and Storm training	Dec-22	May-23	Red	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023. 04/04/2023- Head of Service (Adult Mental Health) confirmed recommendation on track for revised May 2023 date.
DU_AWARCLPSA 0322	Mar-22	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Mental Health	DU_AWARCLPSA0 322_005e	N/A	R5e. The Health Board must ensure processes are in place to deliver quality improvement in the standard of record keeping and recording of risk and safety, and establish routine communication of assessment and intervention outcomes to referrers.	Process for sharing assessment and intervention outcomes are currently being developed by Team managers to ensure a consistent and timely approach with the sharing of information with refers.	Dec-22	May-23	Red	02/08/22 - confirmation from head of service that recommendations are continually being monitored, and that progress updates have been sought by the Patient Safety and Assurance Team. 16/01/2023- The new service specification has detailed and clear processes and standards of documentation, record keeping and risk management and communication with primary care colleagues. This is due to reviewed in Written Control Document Group in March 2023 for approval. This plan, once approved, is then due to be rolled out to services. 07/02/2023- on track for May 2023. 16/02/2023- Lead Officer confirmed this recommendation is on track for May 2023. 04/04/2023- Head of Service (Adult Mental Health) confirmed recommendation on track for revised May 2023 date.
DU_AWRPSMHS1 122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1 122_001a	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	HDUHB will undertake a review of the Health Board Part 1 Scheme in collaboration with partner agencies (LA) and commissioned services to ensure the service is aligned to the MH Measure.	Dec-23	Dec-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for impementation by December 2023.
DU_AWRPSMHS1 122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1 122_001b	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	S-CAMHS will contribute to the update ensuring all the new service developments are aligned to the Measure, including the new SIR Service.	Dec-23	Dec-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for impementation by December 2023.
DU_AWRPSMHS1 122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1 122_003a	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	S-CAMHS will undertake a review of the terminology used in all S-CAMHS documents and ensure clarity and consistency.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1 122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1 122_003b	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	S-CAMHS Service Specification will be updated to ensure consistency.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1 122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1 122_003c	N/A	R3. The Health Board should review the use of terminology to describe service function. A lack of clarity is especially evident in the use of and meaning of SCAMHS in service related literature.	A glossary of terminology will be developed, included in the Service Specification, service literature and shared with all staff.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004a	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	S-CAMHS will establish a Steering Group with specific terms of reference, to develop and monitor a recovery plan.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004b	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	An improvement trajectory will be developed to monitor the numbers of clients waiting for clinical interventions following assessment under Secondary CAMHS.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004c	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Workforce capacity will be reviewed to address demand imbalance in each locality team and increase recruitment into vacant posts.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004d	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A review of clinicians' Job Plans overseen by locality team leads in conjunction with professional clinical leads will be undertaken.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004e	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Further monitoring of DNA's or was not brought (as lost capacity needs to be minimised) discharge and transfer information (to help ensure flow through services and avoid blockages e.g. access to specialist therapies) and actions to improve engagement and letting go if needed.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004f	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A workforce training analysis will be completed and training plan including CAPA Core competencies developed to ensure all staff have the core competencies required to meet service need.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006a	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	A service wide review/audit of adherence to the CAPA model and principles will be undertaken and recommendations implemented.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006b	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	Key staff will undertake a review of CAPA outcomes and delivery in other HB and apply such learning where appropriate to HDUHB to improve compliance.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_006c	N/A	R6. The HB should proceed to review its application of CAPA to improve adherence to the model. The service may benefit from engaging with other HB's who are also reviewing application and adherence to share joint learning and resources.	A service user evaluation will be undertaken to evaluate effectiveness	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_007a	N/A	R7. The service may wish to access further capacity and demand training from the NHS Delivery Unit or other training providers.	LPMHSS S-CAMHS will undertake Demand & Capacity Training.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_007b	N/A	R7. The service may wish to access further capacity and demand training from the NHS Delivery Unit or other training providers.	Secondary S-CAMHS will undertake Demand and Capacity Training.	Jul-23	Jul-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for July 2023 date.
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_001b	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.	Review a representative number of case studies (inclusive of near-miss incidents) of functional ill health [possibly mild cognitive impairment] Service users from Older Adult Mental Health Services with a presenting need to access Crisis Resolution and Home Treatment, Out of Hours, Liaison Psychiatry, NHS 111+2 Services. Bench-mark against the level of service 'age-through' Adult Mental Health Service Users benefit.	Jul-23	Jul-23	Amber	
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_001c	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	Aug-23	Amber	16/03/2023- To be submitted for QS&EG Meeting 21/08/23 at the latest.
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_002a	N/A	R2. The Health Board and partner agencies should explore additional opportunities to develop holistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventions in order to reduce crisis and provide alternatives to admission.	Meet with Health and Social Care Leads (each county) to share and test potential for collaboration for a same-day 'holistic multi-agency multidisciplinary pathways for people living with dementia requiring support in crisis' care pathway.	Jul-23	Jul-23	Amber	
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_002d	N/A	R2. The Health Board and partner agencies should explore additional opportunities to developholistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventionsin order to reduce crisis and provide alternatives to admission.	Identify and visit representative health led initiatives (each county) that could align as a foundation for collaboration on pathway development.	Mar-24	Mar-24	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_002e	N/A	R2. The Health Board and partner agencies should explore additional opportunities to developholistic multi-agency pathways for older adults requiring support in crisis, in particular for those with a diagnosis of dementia, through partnership working to deliver early interventionsin order to reduce crisis and provide alternatives to admission.	Attempt to reach agreement (not necessarily implementation) for at least one health led initiative to pilot/test the concept.	Mar-24	Mar-24	Amber	
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_003	N/A	R3. The Health Board should further consider how the "what matters to me/most" conversations can be incorporated and evidenced within the mental health liaison assessments.	HDUHB current development of the 'Mental Health Service Comprehensive Assessment'. This assessment will include and evidence "what matters to me/most" conversations.	May-23	May-23	Amber	16/03/2023- Management response has been provided by Interim Senior Nurse Mental Health Liaison & In-patient, however these responses and corresponding timescales are to be confirmed with the Head of Adult Mental Health Inpatient Wards and Learning Disabilities Service when they return from leave. 22/03/2023- Timescale of May 2023 confirmed.
DU_AWARCLPSOA0223	Feb-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	DU_AWARCLPSOA0223_004	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	Amber	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.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_001a	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.	The service have commenced a Directorate wide review to update the Health Board Part 1 Scheme in collaboration with partner agencies (LA) and commissioned services to ensure the services are aligned with the MH Measure.	Dec-23	Dec-23	Amber	28/04/2023 - AH to lead on this, initial work done to gather internal pathways. SM to support.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_001b	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.	The MH&LD Directorate will establish a multi-agency steering group with representations from key partners to progress this with an agreed Terms of Reference.	Dec-23	Dec-23	Amber	28/04/2023 - AH to lead on this, initial work done to gather internal pathways. SM to support.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_001c	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.	The HB will ensure that the Part 1 Scheme is reflective of the key services that deliver all mental health services across the HB Footprint with clear pathways to services.	Dec-23	Dec-23	Amber	28/04/2023 - AH to lead on this, initial work done to gather internal pathways. SM to support.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_002a	N/A	R2. 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.	A review will be undertaken to identify the number of Clients who have required Care co ordination to monitor if they were given one in a timely manner.	Aug-23	Aug-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_002b	N/A	R2. 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.	Care and Treatment Training (CTP) will be arranged if indicated to ensure all staff aware of their role and responsibilities under Part 2 MH Measure.	Aug-23	Aug-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003a	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	The HB will ensure that the Patient Access Policy for Psychological Therapies Services outlines the accessibility across the age range with assurances regarding accessibility for different psychological needs across the adult life-cycle.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003b	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	Links will be made with the older adult mental health team to project equity of access targets by reviewing the proportion of referrals received over 65 years old, how this reflects our local population demographic against estimated prevalence of mental health disorders in later life to inform what % referrals for over 65 years there should be locally.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003c	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	3.7 The service will link with the older adult team and aim to identify if access could be improved through: • Reviewing how the service attracts referrals for people in later life (review of how services recognise common mental disorders in later life, are aware of and refer older people for psychological therapy); • Reviewing the effectiveness of referral pathways between the service and primary and secondary mental health services for older people; • Undertaking a review of the evidence base and assure evidence based therapy modalities with any necessary reasonable adjustments are available for this population cohort; • Reviewing any modified 'engagement' procedures for supporting referrals for people in later life / access into the service; • Reviewing any training or support needs for staff in applying therapeutic skills to older people/people in later life.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004a	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The Integration of the LMPHSS and IPTS will be progressed following the implementation of the OCP.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004b	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The service will update all service documents and pathways.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004c	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The service will undertake a Service User Survey to obtain the views and suggestions of a new name.	Dec-23	Dec-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_005a	N/A	R5. The HB should continue to develop the group therapy offer in HD. The DU will share examples of successful models of group therapy delivery from other HBs.	The service will implement group therapy following a successful pilot stage. A number have been introduced within LPMHSS and DBT lite in CBT/IRT (Imagery rescriptive Therapy) and BA (Behavioural Activation) IPTS.	Sep-23	Sep-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_005b	N/A	R5. The HB should continue to develop the group therapy offer in HD. The DU will share examples of successful models of group therapy delivery from other HBs.	The Service Delivery Manager has completed a review of other HB models and are using this information to match what is working whilst still ensuring that patients are empowered to be part of the decision-making process around their treatment plan. All groups are evidence-based and routinely evaluated. There is a plan to increase co-production at all levels of group interventions: development of groups, staff training and evaluation of groups.	Sep-23	Sep-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_006a	N/A	R6. The HB should continue to explore opportunities to diversify the workforce. The DU will share examples of HBs that have created structures to support these new roles.	Further review of workforce diversity opportunities; The service have introduced B4 and B5 group practitioners, to support the delivery of group therapies in LPMHSS.	Sep-23	Sep-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_006b	N/A	R6. The HB should continue to explore opportunities to diversify the workforce. The DU will share examples of HBs that have created structures to support these new roles.	The service will undertake a review of the benefits of peer mentor roles in the service.	Sep-23	Sep-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_006c	N/A	R6. The HB should continue to explore opportunities to diversify the workforce. The DU will share examples of HBs that have created structures to support these new roles.	The service will link with Universities to strengthen links for all student placements to promote future workforce opportunities.	Sep-23	Sep-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_007a	N/A	R7. The service may wish to access further capacity and demand training and support from the NHS Delivery Unit or other training providers.	The IPTS service will link with the Delivery Unit for further advice on trajectory mapping due to the complexity of cases and a non-linear recovery pattern.	Jul-23	Jul-23	Amber	
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_007b	N/A	R7. The service may wish to access further capacity and demand training and support from the NHS Delivery Unit or other training providers.	LPMHSS will undertake further Demand & Capacity Training.	Jul-23	Jul-23	Amber	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_001	N/A	R1. The Health Board should develop a proactive rota management system to ensure training opportunities were adequately directed.	Awaiting management responses.	N/K	N/K	Red	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_002	N/A	R2. The Health Board should ensure trainees have opportunities to raise concerns about patient safety, support, and education.	Awaiting management responses.	N/K	N/K	Red	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_003	N/A	R3. The Health Board should ensure that a workforce behaviours group is created, which includes a senior midwife, a senior gynaecology nurse, trainee representation and a consultant.	Awaiting management responses.	N/K	N/K	Red	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_004	N/A	R4. The Health Board should update the handbook to incorporate the workplace behaviours champion and the process for raising concerns.	Awaiting management responses.	N/K	N/K	Red	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_005	N/A	R5. The Health Board should make the induction handbook available online.	Awaiting management responses.	N/K	N/K	Red	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_006	N/A	R6. The Health Board should take steps to incorporate ultrasound training into the trainees' rota.	Awaiting management responses.	N/K	N/K	Red	
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Women and Children's Services	Medical	TBC	TBC	HEIW_OGGH_0123_007	N/A	R7. The Health Board should make consideration of how to improve the MTI doctors' experience to ensure training is optimised.	Awaiting management responses.	N/K	N/K	Red	
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_001	N/A	R1. The Health Board should take steps to ensure that the management of patients on the ward is not left to F1 trainees.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_002	N/A	R2. The Health Board must ensure that the induction is effective both at the start of the trainees' posts and when they rotate into new departments.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_003	N/A	R3. The Health Board should consider improving support for new IMG trainees.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_004	N/A	R4. The Health Board must ensure that all feedback is constructive, informative, and never undermining.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_005	N/A	R5. The Health Board should offer the consultants with training roles education and training around their role, with information about the curriculum, and the use of the e-portfolio and these opportunities should be accessed by the trainers as needed.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_006	N/A	The Health Board should make sure that all job plans for the consultants are adequate to cover workload and time for training.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_007	N/A	R7. The Health Board should take steps to ensure that the handover has senior support, takes place in a structured way, and ensures clinical prioritisation is emphasised.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_008	N/A	R8. The Health Board should consider better coordination of the rota to balance staffing and workload.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_009	N/A	R9. The Health Board must ensure that F1 trainees are not given inappropriate tasks, including communication.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_010	N/A	R10. The Health Board should implement more formal and regular meetings between the consultants where training is a standing item for discussion.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_011	N/A	R11. The Health Board should take steps to implement a forum for the trainees to raise concerns with managers and consultants.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Unscheduled Care (BGH)	Medical	TBC	TBC	HEIW_GIMBH_0123_012	N/A	R12. HEIW will re-visit in six months' time.	Awaiting management responses.	N/K	N/K	Red	11/05/2023- Management responses are to be presented to the next People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker will be updated following the report being presented at PODCC, and the RAG status of the recommendations will be changed back to amber (unless original timescales have passed).
HIW_TRO0116	Jan-16	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Carly Hill	Director of Operations	HIW_TRO0116_001	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.	N/K	~~Mar-22~~ ~~Mar-23~~ Jun-23	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule,	Progress update/Reason overdue
HIW_21037_WG HSCW	Sep-21	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	HIW_21037_WGH SCW_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	~~June 22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ May-23	Red	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion 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 had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date. QAST Awaiting an update chased Dec 22, Jan 23, Feb 23. 09/05/2023 - Fire works expected to be competed by end of May 2023.
HIW_21037_WG HSCW	Sep-21	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	HIW_21037_WGH SCW_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ May-23	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 sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed.
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	23/02/2022 (BGH) - The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. Doctors' rotas reviewed every day to ensure appropriate cover. The Executive Director of Patient Experience and Quality agreed that if ED have to surge into minors, then one additional RN to be put on duty for nights. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E / AMAU have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST Update 01/11/22 - 27/10/22 (BGH) Free access to kitchen beverages and sandwiches stocked in fridge . Excellent rapport between WAST and Emergency staff regarding fundamentals of care (WGH) Confirmation from WGH that hot food and drinks provided to all patients waiting in department or awaiting handover. QAST Update 27/10/22 update (BGH) Staffing levels reviewed using BEST audit tool which requires need for uplift in staffing levels. Recruitment remains challenging so Dept focusing on retention . Staffing deficit impacting on offload delays . Exec team asked to consider implementation of financial incentives for all permanent staff to improve consistency in care . WGH The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST update 09/05/2023 - no further update received.
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_015	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_016	High	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_017	High	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_018	High	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_019	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_020	High	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_03d	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Health Board would look at other organisations practices and roles, which are not embedded into our current service delivery models and would welcome further discussion with WAST, other HB's and HIW in relation to this.	Dec-22	~~Dec-22~~ ~~Mar-22~~ ~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ N/K	Red	No update received from QSE team on progress against this recommendation as at March 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 had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - not yet due no update received. QAST update 11/07/22 due December 2022, no update therefore requested. QAST update 11/07/22 & 07/09/22 due December 2022, no update requested. QAST update 01/11/22 chased all sites, no further update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 20/03/2023 Chased all sites for a response, awaiting response. QAST update 09/05/2023 no further update recieved.
HIW_20175_NR WAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRW AST0921_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been setup chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation. 23/02/2022 (BGH) - Ambulance offload policy arrangements are ongoing. Meetings due to be held in February. Acute stroke pathway has been in place long standing and the crews can handover immediately to teams in the CT scanner area. 18/05/2022 - position in WGH same as BGH (above). QAST update 11/07/22, no update from PPH & GGH to date. 07/09/22 GGH & PPH Ambulance offload policy being updated currently with WAST representatives on group, individual department handover processes are in appendices within this policy. QAST update 01/11/22 chased sites , no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds . Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified. QAST update 09/05/2023 no further update received.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Sian Passey	Director of Operations	HIW_20175_NRWAST0921_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Ambulance offload policy, embedded in which is the Care of the patient in the ambulance policy. Actions are awaiting to be agreed by the Health Board with a meeting due in early March to discuss, led by Unscheduled care HoN with Task and Finish Group. 18/05/2022 - requested, none received. QAST update 11/07/22 requested update from PPH & GHH Feb, March, April and May 2022, none received. QAST update 07/09/22 for GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. QAST update 01/11/22 chased all sites, no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds .Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified. Patients able to use facilities within the main ED department. Rapid assessment area available to support appropriate care delivery when patients are awaiting offload. QAST update 09/05/2023 - no further update received.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_003	N/A	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	All CMHT's have identified practitioners who will ensure the annual health checks are undertaken. Each CMHT operates a link worker system with GP practices to promote physical wellbeing for patients.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Jan-23~~ ~~May-23~~ Jul-23	Red	18/05/2022 -Current evaluation of the team areas is being conducted –being led by Senior Nurse SC. QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning. QAST update 02/12/22 JDs for roles drafted, to be shared with GOP colleagues w/c 05/12/22. LMHPSS and GP Cluster colleagues to collaborate on where the Well-being Practitioners will be based and how the services link up to ensure smooth referrals. QAST update 09/05/2023 - GP and MH Leads meeting to progress.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_004b	N/A	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	~~Mar-23~~ ~~N/K~~ Jul-23	Red	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning QAST update 09/05/2023 - GP and MH Leads meeting to progress.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_005b	N/A	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	~~Mar-23~~ ~~N/K~~ Jul-23	Red	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning QAST update 09/05/2023 - GP and MH Leads meeting to progress.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_017	N/A	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	To complete the work that is already underway to outline the steps regarding the development and recruitment of the MH practitioner role.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ Jul-23	Red	18/05/2022 - PAS team to liaise with SDM of Psychological Therapies to develop a response and obtain updates QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no service update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 09/05/2023 - GP and MH Leads meeting to progress.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_001	N/A	Patients are assessed in a timely manner if they have physical health problems and for doctors on the ward to feel supported by their colleagues on the general wards	Senior medical staff from Mental Health Services and General Acute Services in Prince Philip Hospital to liaise and discuss how communication to support timely assessments and support can be improved upon for doctors.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ Jul-23	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. QAST update 09/05/2023 chased 21/04/2023, no update received.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_003	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	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.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_007	N/A	Invest in appropriate observation mirrors to enable staff to see concealed areas in section 136 suite.	Estates to review environment and work plan formulated to ensure appropriate observation mirrors are in use.	Dec-22	~~N/K~~ ~~Mar-23~~ N/K	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. QAST update 09/05/2023 - work underway.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Sara Rees / Kay Isaacs	Director of Operations	HIW_BWPPH1022_015	N/A	Shelving in clinical room is replaced and reorganised.	Estates work to be carried out and regular maintenance of shelves and surroundings to be arranged. Shelves to be reorganised once Estates work has been completed.	Dec-22	~~N/K~~ ~~Mar-23~~ ~~N/K~~ Jun-23	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. QAST Update Feb 23 Reviewed by estates and costed, awaiting completion of works. QAST update 09/05/2023 - work in progress.
HIW_03148_BGHAW	Jan-23	HIW	Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Open	N/A	Women and Children's Services	Estates	Senior Nurse Paediatrics	Director of Operations	HIW_03148_BGHAW_003	N/A	The health board should ensure that any outstanding actions stemming from IPC (and related audits) are completed in a timely manner.	All actions from IPC and other related audits are monitored through the Directorate Q&S Committee. In relation to recommendation from the recent IP&C audit funding for the new flooring has been sourced, and the service area is in communication with estates to identify a date for required works to be approved and completed.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	QAST update 09/05/2023 - work to release for tender for Symbiotics underway. Future completion date to be sought.
HIW_03148_BGHAW	Jan-23	HIW	Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Open	N/A	Women and Children's Services	Estates	Senior Nurse Paediatrics	Director of Operations	HIW_03148_BGHAW_004	N/A	The health board must ensure that a review of paediatric menus is completed and implemented in a timely manner to ensure that nutritional needs are more appropriately met.	A Task and Finish group has been set up to review and oversee the development of menus to ensure the nutritional needs are met. The group will engage with patients and families as part of this process to seek their views.	Jun-23	Jun-23	Amber	QAST update 09/05/2023 - T&F underway, new completion date.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_001	High	R1. The health board should consider displaying a designated health promotion board, so relevant information is accessible.	Public Health Midwife and Postnatal Ward Manager to identify a public health promotion board and co-ordinate all activities to this one central board.	Feb-23	~~Feb-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - noticeboard arrived, to be installed.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_002	High	R2. The health board must ensure that signage at the hospital is reviewed to ensure that it is easy for patients to locate all the maternity wards	To improve signage. Estates to cost and provide a timescale for works to be completed.	Mar-23	~~Mar-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - awaiting update
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_003	High	R3. The health board must ensure that pain relief is provided in a timely manner on the post-natal ward	POM (Patient's Own Medication) secure box to be installed on each ward to reduce any delays for patient obtaining medication.	Jan-23	~~Jan-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - women will be invited to bring own medication, ward manager taking forward.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_006a	High	R6. The health board must ensure that all staff signatures are identifiable and contain GMC and NMC pin numbers.	To provide Doctors and Midwives with name stamps.	Mar-23	~~Mar-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - Drs have been provided with name stamps, awaiting midwives to be delivered.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_010	High	R10. The health board must ensure that mandatory training compliance figures are improved.	Communication to be released to all staff to ensure dedication of time to complete training	Mar-23	~~Mar-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - awaiting update
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_011a	High	R11. The health board must ensure that junior doctors are supported with their training and ongoing personal development	Process introduced by College Tutor and Clinical lead to ensure that a programme is in place to support Junior Doctors with timeframes to achieve and progress individual learning needs assessment has been undertaken and monitor individual progress	Jan-23	~~Jan-23~~ N/K	Red	QAST update 09/05/2023 - confirmed completed.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_012a	High	R12. The health board should review the feedback from community staff and aim to improve staff welfare and staff relationships.	The Health Board and Head of Midwifery have reconfirmed their commitment to the Royal College of Midwives Caring for You charter. This will be communicated to all staff.	Mar-23	~~Mar-23~~ N/K	Red	QAST update 09/05/2023 - confirmed completed.
HIW_02032023_GMS	Mar-23	HIW	Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	Open	N/A	Women and Children's Services	Women and Children's Services	TBC	Director of Operations	HIW_02032023_GMS_012b	High	R12. The health board should review the feedback from community staff and aim to improve staff welfare and staff relationships.	Staff are to be given the option of participating and attending in the staff Wellbeing committee, to ensure it is representative of all areas of the service.	Mar-23	~~Mar-23~~ N/K	Red	QAST update 09/05/2023 - confirmed completed.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_007a	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To seek advice from the Health Promotion Team and source suitable promotional material for the department.	Mar-23	~~Mar-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_007b	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure that the health promotion materials are bilingual (English and Welsh)	Mar-23	~~Mar-23~~ ~~N/K~~ Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_007c	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure staff are aware how to access to materials in other languages as required by the local population.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_009a	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To agree a schedule for audit of current practice and compliance to identify key areas of improvement relating to assessment, prescribing, action, monitoring and escalation of pain needs. An initial baseline audit will be undertaken which is then followed up with further audits.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_009b	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To create and arrange provision of a schedule of training from the Pain Team for ED staff, which includes information on how staff can ensure the patients' pain is adequately assessed and managed.	Jun-23	Jun-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_009c	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	Link nurses to act as point of resource for staff within the unit to work alongside the pain team in ED.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_009d	N/A	R9. The health board is required to provide HIW with details of the action taken to provide assurance patients' pain is being effectively managed while in the unit.	To lead and engage with clinical colleagues and specialist teams to ensure timely patient assessment and prescribing of medication.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010a	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To obtain a baseline Information Governance e-learning figure for ED staff and remind all staff to maintain training levels.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010b	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To monitor compliance of IG training on a bi-monthly basis.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_010c	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To obtain and ensure Information Governance posters are clearly displayed in the department as a reminder to staff and patients to maintain confidentiality.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010d	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To offer patients a private space to discuss any confidential matters, a poster advertising this to be displayed in the waiting area.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010e	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To issue a reminder to Nurses onthe NMC Code of Conduct in relation to the patient's right to confidentiality.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010f	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	To issue a reminder to all departmental doctors and attending specialities on the patient's right to confidentiality.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_010g	N/A	R10. The health board is required to provide HIW with details of the action taken to protect patient confidentiality.	Bring the all-Wales Information Governance Policy to theattention of all ED staff through team brief sessions and written reminder.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_011a	N/A	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To arrange provision of new information screens for the department.	May-23	May-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_011b	N/A	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To remind all multidisciplinary staff within the department of the importance of updating patients and carers regarding their care and treatment.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_012l	N/A	R12. The health board is required to provide HIW with an update on the action taken and the processes in place to improve patient flow	TUEC and Improving Together work in progress to stream patients appropriately from ED.	Jun-23	Jun-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_012j	N/A	R12. The health board is required to provide HIW with an update on the action taken and the processes in place to improve patient flow	Implementation of SAFER – Phase 1 Pilot (Policy Goal 5) to support and improve discharge process/length of stay/improve patient experience.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_014b	N/A	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To remind all staff that the viewing room should not be utilised for storage of items	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_014c	N/A	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To facilitate working with '2 Wish' charity regarding the refurbishment of relatives/viewing room	Sep-23	Sep-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_016a	N/A	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	To engage with the estates and the Mental Health Teams regarding creating a safe space to review Mental Health patients in the department	Jun-23	Jun-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_016c	N/A	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	A reminder to be issued to staff to promote the new way of accessing Mental Health and wellbeing support by dialling 111, option 2 for a MH practitioner	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_017a	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	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_017b	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.	Reviewing the opportunity to utilise charitable funds to facilitate improvements to the area in the ED Performance meeting	May-23	May-23	Amber	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018a	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To liaise with the IPC team to facilitate a schedule of refresher training on hand hygiene	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018b	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To ensure sister reviews audit results and implement improvement actions required regarding hand hygiene	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018c	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	Utilise hand wash training UV light box in the department to re-iterate the importance of effective hand washing techniques	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018d	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To obtain additional hand hygiene posters for the department	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018e	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To liaise with estates regarding the need for additional storage space in the department to ensure that the decontamination room is readily available	Mar-23	~~Mar-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_018f	N/A	R18. The health board is required to provide HIW with details of the action taken to: • promote effective handwashing by staff working in/visiting the unit • share up to date results of relevant infection control audits to raise awareness of noteworthy practice or improvement needed • maintain the decontamination room so that it can be easily used when required.	To arrange Fire audits reminder for staff of the need to keep areas clutter free	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_020a	N/A	R20. The health board is required to provide details to HIW of the action taken to ensure oxygen therapy is prescribed and staff record when this is administered.	To issue communication reminder to all ED Doctors and specialities the importance of prescribing oxygen therapy	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_020b	N/A	R20. The health board is required to provide details to HIW of the action taken to ensure oxygen therapy is prescribed and staff record when this is administered.	Oxygen Audit compliance to be undertaken to review current practice and identify key learning.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_021b	N/A	R21. The health board is required to provide HIW with details of the action taken to improve staff confidence regarding their concerns about unsafe practice being addressed.	Arrange weekly reviews and monitoring of Safeguarding referrals, ensuring correct referral method and compliance	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_021d	N/A	R21. The health board is required to provide HIW with details of the action taken to improve staff confidence regarding their concerns about unsafe practice being addressed.	Enable staff to attend / undertake Safeguarding training and monitor compliance	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_023b	N/A	R23. The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	SNM monthly audits currently under review.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_023c	N/A	R23. The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	To ensure that medical staff within the department are supported to and undertake regular clinical audit.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_024a	N/A	R24. The health board is required to provide HIW with details of the action taken to ensure unit staff: • are aware of the Bronze, Silver and Gold on call structure arrangements • are provided with updates, as appropriate, during periods of escalation.	The Bronze, Silver and Gold details of escalation and patient flow and on call arrangements to be shared with all department staff.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_024c	N/A	R24. The health board is required to provide HIW with details of the action taken to ensure unit staff: • are aware of the Bronze, Silver and Gold on call structure arrangements • are provided with updates, as appropriate, during periods of escalation.	All Senior Staff to receive training / refresher training on responding to and managing incidents in line with the Major Incident Plan.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_025a	N/A	R25. The health board is required to provide HIW with details of the action taken to improve unit staff compliance with mandatory training.	To remind all multidisciplinary staff and arrange for protected time for staff to undertake refresher / mandatory training	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.

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HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_026a	N/A	R26. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report. This must include the action taken in relation to communication between senior management and staff and senior managers acting on feedback.	Senior Nurse Manager to link with Organisation Development Relationship Managers for ED to arrange regular checks-in with ED staff regarding any staff concerns	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_20230315_EUGGH	Mar-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	HIW_20230315_EUGGH_026c	N/A	R26. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report. This must include the action taken in relation to communication between senior management and staff and senior managers acting on feedback.	To facilitate weekly ED performance meetings where concerns/issues can be discussed.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_001a	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.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level eg Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions a)**D**evelopment of standards for physical health screening to be incorporated into Service Specifications. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_001b	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.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level eg Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions b)**F**urther 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	Nov-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_002	N/A	R2. The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	WARRN is used as a standardised approach to formulation based risk assessments across the MH/LD Directorate. A cohort of WARRN trainers deliver monthly training sessions for initial and refresher training. The presence of a WARRN is verified through Care and Treatment Planning audits undertaken monthly by team leaders. The MH/LD Directorate is linked into All Wales work surrounding development of a national approach to safety planning. Further Action c)**R**eview of WARRN training provision and monitoring of uptake to inform longer term, sustainable approach and ability to provide targeted practice development in response to lessons learnt from SI's. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_004	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.	Routine offer of Carers Assessment is built into the Comprehensive Assessment Tool referenced in recommendation 1 and is explicitly referenced in its accompanying guidance. Documentation of routine offer of Carers Assessment is incorporated into CAT forms on the Electronic Patient Record. WARRN and Care and Treatment Planning Reviews also prompt staff to offer Carer Assessment and document outcomes to this. The Health Board is signed up to the Investors in Carers scheme and all teams across the MH/LD Directorate are actively benchmarking services against the schemes standards. There are Carer Leads on all Inpatient Wards and specific support for dementia carers can be accessed through Admiral Nurses and Dementia Wellbeing Teams. Further Action d)**A**ll 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_006	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.	Daily Board Rounds plus scheduled Ward Rounds take place across Inpatient areas. The structure, format and approaches to quality assurance of Ward Rounds vary across services. There is feedback to indicate that short notice for Ward Rounds impacts on Service User and Carer involvement. Further Action e)**C**oproduce 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	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_007a	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.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- -MDT attendance by Ward & CMHT (Care Coordinators) -Pre-discharge Care and Treatment Planning Meetings -Directorate wide access to Electronic Patient Records -Current pilot of Medicines Transcribing and e-Discharge (MTeD) system -Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow -Sector Approach within OA Mental Health Services promoting continuity of care 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_007b	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.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- -MDT attendance by Ward & CMHT (Care Coordinators) -Pre-discharge Care and Treatment Planning Meetings -Directorate wide access to Electronic Patient Records -Current pilot of Medicines Transcribing and e-Discharge (MTeD) system -Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow -Sector Approach within OA Mental Health Services promoting continuity of care 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_008	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.	There are a range of mechanisms that support embedding practice for timely and effective communication and information sharing relating to patient discharge process however no single specific training to outline expected standards in place that is monitored. 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	Oct-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_009	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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_010	N/A	R10. The health board must ensure that adequate administrative support is available within inpatient mental health units.	All Inpatient Wards are supported by Ward Clerk roles. A recent Quality Improvement project was undertaken by the MH/LD Directorate to focus on releasing Ward Management time spend on admin tasks. This led to a pilot of a new band 4 admin role to complement existing band 2 Ward Clerk roles. Further Action i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_011	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.	Mechanisms to prompt patient, family, carer and/or advocate views to inform inpatient care and discharge plans are incorporated within Care and Treatment Planning process and within the Comprehensive Assessment Tool and guidance. The Electronic Patient Record has functionality to enable sensitive information (potentially provided by patients, family, carers) to be recorded separately. All inpatients are offered advocates on admission which is documented in the Electronic Patient Record and routinely monitored by the MH/LD Directorate. Quarterly reports to provide assurance on practice surrounding the offer of advocates are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures. Advocates regularly visit wards and participate in Ward Review/MDT Meetings. Inpatient services operate a 'named nurse' model which promotes engagement with patients, family, carers and / or advocates to inform person-centred care planning. Inpatients are allocated a community Care Co Ordinator prior to discharge to support discharge planning. We will develop an auditing mechanism to routinely audit records to be assured that family carers and advocates are able to provide their views to inform inpatient care and discharge planning. Further Actions as per Recommendation 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_012	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.	Crisis plans are jointly developed between ward/community staff (CMHT/CRHT), patients, families / carers and /or advocates through discharge planning and cover plans for the next 7/14 days including 72 hours follow up (by who and when), medication /crisis numbers and details of any other actions agreed. A Service User information leaflet to support person centred crisis planning has been developed and is currently being piloted. Comprehensive Assessment Tool (CAT) and Care and Treatment Plans (CTP) are reviewed and updated at transfers of care (including discharge from inpatients). An updated Care and Treatment Planning review tool has been developed and is in the process of being implemented. The tool is incorporated within the Electronic Patient Record and is covered within CAT Training and guidance. Older Adult Mental Health Services have a Clinical Risk Management Lead monitoring high-risk presentations and transitions (admissions/discharges) to support & upskill Care Coordinators. Further Actions as per recommendation 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_013	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.	A discharge checklist is in place across MH/LD inpatient services. This is completed during the discharge process to record information associated with the completion of discharge tasks and notifications. Once complete this is scanned and uploaded to the Electronic Patient Record. 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	Sep-23	Amber	

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HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_014	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.	Please see response to recommendation 13. The health board has a daily bed conference (twice daily Monday – Friday), originally established in the pandemic and now an embedded process, to review and proactively manage bed utilisation, availability, access and discharge which has MH/LD directorate wide multi-disciplinary input from services across admission and discharge pathways, MH/LD commissioning roles and multi-agency representation (including Police and Local Authority reps). Action notes are made and shared following bed conferences to ensure communication of key outcomes. Electronic Patient Records are updated with patient specific information. Older Adult mental health services also participate in additional discussions about regional admission needs across daily Acute Pathway Meetings (Multi Agency and Health Board wide). MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator provide additional support with coordination of discharges in more unusual circumstances. Further Action as per Recommendation 6 and 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_015	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.	Please see response to recommendation 14 in relation to bed conferences and daily Acute Pathways Meetings. MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator lead on coordination of risk based MDT decisions in the event of contingency plans needed for patients that require return to hospital from leave. Escalation processes are in place to support out of area bed / placement requests. Use of out of area placements by the MH/LD directorate are low. Further Action j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_016	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	Dec-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_017	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.	The health boards policy on Discharge and Transfer of Care incorporates definitions and guidance on delayed discharges. Delayed discharges in MH/LD directorate are operationally reviewed at a service level through the daily bed conference process referenced in the response provided to recommendation 15. Delays are identified and actions to address delays are agreed and reviewed with escalation as needed. Monthly reports of delayed transfers of care are produced and reported to the MH/LD Business Planning and Performance Assurance Group. Further Action as per Recommendation 15.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_018a	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.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions k) Develop procedural guidance and standards for uploading paper records to the Electronic Patient Record across the MH/LD Directorate	Aug-23	Aug-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_018b	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.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_019	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.	The MH/LD Directorate operates a consistent Electronic Patient Record (Care Partner) across all of its services. The system allows access to contemporaneous records across inpatient and community services and has business continuity plans to guide staff in the event of system outage. 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	Nov-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_020	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	Nov-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_021	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.	Details of discharge plans, including 72 hour follow up are included in discharge Care and Treatment Plans. The inpatient Discharge Checklist includes the need to check and record that discharge notifications have been completed and shared with relevant people. METeD, a system that digitally transfers discharge notifications and details of medication on discharge to GPs is currently being piloted for full roll out across the MH/LD directorate. Standard templates for discharge letters are in place. These require review to ensure they are reflective of NICE guideline standards for Transition between inpatient mental health settings and community or care home settings (NG 53). Work to strengthen assurance of consistency in quality and timeliness of discharge letters and discharge summaries being shared is required. Feedback indicates a regular theme of these not being shared in a timely way. Patient information leaflets outlining rights to re-refer are in use. Scrutiny of trends in cases that re-refer to services and referrals from GPs that could have re-referred themselves under the Mental Health (Wales) Measure 2010 is undertaken through the MH/LD Legislation Scrutiny Group. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	

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HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_022	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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_023	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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_024	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.	Planning for 72-hour contact is undertaken as part of the Care and Treatment Planning process for discharge alongside crisis planning. Please see response to recommendation 12. There is no current system to routinely track and monitor compliance with 72 hour follow up. Previous audit gave good assurance of consistent achievement of this standard. There are no current learning themes from reviews or feedback in relation to 72 hour follow up. Further work is needed in this area to ensure documented standards and to strengthen routine assurance. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_025a	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions n)Review the health boards safe staffing escalation process to ensure this is fully reflective of processes across the MH/LD directorate.	Jul-23	Jul-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_025b	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_025c	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Nov-23	Nov-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_025d	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions q)Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Dec-23	Dec-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_026a	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.	The MH/LD directorate currently utilises monthly reports on caseload activity and referral rates to monitor capacity needs across community teams at a service level as well as Care and Treatment Planning compliance. A caseload weighting tool is in place, intended for use at a team level within management supervision where discussions about caseload take place and clinical documentation is reviewed and audited. Further work is needed to gain assurance surrounding the use and effectiveness of the caseload management tool. Vacancies are being evaluated to ensure staff are utilised and recruited to the areas required. Staff vacancies have been moved between teams to support areas with higher levels of referrals and care coordination. The impacts of vacancies on service capacity is held as a risk on service level risk registers for specific teams. (Risk 1612) There are currently no delays with allocation of care coordinators. An escalation process is used to highlight and promptly address delays as they occur. There are known breaches to the current 28 day standard for routine assessments of referrals into Adult CMHTs. Breaches are reported to the MH/LD directorate Mental Health Legislation Group which is overseen by the health board Mental Health Legislation Committee. All referrals are screened through a Duty System to review urgency which involves direct contact with the patient. There are no OAMH waiting lists associated with referrals to CMHT. Further Action r) Review application of MH safe staffing principles and version 3 of All Wales Staffing Levels for use across community teams.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_026b	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.	The MH/LD directorate currently utilises monthly reports on caseload activity and referral rates to monitor capacity needs across community teams at a service level as well as Care and Treatment Planning compliance. A caseload weighting tool is in place, intended for use at a team level within management supervision where discussions about caseload take place and clinical documentation is reviewed and audited. Further work is needed to gain assurance surrounding the use and effectiveness of the caseload management tool. Vacancies are being evaluated to ensure staff are utilised and recruited to the areas required. Staff vacancies have been moved between teams to support areas with higher levels of referrals and care coordination. The impacts of vacancies on service capacity is held as a risk on service level risk registers for specific teams. (Risk 1612) There are currently no delays with allocation of care coordinators. An escalation process is used to highlight and promptly address delays as they occur. There are known breaches to the current 28 day standard for routine assessments of referrals into Adult CMHTs. Breaches are reported to the MH/LD directorate Mental Health Legislation Group which is overseen by the health board Mental Health Legislation Committee. All referrals are screened through a Duty System to review urgency which involves direct contact with the patient. There are no OAMH waiting lists associated with referrals to CMHT. 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_027	N/A	R27. The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	The MH/LD Directorate has an established Accommodation Strategy Group that meets monthly. Its remit is: • To ensure that services experiencing the greatest demand and growth are able to access suitable estate. • Govern and oversee the repurposing of current MH&LD estate to minimise impact on service delivery. • Improve access to accommodation to enable sustainable service provision in order to increase efficiency and maximising clinical time. • Ensure MH&LD accommodation is safe and appropriate in which to delivery therapeutic/clinical interventions. • Act as the point of escalation for risks, issues and actions to the MH/LD Business Planning and Performance Assurance Group. • Progress appropriate Capital bids in collaboration with partner agencies and ensure MH&LD Estate is included in Health Board maintenance and refurbishment schedules. • Report formally, regularly and on a timely basis to the MH&LD BP&PAG on options, plans and progress relating to the Group's activities. • Ensure appropriate escalation arrangements are in place to alert the Hywel Dda University Health Board (HDUHB) Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of HDUHB. • To monitor the completion of Point of Ligature Audits, ensuring they are reviewed and completed in a timely manner. • To receive the requests for environmental improvements required and agree a prioritisation process for completion of essential works. CRHT services have identified a current risk in relation to being able to access space within emergency departments which is held on the service risk register. Progress has been made with now just one locality to be resolved. Further Action t) Resolve CRHT access to space within all emergency departments.	Jul-23	Jul-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_028	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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_029	N/A	R29. The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Actions to ensure sufficient medical capacity across all mental health teams are ongoing within the directorate and active approaches to recruitment and retention are underway through active and frequent review of medical vacancies at the MH/LD Directorate Business Planning and Performance Assurance Group (BPPAG) and Workforce Group, targeted, refreshed, national recruitment campaigns, provision of relocation packages, implementation of a Clinical Fellowship Model, post graduate development support. The MH/LD Directorate holds a risk on its risk register in relation to sustainability of the medical workforce across the MH/LD Directorate (Ref 1525) in response to difficulties and challenges experienced in recruiting doctors and retention risks associated with the age profile of the existing Consultant workforce. The risk is currently mitigated through service awareness and plans to manage impacts through service level risk registers, recruitment, and development of complimentary workforce (for example Advanced Practitioners and introduction of Physicians Associate roles), implementation of an escalation process in the event of medical deficits and through attendance at HEIW Workforce Meetings. The risk is reviewed and updated regularly. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_030	N/A	R30. The health board must ensure therapies staff working within its mental health services have sufficient facilities to enable them to undertake the full requirements of their relevant roles.	The MH/LD directorate currently holds service level risks on its risk register in relation to the quality and capacity of its estate to deliver services (Risk 839 and 1260). An Accommodation Strategy Group meeting has been established within the MH/LD directorate with the Property Team, IT and Heads of Service to maximise current capacity and source potential solutions. (Please see response to recommendation 27). Arrangements with private providers are in place to hire suitable venues in which staff can deliver therapeutic interventions. The health boards Occupeye system has been used in key areas and data analysis is informing discussions to maximise space optimisation. The MH/LD directorate are engaging in all known developments across the three counties. Mapping work continues across MH/LD properties in terms of capacity, fit for purpose and condition completed. Greater consideration of digital formats for delivery of services is being made and supported through regular meetings with the Digital Director and Informatics team. We will work with the HB digital strategy team to ensure there is a specific focus on developing digital services for mental health services.	N/K	N/K	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_031	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.	Capacity and demand work across mental health therapy services is underway to strengthen capacity where needed and develop flexibility in use of skills. Therapy workforce plans are in place across each MH/LD service speciality. Current deficits as a result of being unable to recruit to specialist psychology roles is held as a service level risk (Risk 138). Mitigations and actions include: -Cross Directorate cover to ensure that there is no inequity in the availability of services across both specialities and localities. -Upskilling the wider multi-disciplinary workforce to deliver interventions under the supervision of psychology and psychotherapy and use of CBT Therapy roles. -Continued efforts to recruit to psychology roles and plans for a 'grow your own' scheme coming into place during 23/24 for 3 funded places on the Clinical Psychologist programme. Waiting lists are frequently reviewed to identify and reassess individuals and 'Keeping in Touch' processes are in place. A continued focus on recruitment and retention to include therapy roles across MH/LD directorate will be undertaken through the MH/LD Workforce Group. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_032	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.	A range of developments to ensure that MH/LD directorate inpatient and community mental health staff have the appropriate knowledge and skills to effectively undertake their role are being undertaken including delivery of training to support risk assessment and suicide prevention through WARRN and STORM training. Further work is needed to provide a systematic approach to this to ensure needs are fully assessed and gaps identified, sustainable methods of provision planned and mechanisms for monitoring applied. Further Action u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Nov-23	Nov-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_033	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.	The Psychological Wellbeing Service is widely promoted by team leaders via Workforce Advisers monthly sickness absence catch up meetings with Team Leaders and during sickness absence meetings and through completion of All Wales Sickness Absence Training. Regular 1:1 meetings are held with managers and the workforce operational team advisers, ensuring appropriate wellbeing advice is given on a case by case basis so they can cascade this information to their staff members. Managers are supported to actively engage and refer staff to Occupational Health for appropriate support. 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	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_034a	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.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of compliance with 72 hour follow up	Dec-23	Dec-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_034b	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.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_034c	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.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. 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	Dec-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_034d	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.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. 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	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_035	N/A	R35. The health board must ensure that there is a robust and sustainable audit action management plan in place within its mental health services, to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	Please see overarching Clinical Audit Action (Recommendation 34)	Mar-24	Mar-24	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_036a	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.	Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. Further Actions aa) Strategic review of forward plan for written control documents across MH/LD services for 2023/24 to identify co dependencies and establish integrated planning and development for documents that span pathways and services.	Sep-23	Sep-23	Amber	
HIW_MHDR_050 52023	May-23	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	HIW_MHDR_0505 2023_036b	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.	Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. 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	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_037	N/A	R37. The health board must ensure that risk registers are routinely reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	Risk Management Framework and Risk Management Strategy in place, which were reviewed and updated 2022/23. These are supported by a series of process and procedural documents available to all Health Board staff via the Assurance and Risk webpage on the staff intranet site. The Assurance and Risk Team support the wider Health Board in terms of risk management and risk training by way of a business partnering approach. The MH/LD Directorate has access to an Assurance and Risk Officer, who is certified with the Institute of Risk Management (IRM), and provides monthly risk reports from Datix via MHLD QSE and BPPAG meetings which are attended by all Heads of Service as well as Directorate leads. The Assurance and Risk Officer also provides risk management training in terms of technical risk management as well as the use of the Datix system to key staff within the Directorate. Risks are scrutinised by Executive Directors via departmental Improving Together sessions which commenced in January 2023. Further Action cc)dMH/LD Directorate to hold a "risk workshop" in order to review and challenge where necessary the existing risks on the risk register to ensure mitigating actions, milestones and expected outcomes are clearly articulated.	Jul-23	Jul-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_038	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.	Social Worker identified incidents are currently reported on Datix via health board managers as direct system access is not currently in place. Further Action dd)dReview 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	Jul-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_039	N/A	R39. The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	The health board has an Incident, Near Miss and Hazard Reporting Procedure and dedicated sharepoint site which can be accessed by all staff. The procedure details roles and responsibilities within the incident management process which for incident mangers includes ensuring feedback to staff who have raised the issue and reported an incident. This includes staff who may have raised concerns through the Speak Up Safely Process. A feedback mechanism is incorporated within the DATIX system which facilitates direct feedback to the incident reporter following the incident review process. Performance against the incident management process is reported and tracked through a board wide performance dashboard which is accessible to all staff via the health boards intranet. Incident management performance is overseen at a directorate level by MH/LD Business Planning and Performance Assurance Group and at a board level through Exec Led Quarterly Improving Together sessions with each directorate leadership team. Standards of system completion are addressed through ongoing engagement with incident reviewers, training and via Ward Manager and Community Manager Forums. MH/LD directorate level incident themes and trends are reviewed by the MH/LD Quality, Safety and Experience Group. Further Action ee)AAmend the service line reporting template for MH/LD Quality, Safety and Experience Group to include service line data in relation to incident management process to strengthen consistency of reporting, oversight and monitoring of compliance with Datix incident management and feedback process.	Jul-23	Jul-23	Amber	
HIW_MHDR_05052023	May-23	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	HIW_MHDR_0505 2023_040	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.	Improvement planning meetings are facilitated by the Quality Assurance and Practice Development Team as standard following completion of all Level 4 and 5 incidents which include senior stakeholders and services involved. Where needed, follow on review meetings are also booked to review and ensure implementation. Further cascade of learning and consistent embedding of actions are delegated to service managers for operational implementation. Forums including Ward Manager, Community Manager, Professional Nurse Forums are used to discuss themes from learning and communication methods such as 7 minute briefings are used where wide cascade is needed. 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	Amber	
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_001	High	R1. The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion information within the Diagnostic Imaging Dept.	shared with our communities via our social media channels to ensure formal recognition for the time women and	Feb-23	~~Feb-23~~ N/K Jun-23	Red	QAST update 09/05/2023 - chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_002b	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.	Create a working group to standardise the letter format for radiology using the HB guidelines.	Sep-23	Sep-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_004	High	R4. The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	A review of the procedure for patient identify checks will be undertaken to update the Employer's Procedure (EP).Introduce an audit to be performed on compliance with identity checks.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_005a	High	R5. The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of the enquiries of individuals of child bearing potential Employer's Procedure will be undertaken and updated with any gender specific reference to be removed.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_005b	High	R5. The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of all service documentation including letters and posters will be undertaken with any gender specific reference to be removed.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_006	High	R6. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for non-medical imaging exposures so that it includes reference to Tuberculosis (TB) screening.	Introduce a process whereby all Employer's Procedures will be reviewed in February 23 and updated to include all examinations currently performed.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_007	High	R7. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedures providing guidance on making a referral so that they reflect the need to avoid using acronyms and include reference to current guidance where applicable.	All Employer's Procedures will be reviewed in February 23 and updated to include that we do not accept referral forms with acronyms. We will also ensure that all referrers receive a copy of the Employers Procedures for referrers.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_009	High	R9. The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_010a	High	R10. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks.	Introduction of a procedure to review EP's to include the logbook checking frequency.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_010b	High	R10. The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks.	Instigate an audit to check compliance as part of the audit schedule.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_011	High	R11. The employer is required to provide HIW with details of the action taken to review and revise the employer's written proceduresfor the assessment of patient dose and administered activity so that it includes details of the procedure for exposures performed in surgical theatres and interventional radiography.	Introduction of a procedure to review all Employer's Procedures to include theatre procedures and interventional radiography.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_012	High	R12. The employer is required to provide HIW with details of the action taken to promote a consistent approach for the process and presentation of clinical audits.	Instigate a procedure to promote a consistent approach for process and presentation of clinical audits.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_013	High	R13. The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to identify individuals entitled to act as referrer, practitioner or operator so that it clearly sets out the position in relation to anaesthesia associates.	Introduce a procedure to review all Employer's Procedures to include the position on anaesthesia associate. The policy will be clearly reworded to reflect that only registered professionals are able to refer.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_014	High	R14. The employer is required to provide HIW with details of the action taken to maintain a complete and up to date record of the training, entitlement and scope of practice for entitled duty holders, including non-medical referrers	A review of the entitled duty holder matrix will be undertaken with the suggested change being made to provide a more thorough record.	Jun-23	Jun-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015a	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These competencies will be added to matrix.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015b	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	The Employer's Procedure will be updated to include the justification process.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_015c	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Introduce a process to establish dose constraints and add to Employer Procedures.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_016	High	R16. The employer is required to provide HIW with details of the action taken to develop and implement written protocols, where appropriate, for paediatric patients.	A process has been introduced to review all adult protocols. The review will inform the development and implementation of paediatric protocols.	Jun-23	Jun-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_017a	High	R17. 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.	A process has been introduced whereby the Lead Radiographer coordinates all written documentation to ensure no conflict with the employers written procedures.	Apr-23	~~Apr-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_017b	High	R17. 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	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_018a	High	R18. The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Hard copies of the protocols are available at all times in the department. A process will be undertaken to ensure any remaining old copies of protocols are removed and that the author is identified.	Mar-23	~~Mar-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_018c	High	R18. The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Written examination protocols will be made available to all staff in electronic and paper formats for all areas.	Feb-23	~~Feb-23~~ N/K Jun-23	Red	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019a	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	The management team have approached the Health Board's values and culture team for expert advice on how to ensure the staff's voices are heard and action taken.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019b	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	A series of staff engagement events are planned to instigate 'culture change' within the department and empower staff's confidence in the management.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
HIW_160223_DIDGGH	Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 Novemeber (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	HIW_160223_DIDGGH_019c	High	R19. The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	Staff meetings are being strengthened and a regular schedule of meetings are being arranged in advance and circulated to staff.	May-23	May-23	Amber	QAST update 09/05/2023 chased, awaiting progress.
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_002	N/A	R2. To consider developing 'Decision Making whilst in emergency response' Guide for Health Board staff.	The importance of making safe decisions during emergency responses will be reiterated in the revised Board and Committee Standard Operating Procedure. This will indicate that any deviation from business-as-usual decision making processes must be communicated to and approved by the Executive Team.	Mar-23	~~Mar-23~~ Nov-23	Red	01/06/2023 - This will be included along with other amendments in the Board and Committee SOP which will be revised as planned by November 2023.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
IR_GDMRBFH_11 22	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_11 22_003	N/A	R3. To review the governance processes in relation to decision making groups between the Health Board and Pembrokeshire County Council (PCC) to ensure that decisions are clearly recorded in the minutes.	A review will be undertaken of the joint groups established between the Health Board and PCC. Furthermore, a review will be undertaken of the governance and reporting arrangements of the Integrated Executive Group which reports into the West Wales Care Partnership.	May-23	~~May-23~~ Sep-23	Red	01/06/2023 - This will be incorporated into the review of our partnership governance arrangements which will be reported to September 2023 Board meeting.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_004	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	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.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	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	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.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	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	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.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_007	Medium	R7: Management should establish refresher sessions to ensure existing staff receive records management training.	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.	Feb-19	~~Jun-21~~ ~~Nov-22~~ ~~Mar-23~~ ~~Apr-23~~ May-23	Red	19/04/2022 - update provided to ARAC with the following work remaining to be undertaken in order to close the recommendation 1) Identify shortfalls in records management processes and non-compliance with appropriate standards, within relevant services (November 2022). 2) Following on from (1) develop a plan for records management training within those areas (November 2022). 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 – Health Records training remains part of the agenda for the Welsh Health Records Management Group, however no further progress has been made to date due to a prioritisation of work to the development and implementation of eth Records Management Code of Practice, Transgender procedures and adoption protocols. 28/03/2023 - the health records service has agreed a plan to develop a competence evaluation questionnaire, for all staff members to complete and be assessed against. This will be rolled out across the service over the next 6 months. 15/05/2023 - confirmation obtained at the Central Operations Improving Together session in May 2023 that questionnaires will be sent by the end of May 2023, and for the revised completion date to be noted as such.
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development, issued April 2021	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lisa Humphrey/Project Director	Director of Strategic Development and Operational Planning	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP:SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ Jul-23	Amber	10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract. 02/03/2022 & 03/05/2022- Expected to remain open until July 2023. 03/05/2022- outstanding rec expected to remain open until July 2023. Exec Lead amended from Director of Operations to Director of Strategic Development and Operational Planning as remaining recommendation is for Strategic Development and Operational Planning Directorate to implement. 12/08/22-Date remains July 2023 30/08/2022 - Director of Strategic Developments and Operational Planning confirmed no change. 10/11/2022 - Head of Captial Planning confirms no change. 10/01/2023 & 01/02/2023-Head of Captial Planning confirms no change - ongoing monitoring of contractor performance which will continue until completion of the contract planned for July 2023. 16/03/2023- update remains as above. 28/04/2023- Update remains as above.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001a	N/A	R1a. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	~~Mar-22~~ ~~Mar-23~~ N/K	External	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 31/10/2022- agreed by Director of Primary Care, Community and Long Term Care that this recommendation is changed to 'external'. Discharge requirements are being reviewed at an All Wales basis, in light of developments following Covid-19.Once these are reissued (the All Wales review is expecting to be completed imminently), the UHB discharge policy will be refreshed. The current discharge policy will be requested to be extended for three months, whilst the UHB awaits guidance from WG following the All Wales review, as well as awaiting ministerial advice on the Delayed Transfer of Care (DTOC), which will also feed into the amended policy. Revised date of March 2023 timescale provided, and the recommendation changed from red (overdue) to external (outside the gift of the UHB to implement) whilst the outcome of All Wales review is awaited. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002a	N/A	R2a. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. The importance across the Region is that the key principles and standards within the discharge policy are met and considered within the partnership boards. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	Sep-22	~~Sep-22~~ Aug-23	Red	31/10/2022- Discharge to Recover then Assess (D2RA) pathways are being reviewed as part of the All Wales level work which feeds into the Policy Goal 6 work. Local Authority representatives are advising this national work. The Policy Goal 6 work is reviewing the processes and looking at a consistent approach. This is linked to the Programme delivery group structure now in place, as noted in the recommendation above. We recognise there is more work to do and therefore the work of this recommendation will be added into the relevant workstreams. Work is continuing however the UHB is mindful of the All Wales guidance which is expected imminently. Assurance and Risk Officer awaiting confirmation this recommendation has been added to the relevant workstream. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss these recommendations and if it has been added to the relevant UEC workstream. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002b	N/A	R2b. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level.	Apr-22	~~Sep-22~~ N/K	Red	31/10/2022- Focusing on the ask of the original recommendation, across the Regional UEC Programme Delivery Group undertakes a monthly review of the agreed high level 3Cs outcome measures (Conveyance, Conversion and Complexity) and, to highlight any worsening trends, and focus through the delivery groups the expectation will be that focused outcome measures will be agreed by each Policy Goal Delivery Group, with exception reporting feeding up to the programme delivery board. This will develop equitable outcomes across the Hywel Dda patch, even if separate models across the counties is required and regardless if a dashboard is in place. Through the Policy Goals 5 & 6, the outcome measures that have been identified will be shared with all the Policy Goals Delivery Groups as required. Recommendation to be requested to be closed once the above is being reported through the Delivery Groups and explicit within the workplans, approximate date not yet known, this will be a long term recommendation to fully implement with the date currently not known. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this is now being reported through the UEC Delivery Groups and explicit within the workplans. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002c	N/A	R2c. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PG5 & 6 workstream.	Jul-22	~~Jul-22~~ N/K	External	31/10/2022-This recommendation is being driven through the delivery groups of the UEC programme, as described above. These recommendations are to be included in the workstream workplan, along with the WG guidance once received. Timescale not yet known as awaiting WG guidance. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003a	N/A	R3a. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Following a recent staff survey one of the key recommendations is to develop better, very practical and locally delivered discharge planning training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days	Apr-22	N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003b	N/A	R3b. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Important to note that there is still work to be done on data quality,, which is being considered via performance teams and UEC board. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can commence on admission and information can be provided to facilitate a conversation.	Apr-22	~~Sep-22~~ N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_006	N/A	R6. Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	~~Jun-23~~ Aug-23	Red	31/10/2022- There are processes in place through the weekly panels, where process issues are identified, however as a UHB we are aware the learning is not routinely fed back. As part of the Policy Goal 5 Delivery Group work Safer review, learning will be considered and processes identified to support embedding this learning. As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by Improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the PG5 workplan, approximate timescale August 2023 for this process to be embedded. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-22~~ ~~Mar-23~~ N/K	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_008	N/A	R8. Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	Apr-22	~~Jun-22~~ Aug-23	Red	31/10/2022- Related to the Policy Goal 5 Delivery Group Safer review and outcome measures. Approximate timescale of August 2023. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request progress of this recommendation. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_009	N/A	R9. A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	~~Jun-22~~ N/K	Red	31/10/2022- Director of Primary Care, Community & Long-Term Care confirmed this recommendation is to remain open- even if it is picked up under UEC as it is clear from recent reviews across all sites that in the main the discharge planning process commences at too late a stage following admission. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request approximate completion date for this recommendation. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report.
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001b	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	Oct-23	Amber	11/11/2022-Progress to be requested in early 2023 to ensure this is on track.
SSU_WHSSC_2122-02	Apr-22	Internal Audit	Glangwili Hospital Women & Children's Development, issued April 2022	Open	Reasonable	Women and Children's Services	Women and Children's Services	Lisa Humphrey	Director of Operations	SSU_WHSSC_2122-02_005	Medium	R5. The Health Board should confirm provision of a Parent Company Guarantee in respect of Phase II of the Women and Childrens project at Glangwili.	5.1 Agreed. A new Parent Company Guarantee which includes changes to registered head office for both contractor and parent company, and the rebranding of the contractor, are in the process of being completed. The SCP is currently actioning, and has advised that this could take a further two months to complete.	Jul-22	~~Jul-22~~ ~~Sep-22~~ ~~Mar-23~~ May-23	External	08/07/2022: Update received from Assistant Major Capital Development Manager as follows - "Extension of time agreed. The SCP has announced that it is becoming an independent company. Framework Managers to confirm new company status, and whether PCG or other form of guarantee is required." Revised extension of September 2022 provided, this is outside of our control to action and could take longer. 12/08/22-No changes, Interim General Manager Women & Children needs to respond. 09/11/2022 - Internal audit to request progress updates and revised timescales. 11/11/2022- Welsh Government has issued revised Parent Company Guarantees to Tilbury Douglas (external company) and are awaiting their response/sign off. Should be received by end November 2022. Revised timescale March 2023. This is not a scheme specific problem, but a framework problem across the whole of Wales re. Tilbury Douglas contracts. 09/01/2023- Tilbury Douglas when reviewing, modified and added a clause so now this sits with TD and the framework manager (shared services) for discussion. Awaiting response from Tilbury Douglas. Sitting outside the UHB to currently implement, recommendation changed from red to external, as agreed with Internal Audit. 01/02/23 - Framework manager continues to gain a response from TD. If a response is not recieved by end Feb 23 TD will be issued with a revised PCG. 16/03/2023- Updates remains as above. 18/04/2023- TD were sent a revised PCG on 25/10/22, signature remains outstanding. Framework manager continues to gain a response from TD. 24/04/2023- TDC accepted the revised PCG terms following their restructure. Awaiting PCG for engrossment anticipated response 4 weeks. Revised timescale of May 2023 provided.
SSSU_HDU_2122_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07_007a	Medium	R7a. Identity checks should be undertaken to ensure correct labour rates are being applied.	Agreed	Aug-22	~~Mar-23~~ Jul-23	Red	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 26/04/2023- Draft follow up report states partially implemented – it was clear that the external project manager had scrutinised CV of SCP staff. However, noting the labour-intensive nature of the works and the SCP intention to change a number of key staff, it is important that a fully auditable trail is maintained linked to staff rates being applied. Revised timescale of July 2023. This report will be superseded by the follow up report once it is received at ARAC in May 2023.
HDUHB-2223-12	Aug-22	Internal Audit	Directorate Governance – GGH Unscheduled Care	Open	Reasonable	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Sarah Perry	Director of Operations	HDUHB-2223-12_005	Medium	R4. The directorate should target areas with low compliance rates and set a deadline for achieving the Health Board target compliance rate of 85%.	Statutory and Mandatory Training Compliance being reviewed within Sister/Charge Nurse & SNM 1:1 on a monthly basis. Plans to be devised to work towards compliance rate of 85% by November 2022. To monitor compliance through monthly Budget & Management meeting – and target areas of non-compliance (also looking at allocated staff time/flexible working to support). Review individual statutory & mandatory compliance through PADR (especially with implementation of pay progression PDR).	Nov-22	~~Mar-23~~ N/K	Red	16/01/2023- still to be achieved, delayed due to vacancies, operational pressures, etc. Revised target date of end March 2023. 72.39% compliance rate for Unscheduled Care as of January 2023.
HDUHB-2223-19	Oct-22	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	HDUHB-2223-19_001	Medium	R1. Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	In-patient falls group set up and Task & Finish group established to update Falls Policy.	Dec-22	~~Dec-22~~ ~~N/K~~ Jun-23	Red	20/01/2023 - Extended period of bereavement/sickness leave for Head of Nursing (Scheduled Care) resulting in meetings being postponed. Meetings now re-established and policy review in progress. Request has been made for final extension; date to be confirmed. 10/03/23 - The work that has been progressed so far was received at SNMT (09/03/23). Current Policy has been extended to June 2023 to ensure that all updates have been incorporated. 30/04/2023 - Recommendation is on track to be completed by 30/06/2023
HDUHB-2223-19	Oct-22	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	HDUHB-2223-19_002	Medium	R1. Consider re-launching the updated policy with an awareness campaign to ensure all clinical staff are au fait with the requirements	Falls policy following completion to be ratified through relevant Governance committees. Relaunch following approval	Feb-23	~~Feb-23~~ ~~N/K~~ Jul-23	Red	10/03/23- Once ratified further awareness raising of the revised policy and tools will be undertaken-Jul23 30/04/2023 - Recommendation is on track to be completed by 31/07/2023

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HDUHB-2223-19	Oct-22	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	HDUHB-2223-19_005	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	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
HDUHB-2223-19	Oct-22	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	HDUHB-2223-19_006	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	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
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_001	Low	R1. The entire catalogue of documentation must be reviewed and updated. All documents must have a date reviewed, and a due date for the next review to assist with confirming its relevance. We note that this could be partially or wholly addressed by the cyber security programme Policies and Procedures workstream.	We will add this recommendation to the policies and procedures workstream of the cyber programme to undertake a documentation review and ensure they are updated.	Mar-23	~~Mar-23~~ Jun-23	Red	16/01/2023 - One policy updated and approved. 5 going to next IGSC. 17/05/2023 - Two Digital policies remaining which have been to SRC for approval and require minor changes, following this the recommendation can be closed.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_002	Medium	R2. The Health Board should have one asset management system that contains all necessary data for its identification and remote monitoring. It should contain enough information on each asset so that its make/model/os/SNo./location, assigned user etc is recorded.	The Health Board has procured the FreshService Asset Management module which is part of our Service Management tool. This will be integrated with our various management platforms to provide a single asset register for the Health Board. This work forms part of the Asset Management Workstream of the cyber programme.	Aug-23	Aug-23	Amber	16/01/2023 - Project is commencing and the kick-off meeting is 25th January 2023 to implement system. 17/05/2023 - Workstream has now commenced, audit has been completed of the WGH Digital Stores and weekly meetings are now occuring to undertake all the tasks associated with the asset workstream of our cyber programme.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_003	Medium	R3. Suppliers should be monitored regularly, at annual review points, to ensure all contractual obligations, including claimed standards and accreditations for themselves and their staff are being maintained.	This recommendation is being picked up as part of the supply chain security workstream of our cyber programme where assurances will be sought at contract award and annual renewal of their standards and accreditations.	Jul-23	Jul-23	External	16/01/2023 - Work in progress. On track. 17/05/2023 - The Health Board is waiting for NWSSP to complete the All Wales Cyber assurance process which we will adopt. Rec status changed to External as outside the gift of the HB to complete rec at present.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_004a	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	Red	16/01/2023 - Work in progress. On track. 17/05/2023 - The integration of Solarwinds with FreshService is underway with requirements being scoped.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_005a	High	R5a. A process for patching of unpatched switches or other network components should be established. A mechanism to deal with/isolate equipment that cannot be brought up to the required security specification should be defined.	A change process has now been developed for upgrading switch firmware and is being tested in Elizabeth Williams Clinic and Ty Elwyn This process will be documented as a standard change once successful and a programme of deployment across the organisation as part of "Securing the Boundary" cyber workstream will be created. It should be noted it is envisaged this programme would take many months as would need to be carefully planned to ensure minimum disruption for clinical areas.	Mar-23	~~Mar-23~~ Dec-23	Red	16/01/2023 - Upgrades completed. Awaiting update. 17/05/2023 - Upgrades ongoing and are brought to the Change Advisory Board prior to implementation.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_005b	High	R5b. All equipment that utilises obsolete/unsupported, or insecure operating systems should be located, updated, removed, replaced, or isolated as a matter of urgency. An asset management process should be created, documented, and implemented to ensure the obsolescence of all equipment is monitored so that this situation cannot recur.	This work is already underway, and the latest dashboard is shows that over 99% of the desktop estate has been updated and the last devices remaining are a challenge due to legacy systems in use. The "securing the servers" workstream is improving patching compliance, deploying new anti-virus platform, and removing legacy objects and a dashboard is under development. Monitoring is now undertaken through NESSUS and Windows Defender which highlight old items.	Sep-23	Sep-23	Amber	16/01/2023 - Upgrades completed. Awaiting update. 17/05/2023 - New Anti-Virus platform has been fully deployed and the securing the servers workstream is working through the remaining legacy operating systems. There are 510 legacy desktop devices remaining and 136 servers.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_006	Low	R6. All data held, and that is about to be created by the digitisation project, should be reviewed and its data-quality dimensions established as per the HMG data quality framework. An assessment of the likely required network capacity should be undertaken to ensure that the network can handle the increased traffic.	The review of scanned images is a component of the Digitalisation of Health Records Project and CITO (our supplier) complies with the relevant ISO certification for health records scanning. The scanning communications take place between the scanning providers and our Azure platform therefore this process sits outside our network. However, network upgrade projects are underway at WGH and PPH hospitals and this will include capacity assessment.	Mar-24	Mar-24	Amber	08/03/2023 - Update from Carolyn: Preferred solution is cloud-based and therefore not on prem which means it should not impact our network. Expecting report some time in March 2023 (Auditor not raised this question yet).
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_003	N/A	R3. DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	This is agreed and linked to above development of the DAP costings and investment strategy development.	Mar-25	Mar-25	Amber	20/12/22- Internal Audit report states deadline to be aligned to meet targets for 2025 and 2030. 23/01/2023- to be clarified with Director of Strategic Development & Operational Planning if there is secured funding or outline where the funding will be sourced from.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_004	N/A	R4. NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	This is agreed. There is a requirement for Welsh Government to establish a fixed baseline that will better supports HBs to target set and reduce risk of reporting inaccuracies.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_008	N/A	R8. Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	This is agreed.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_009	N/A	R9. In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	This is agreed. The HB to utilise to the WG / PHW Carbon Awareness documentation once this is established.	N/A	N/A	External	20/12/22- Internal Audit report states Subject to external timescales, but this will continued to be monitored. 23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement.
SSU_HDU_2223_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_015	N/A	R15. The Health Board should, as a matter of priority, ensure the following from the Decarbonisation Action Plan is fully realised: Delivery Plan to be developed into detailed and costed departmental actions plans, in areas of transport, procurement, buildings and wider healthcare; and build responsibility for delivery across the organisation through divisional action plans and workstreams aligned with mapped objectives– assigning specific projects as required.	Submitted the Delivery Plan to Board for approval – Board approval provided 29th September. The HB DAP was the few plans to identify early funding need to enable us to deliver early win projects, develop design feasibility that will inform the DAP funding costs and investment strategy going forward. The HB to continue to explore opportunities to secure funding to support this work.	Jan-25	Jan-25	Amber	20/12/22- Internal Audit report states AP plan to align to funding opportunities and be targeted to meet targets for 2025 and 2030.
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_003a	High	R3.1 The WLS Team should chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director	The WLS Team to chase up the outstanding directorates and service for their self-assessment tool and escalate areas of non-engagement to the appropriate Executive Director, and support directorates and services, who request it, in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	~~Sep-23~~ ~~Mar-23~~ N/K	Red	05/12/2022 - This report superseded HDUHB-2122-12. 05/12/2022 - The action required in response to the recommendation has yet to be fully implemented. Whilst the majority of directorates and services have submitted a completed self-assessment tool to the Welsh Language Team, returns have not been received from the Nursing and Operations Directorates. A revised timescale for obtaining these has been set as the end of December 2022, which has been noted within Risk No.1232 on the Health Board risk register. A revised target completion date has been set for March 2023. Conclusion: Action Ongoing – Further Action Required. 20/02/2023 - Nursing have now completed their self-assessment. Operations Directorate still in the process of completing theirs. Service to chase up whether this will be completed by March 2023. 15/03/2023 - As of yet, still no response from Ops Directorate on this - they are going to check in with them this week to see how far they have progressed.

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HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_003b	High	R3.2 The WLS Team should support directorates and services in their development of action plans to address areas of non-compliance with the Standards.	The WLS Team will support directorates and services that engage with them in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	~~Sep-23~~ ~~Mar-23~~ N/K	Red	05/12/2022 - This report superseeded HDUHB-2122-12. 05/12/2022 - The action required in response to the recommendation has yet to be fully implemented. Whilst the majority of directorates and services have submitted a completed self-assessment tool to the Welsh Language Team, returns have not been received from the Nursing and Operations Directorates. A revised timescale for obtaining these has been set as the end of December 2022, which has been noted within Risk No.1232 on the Health Board risk register. A revised target completion date has been set for March 2023. Conclusion: Action Ongoing – Further Action Required. 20/02/2023 - Nursing have now completed their self-assessment. Operations Directorate still in the process of completing theirs. Service to chase up whether this will be completed by March 2023. 15/03/2023 - As of yet, still no response from Ops Directorate on this - they are going to check in with them this week to see how far they have progressed.
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_004	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	~~Mar-23~~ ~~Mar-23~~ ~~Apr-23~~ Sep-23	Red	05/12/2022 - This report superseded HDUHB-2122-12. 05/12/2022 - The Welsh Services Manager confirmed that the Steering Group will be formed once the Welsh Language and Culture Discovery report has been completed. The target date for this is by the end of March 2023. Conclusion: Not Implemented – Further Action Required 15/03/2023 - Aiming to establish the Steering Group in April 2023. 19/05/2023 - The timeline for the Discovery Group has slipped having a knock-on effect on the Steering Group. Revised completion date changed to Sept 2023.
HDUHB-2223-10	Jan-23	Internal Audit	Continuing Healthcare and Funded Nursing Care	Open	Reasonable	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	Head of Long-Term Care	Director of Primary Care, Community and Long Term Care	HDUHB-2223-10_003	Medium	R3. A formalised reporting structure should be introduced that allows for appropriate monitoring and assurance reporting to the Health Board or appropriate sub-committee.	There has been some work to try to develop a reporting template with the Corporate Team to align reporting with IPAR, however due the CHC sitting in 3 separate directorates it was difficult to combine these into a single format. Following discussion with the Director of Primary, Community and LTC an agreed format for scrutiny and performance monitoring will be in place going forward with the monthly service reports: Community & Care Home Report, LTC Pathway Report & Summary, Community Packages, LTC & DoLS staff Report, Monthly Performance, and Corporate Report. These are scrutinised monthly and challenged in a quarterly Key Performance meeting with the Head of Service and Team Leads. These reports will be sent to the Director of Primary Community and LTC for further Scrutiny on a quarterly basis prior to the planned dates for the Strategic Development & Operational Delivery Committee (SDODC). The Reports will then be summarised and submitted to SDODC for Executive oversight.	Feb-23	Jun-23	Red	22/02/2023- Senior Nurse Manager (Long Term Care) confirmed this has been delayed due to current workforce changes in the LTC team (performance manager role starting in April 2023, and Head of Long Term Care retiring in March 2023 with replacement to start in May 2023), with a revised date of June 2023 has been provided.
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_001	N/A	R1. Develop/Approve Programme governance and management framework – defined within a Project Initiation Document.	The existing Project Execution Plan proforma utilised for capital projects will be developed for the overall programme.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_002	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	Jan-24	Amber	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.
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_003	N/A	R3. The terms of reference of the Programme Groupshould clearly defined activities within and outside of scope.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_004	N/A	R4. When linkage is required to the Executive Team/ Executive Steering Group, the accountability arrangements should be clearly defined.	Agreed.	Jan-24	Jan-24	Amber	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.
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_005	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	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_006	N/A	R6. Terms of reference should be updated to confirm those members with and without delegated authority.	Only Health Board employees will have decision making responsibility and this will be confirmed with in respective terms of reference.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_007	N/A	R7. Project Initiation Documents should be produced for all workstreams.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_008	N/A	R8. Programme Team to set master programme targets to inform workstream targets.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_009	N/A	R9. The master programme should be activity/ task based.	Agreed.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_010	N/A	R10. The existing slide pack reporting to the Programme Groupshould be enhanced to include performance monitoring.	A full review will be undertaken of the slide pack to incorporate changes suggested at the audit and other best practice observed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_011	N/A	R11. The changes outlined should be extended to the Programme Team monitoring of the workstreams.	Agreed.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_012	N/A	R12. A concise and standardised method of workstream monitoring and reporting should be introduced.	The terms of reference will clearly state whether workstreams should produce action orientated or full minutes. A consistent format will be applied across all workstreams.	May-23	May-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_013	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	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_014	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	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_015	N/A	R15. Adequate representation will be secured from all key functions e.g workforce, clinical, finance, IT, hotel services etc.	Agreed.	Sep-23	Sep-23	Amber	
SSU-HDUDB-AHMWWP-0223	Feb-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	SSU-HDUDB-AHMWWP-0223_016	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	Sep-23	Amber	

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HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-002	Medium	R2.1 Ensure POL audits are completed as soon as possible for the remaining MH&LD sites and risk scores are correctly calculated in line with procedure.	We will complete POL audits for the outstanding Older Adult, Primary Care and Older Learning Disability Community Teams	Aug-22	~~Mar-23~~ Jun-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past. 16/05/2023- Deputy Directorate Support Manager confirmed Health & Safety Officer has reviewed the completed audits and action plans, and they need to be streamlined. H&S Officer revisiting Community Sites with Business Managers and Team Leads. Revised timescale of end of June 2023.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-003	Medium	R2.2 For the POL audits already completed, review and update the overall risk scores in line with procedure.	Risk scores will be rectified and the Risk Assessment Document will be amended.	Aug-22	~~Mar-23~~ Jun-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past. 16/05/2023- Deputy Directorate Support Manager confirmed risk scores will be reflected in the streamlined audits and action plans by end of June 2023.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_002	Medium	R2. The UHB should liaise with Specialist Estates Services to agree a framework approach to ensuring the SCP completes contractual documentation in a timely manner.	Future assurance – at future contracts	Mar-24	Mar-24	Amber	14/03/2023- IA confirmed this recommendation is for future contracts, and the suggestion of a 12 month deadline (March 2024) would be sensible as there are likely to be more contracts executed with this specific contractor in that period – which should allow us to close the recommendation.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_004	Low	R4. Reporting within the WG dashboard reports should be enhanced to ensure a consistent message is being shared.	The sensitivity analysis reported within the commercial report will be embedded within the dashboard to provide the potential forecast outcomes based on current assumptions.	May-23	May-23	Amber	09/03/2023- Estates colleagues confirmed this recommendation is on track for May 2023 timescale. 26/04/2023- the cost advisors report is presented to each Project Team meeting, which will include potential forecast outcomes based on current assumptions. On track for May 2023 timescale.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_005	Medium	R5. Identity checks should be undertaken to ensure that the correct labour rates are being applied.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	26/04/2023- on track. Similar exercise being undertaken with WGH.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_006	Medium	R6. Additional labour rates should be removed or agreed with the UHB as a contractual amendment.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	26/04/2023- on track. Similar exercise being undertaken with WGH.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_007	Medium	R7. A time & cost analysis of shared resource across both GGH and WGH project should be undertakento demonstrate value for money.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	26/04/2023- on track. Similar exercise being undertaken with WGH.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_008	Low	R8. Additional information should be supplied within the commercial report differentiating disallowed and unsubstantiated costs.	Agreed - UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented.	Jun-23	Jun-23	Amber	26/04/2023- on track. Similar exercise being undertaken with WGH.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_009	Medium	R9. Delegated limits should be reviewed to provide an upper financial limit for Project Manager approvals. Where external resource is used to support items such as room clearances; these instances should be recorded/ approved by the UHB.	Enhanced approval mechanisms will be implemented. However, the requirement for external resource will be reduced with the approval of soft FM support for the project at the January Project Group.	Jul-23	Jul-23	Amber	26/04/2023- on track.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_010	Low	R10. The reporting of project changes should be made more specific and meaningful for the Project Group.	UHB will co-ordinate with the Cost Adviser to ensure recommendation is implemented	Apr-23	~~Apr-23~~ N/K	Red	26/04/2023- Major Capital Development Manager to confirm if this has been implemented.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_011	Medium	R11. Further efforts are required to ensure design resolutions are undertaken in a timely manner; and an effective audit trail of evidence needs to be maintained that supports the performance issues raised with the contractor.	UHB will co-ordinate with the Project Manager to ensure the performance of the design team is improved.	May-23	May-23	Amber	26/04/2023- on track.
SSU-HDUHB-2223-02	Feb-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	SSU-HDUHB-2223-02_002	Low	R2. The Project Manager's report should ensure clarity as to the outstanding number of Compensation Events, Early Warnings and other notifications awaiting action by the client and the SCP.	The Project Manager will clearly report the outstanding number of Compensation Events, Early Warnings and other notifications awaiting action by the client and the SCP.	Mar-23	~~Mar-23~~ May-23	Red	16/03/2023- Reporting of CE's will be addressed in the PM report due at the end of the month. 18/04/2023- Evidence submitted to Audit 17/04/2023. Awaiting audit response. 15/05/2023- Audit were not entirely happy with the revised format for reporting Compensation Events, Early Warnings, etc. The Project Manager will address these comments in their next PM report in the next two weeks.
SSU-HDUHB-2223-02	Feb-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	SSU-HDUHB-2223-02_003	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 whichhas 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.
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001a	N/A	R1a. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business case will be the case for change, which will outline the proposed plan. Timeline: • Strategic Options Appraisal– February 2023	Feb-23	~~Feb-23~~ N/K	Red	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001b	N/A	R1b. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business ca se will be the case for change, which will outline the proposed plan. Timeline: • Case for Change / Business Case – September 2023	Sep-23	Sep-23	Amber	

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HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001c	N/A	R1c. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business case will be the case for change, which will outline the proposed plan. Timeline: • Design / Delivery –October 2023 – March 2024	Oct-23	Oct-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_002	N/A	R2. The Health Board should make a full assessment of the current digital capability and willingness of all key stakeholder groups and get their commitment to a shared digital future.	Access to information, and the capability to use digital systems is an integral component of the Health Board's Digital Inclusion Programme. The Health Board has subsequently signed the Digital Inclusion Charter for Wales and were accredited in September 2022 having successfully demonstrated its commitment to implementing the Digital Inclusion Charter principles. The Health Board will continue to work with stakeholders to ensure that the digital enablement plan is embedded within the organisation but also with our partners. An important element of the programme is Parity of access to ensure patients / staff using digital routes (e.g. an online access method for appointments) do not have an unfair advantage over patients using traditional access methods (e.g. a walk in enquiry or telephone call). Equity of access to care should ensure all patients are able to access effective, safe and timely care regardless of the method of care they choose to adopt.	Dec-23	Dec-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_003	N/A	R3. The Health Board should relaunch both their Strategy and Digital Response to reinforce the message of the need for change to achieve the digital and overall ambitions.	The Health Board acknowledges that the previous Digital Response was not fully socialised across all areas of the organisation and will be ensuring that the next version of the digital enablement plan is closer aligned to the Health Board's strategy "A Healthier Mid and West Wales".	May-23	May-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_004	N/A	R4. The Health Board should define the digital skills that are required for each role and provide training to ensure that staff are digitally upskilled to a level appropriate for the technology they are going to have to use. Training and awareness sessions should be provided to communicate to staff what applications are available and what they do. With training provided on digital skills in general, and on specific products to enable the full use of the functionality within the digital tools available, such as Office 365. Consideration should be given to stating a requirement for a minimum level of digital literacy for staff.	The Learning and Development and Digital Teams are working closely together to ensure that digital training and awareness sessions are made available to all staff. The Digital team are also engaged with the Office 365 Centre of Excellent to ensure that courses that are feely available are communicated via the Digital Champions network and through global communications.	Nov-23	Nov-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_005	N/A	R5. The Health Board should consider establishing a formal committee for digital. Should this not be possible, then the terms of reference for the relevant committee be expanded to ensure digital is fully covered and digital should be explicitly included as a standard agenda item within another committee.	The Digital programme reports to the Sustainable Resources Committee. There is a requirement for a report from the Digital Director every meeting. The Executive Director of Finance supported by the Digital Director and Chief Clinical Information Officer (CCIO) provide the Board with the necessary assurances around the entirety of the digital agenda. The Board is also supported by an experienced independent member who providesthe necessary security upon the digital programme, and risks.	Mar-23	~~Mar-23~~ N/K	Red	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_006	N/A	R6. The Health Board should consider the 'Digital Business Partner' idea, especially for any clinical directorates that are heavily reliant on ICT who have their own digital expertise. There are areas E.G supplier equipment updates where there could be real benefits from high level cooperation and rapid request response times.	The Digital Director will look to expand the current arrangements in place for radiology, and ophthalmology who have dedicated staff. Senior members of the digital team will also be looking to provide support to be created clinical support network of the Chief Clinical Information Officer. The approach is to ensure that the clinical lead is partnered with a member of the senior digital team	Sep-23	Sep-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_007	N/A	R7. The digital team should ensure that all planned development listings are regularly updated and publicised to all participantsand contributors. Explanations for any delays to planned delivery, priority changes etc must be included if ongoing support through continuous suggestions and submissions are to be maintained.	The development of the project support package (PACE) will improve the visibility of all digital programmes.	Aug-23	Aug-23	Amber	
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_008	N/A	R8. The Health Board should retain oversight of all digital change through a centralised change control process. All digital changes, regardless of their originating directorate should go through this process, which should be managed by a change control groupreporting through senior management to the full Health Board as necessary.	The Health Board currently operates a Change Advisory Board (CAB) held weekly to discuss technical changes to the underlying infrastructure. Changes will not routinely be escalated to the Executive Team for approval, however each proposed change is risk assessed, and if required will be raised to the Executive Team. The Digital Team do acknowledge that the current Change Advisory Board need to be expanded to include all changes affecting Health Board systems, such as upgrades to functionality.	Sep-23	Sep-23	Amber	17/05/2023 - The new digital change advisory structure has been agreed and the department is currently creating a Community Systems CAB and a Clinical Applications CAB along with the current ICT CAB. These will escalate any significant and / or high risk changes to the Digital Senior Team for approval and escalation where required.
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_009	N/A	R9. A review of the funding allocated to digital and digital technologies should be undertaken to ensure that the resource is sufficient to deliver on stated and planned strategies.Where funding is unavailable, the impact of that on delivery of the Digital Response and plans should be made clear.	The Executive Director of Finance and Digital Director are currently working through the financial implications of the digital enablement plan, and the funding required. Each of the funding proposals will be risked assessed, and where required will be supplemented with a business case for investment.	Jun-23	Jun-23	Amber	
HDUHB-2223-17	Mar-23	Internal Audit	Patient Experience	Open	Reasonable	Nursing	Nursing	Assistant Director (Legal & Patient Support)	Director of Nursing, Quality and Patient Experience	HDUHB-2223-17_001	Medium	R1. Establish a plan for review and formal launch of the Charter for Improving Patient Experience.	The formal plan for review and launch of the Charter for Improving Experience will be presented to the Listening and Learning Sub-Committee.	May-23	May-23	Amber	21/04/2023-In target to be completed by May 2023; work is ongoing in accordance with the Quality and Engagement Act charter.
HDUHB-2223-17	Mar-23	Internal Audit	Patient Experience	Open	Reasonable	Nursing	Nursing	Assistant Director (Legal & Patient Support)	Director of Nursing, Quality and Patient Experience	HDUHB-2223-17_002	Medium	R2. Develop a system implementation and training plan to ensure timely and controlled rollout of full system functionality, and ensure all required staff are appropriately trained in using the system.	Training dates continue to be offered via the global system and direct communication with the service leads. Accounts will only be activated once the training has been undertaken with the relevant staff members. Initial training is aimed at awareness and basic operation of the system to access feedback. Further training will be targeted to individual teams to operate the enhanced features of the system once the team is regularly accessing feedback. Support and assistance will be available from the patient experience team throughout. System Implementation Plan progress updates will be provided as part of a standing agenda item to Listening and Learning Sub-Committee. Exception reporting of any issues preventing full implementation will be escalated to QSEC/OQSEC.	May-23	May-23	Amber	21/04/2023-Training has been provided and accounts have been activated following training sessions.
HDUHB-2223-17	Mar-23	Internal Audit	Patient Experience	Open	Reasonable	Nursing	Nursing	Assistant Director (Legal & Patient Support)	Director of Nursing, Quality and Patient Experience	HDUHB-2223-17_003a	Medium	R3. Monitor system use and engage with users to identify and address any additional training needs.	A report of the training attendance and user accounts will be made available as part of the assurance report on the implementation plan.	May-23	May-23	Amber	
HDUHB-2223-17	Mar-23	Internal Audit	Patient Experience	Open	Reasonable	Nursing	Nursing	Assistant Director (Legal & Patient Support)	Director of Nursing, Quality and Patient Experience	HDUHB-2223-17_003b	Medium	R3. Monitor system use and engage with users to identify and address any additional training needs.	Service area usage of the system will also be reported to Triumvirate Teams and will be a key performance measure to success of the system.	Jul-23	Jul-23	Amber	
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_001a	Medium	R1. Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	All Heads of Nursing to discuss at Professional Nurse Forums (PNF) the importance of timely completion of Purpose T risk assessments and completion of associated care plans.	Apr-23	~~Apr-23~~ N/K	Red	25/04/2023 - HoN BGH has confirmed that this recommendation is implemented in BGH. 04/05/2023 - Deputy HoN has confirmed that this recommnedation is completed in PPH
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_001c	Medium	R1. Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	Spot check audits in relation to Purpose T Risk Assessment and associated Care plans to be undertaken as part of the agreed standardised Audit development framework plan.	Jun-23	Jun-23	Amber	
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_002	High	R2. Investigation and closure of open incidents should be prioritised, with a timescale for completion.	All staff need to be reminded of the importance of timely investigation of incidents in line with Patient Safety flow chart.	Apr-23	~~Apr-23~~ N/K	Red	
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_003	High	R3. In line with the patient safety flow chart: • Management review of incidents must be undertaken within 72 hours. If this is not feasible in the short term due to service pressures, an improvement plan should be developed to support achievement. • Incident investigation must be completed within 30/60 days • Investigation of pressure damage incidents must include completion of the focussed review	All areas to develop improvement plans as to how the 72 hour target is to be metwith target dates, this will need to be monitored via the Improving Together Meetings	Jul-23	Jul-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_004	Medium	R4. Scrutiny & Assurance meetings to be held monthly at all four sites in line with the terms of reference, with regular review of pressure damage and medication error incidents.	All sites to be reminded of the importance of undertaking scrutiny meetings monthly and audits to be undertaken in relation to monitoring compliance against this standard	May-23	May-23	Amber	
HDUHB-2223-28	Apr-23	Internal Audit	Regional Integration Fund	Open	Reasonable	Finance	Finance	Director of Finance	Director of Finance	HDUHB-2223-28_001	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	Amber	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).
HDUHB-2223-28	Apr-23	Internal Audit	Regional Integration Fund	Open	Reasonable	Finance	Finance	Senior Finance Business Partner	Director of Finance	HDUHB-2223-28_002	Medium	R2. The forecast overspend (and therefore potential financial loss to the Health Board) related to Health Board led projects should be included in reporting to SRC.	We will include performance on Health Board-led projects in our reporting to SRC and to Board.	Jun-23	Jun-23	Amber	11/05/2023 - Sustainable Resources Committee (SRC) June 2023 financial reports to incorporate Regional Integration Fund (RIF) reporting as appendix. The same format paper is to be included within Board and SRC reporting to mirror Board in July 2023 and beyond.
HDUHB-2223-04	Apr-23	Internal Audit	Service Reset and Recovery	Open	Reasonable	Acute Services	Scheduled Care	Director of Scheduled Care	Director of Operations	HDUHB-2223-04_001	Medium	R1. New or amended delivery ambitions and targets should be identified, documented and communicated to the Health Board to aid the continued progress of reducing waiting list figures.	To supplement regular reports provided to Board and SDODC regarding performance progress against the planned care ministerial priorities, periodic reports to SDODC during 2023/24 will also include progress against supporting transformational delivery ambitions.	Aug-23	Aug-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_001	High	R1. An additional funding request should be made to Welsh Government.	Agreed – the additional funding request is currently being compiled for consideration by Welsh Government. Welsh Government has requested this be submitted by May 2023.	May-23	May-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_002	High	R2. An option appraisal should be undertaken highlighting the various scenarios with associate risks if additional full, partial or no additional funding is realised.	Agreed – Should funding support not be forthcoming, an assessment will be undertaken of alternative means of funding this deficiency, with a report issued to Executive Directors.	Jul-23	Jul-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_003	Medium	R3. Further efforts are required to gain assurance surrounding the level of VAT reclaim at this project.	Agreed – We will continue to contact HMRC monthly to determine a guide date from HMRC to when they will respond.	Sep-23	Sep-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_004	Medium	R4. Costs associated with replacement fire doors should be appropriately determined with an effective audit trail being maintained.	Agreed – Additional information had been provided to the cost adviser by the supply chain partner to sufficiently enable the placing of orders for part of the projectThe remaining part of the project is still subject to review with additional evidence in preparation for assessment by the cost adviser.	Jul-23	Jul-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_005	Medium	R5. Enhancement should be made to the dashboard reports, to ensure a full range outcome are appropriately presented.	Agreed – additional details will be provided through the dashboard return.	Jun-23	Jun-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_006	Medium	R6. A review should be undertaken to analyse and learn lessons of performance issues at this project, so that similar issues and other similar projects can be mitigated at an early stage.	Agreed – a lessons learned exercise will be undertaken covering the performance issues raised above and results used to inform future projects of this type. We will contact NWSSP SES to discuss the facilitation of this exercise given the wider learning possible.	Feb-24	Feb-24	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_008	Medium	R8. Project group should proactively monitor timely resolution of the request for information process.	Agreed – This will form a specific part of the PM report and will receive scrutiny at the monthly Project Group meetings.	Jun-23	Jun-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_009	Medium	R9. Tracking of the community benefits should be updated to reflect target dates with meaningful commentary as to the current position.	Agreed – an updated position will be provided through the commercial reports that are submitted to the Project Group.	Jun-23	Jun-23	Amber	
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_010	Low	R10. A summary position of the performance for implementing community benefits should be routinely reported.	Agreed – This will form a specific part of the PM report and will receive scrutiny at the monthly Project Group meetings.	Jun-23	Jun-23	Amber	
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional	Medical Director	HDUHB-2223-20_001	Medium	R1. Consultants with a non-compliant current job plan should be promptly reviewed and approved by all parties involved.	Managers to provide schedule of job plan review meetings for every doctor within their specialty for the year ahead.	Jul-23	Jul-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_002	Medium	R2. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15 month period of the last review.	Proposal to allocate clinicians with allocated quarters in which job plan reviews should be carried out each year. Job plan communications and non-compliance process will then mirror that of the appraisal process, which has proved effective. This approach may need to be approved by the LNC before implementation.	Jul-23	Jul-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_003	High	R3. Service management 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.	Service managers and clinicians to be reminded of the need to include service outcomes and training to be delivered to support. Job planning team to work with managers to create baseline lists of service outcomes for each specialty to include in the service outcome section. Job planning team to review the job plans that are in process so that prompts can be sent to managers before sign off in the event that service outcomes have not been included.	Aug-23	Aug-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_004	Low	R4. Personal outcomes should be explicitly set out and agreed by the consultant and service management in all job plans.	Job planning team to continue to remind the managers and clinicians of the need to include the personal outcomes and provide support where needed.	May-23	May-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_005	High	R5. Service management should ensure that all agreed consultant sessions recorded on job plans are accurately reflected in ESR through the prompt submission of a change form to NWSSP Payroll Services.	A review of the process surrounding job planning will be undertaken by a group linked to the medical workforce effectiveness workstream. This group will ensure managers are reminded of their responsibilities which includes accurately recording the detail of job plans in allocate and also producing the paperwork for changes to sessions agreed as part of the process.	Jun-23	Jun-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006a	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	A regular audit of job plans and ESR records will be developed and administered by the medical workforce team.	Jul-23	Jul-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006b	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 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.	Jul-23	Jul-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.

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HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006c	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Roll out schedule for correcting any inconsistencies to be developed & agreed.	Jun-23	Jun-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006d	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Changes to be actioned in ESR where necessary.	Jun-23	Jun-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006e	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Arrangements in place for bi-annual audit.	Dec-23	Dec-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_007	High	R7. Quantify the total over/underpayments for the 12 identified in this audit and take action to recover/pay.	Finance Business Partners to work with relevant Service Delivery Managers and Medical Workforce to quantify total over/underpayments for the 12 identified in this audit and take action to recover/pay.	Jul-23	Jul-23	Amber	16/05/2023 - A meeting is planned for 23/05/2023 between the Head of Medical Education & Professional Standards and the Director of Secondary Care to discuss this report. A progress report is expected following this meeting.
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Digital and Performance	Central Operations	Digital Director	Director of Finance	HDUHB-2223-25_001	High	R1. A single, overarching programme should be created for digitalisation. It should include all projects with an outline delivery schedule and key milestones to facilitate progress and measurement. Financial projections should be included for all projects, and combined as necessary to indicate total programme cost. Project and programme progress reports should accurately report: • all costs to date, comparison against budget/plan. • Progress against milestones, interim objectives. • Immediate risks • Next steps • RAG status on achieving overall objective	We will aim to establish an overarching programme to provide the necessary governance and assurance to the Board, and would enable the bringing together of the two current workstreams in a more formal approach.	Jul-23	Jul-23	Amber	
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Digital and Performance	Central Operations	Digital Director	Director of Finance	HDUHB-2223-25_002	Medium	R2. Once costs are projected (MA1) a full Cost Benefit Analysis should be prepared to include the projects effect on the boards cashflow and overall financial effect. It should be updated accurately with the latest 'known' information and realistic estimates included as necessary. This process should be constantly maintained and reported through all appropriate channels regularly as considered appropriate.	In order to comply with Recommendation 1, a full review of the costs will be undertaken, which will include the on-going revenue costs for the continued roll out of the digitalisation of health documentation across the Health Board.	Sep-23	Sep-23	Amber	
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Digital and Performance	Central Operations	Digital Director	Director of Finance	HDUHB-2223-25_003	High	R3. A benefits tracker for the current project(s) should be completed showing expected realisation dates and effects/values. (Either for each project separately, or a combined one for the overall digitalisation programme.) There should be clarity as which part of the whole digitisation programme the benefits are attributable to so as to avoid double counting, and the tracker should include the following: • Benefit owners should be identified • Current baselines should be established and recorded. • Measurement criteria should be clarified and agreed. • Measurement methodology and monitoring, (kpi/automation as appropriate) should be agreed. • Expected benefit delivery schedule should be agreed.	To fulfil Recommendation 1, the current digital benefits realisation framework will be retrospectively applied to the new overarching programme, and it will detail a full benefits plan with associated metrics for tracking said benefits.	Sep-23	Sep-23	Amber	
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Digital and Performance	Central Operations	Digital Director	Director of Finance	HDUHB-2223-25_004	Medium	R4. Feedback from the tests (reported February 2023) should be used to refine/improve the processes and address any issues raised during testing. Larger scale UAT with testers representative of all groups and grades of users from all disciplines and areas should be repeated on the final proposed system prior to going live.	As we have only undertaken a soft launch of the product (specifically in Medical Records) a limited number of staff were used to UAT the system. For assurance purposes, during the quality assurance of the ingested records, 15 staff were accessing the system routinely, both from medical records and digital, to validate the records. Before full roll-out across the Health Board a full UAT test plan, and wider stakeholder engagement will be undertaken.	Dec-23	Dec-23	Amber	
MHRA-28172/119309-0018	May-22	MHRA	Insp BLCA 28172/119309-0018 - Withybush General Hospital	Open	N/A	Pathology	Pathology	Hannah Albery	Director of Operations	MHRA-28172/119309-0018_012c	High	R12. Laboratory training was inadequate in that there has been no assessment to determine staff training requirements for the maintenance and troubleshooting of the Ortho Vision analyser. For example, staff could not demonstrate how to troubleshoot analyser maintenance failures to bring the analyser back into operational use.	Review training and competency documentation for Ortho Vision analyser to ensure it adequately covers maintenance and troubleshooting.	Jun-22	~~Jun-22~~ ~~Sep-22~~ ~~Feb-23~~ ~~May-23~~ Sept-23	Red	15/03/2023 - In order to fully address the training the MHRA noted in its findings, funding was agreed to send the blood bank manager at WGH and one other member of staff to receive advanced operator training. Study leave forms were completed for the 2 staff members in December 2022 and the training was scheduled for May 2023. This has since been postponed until September 2023. Following completion of this training, this report can be closed.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 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. Forecasted completion date presented to, and agreed by, MWWFRS is July 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber	Progress update/Reason overdue
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the M 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.WWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 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. Forecasted completion date presented to, and agreed by, MWWFRS is July 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 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. Forecasted completion date presented to, and agreed by, MWWFRS is July 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 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. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 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. Forecasted completion date presented to, and agreed by, MWWFRS is July 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.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	Amber	This work is part of the pHase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 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. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 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. Forecasted completion date presented to, and agreed by, MWWFRS is July 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.
BFS/KS/SJM/00114719- KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719-KS/890/04	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/00114719_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber	Progress update/Reason overdue
KS/890/08	Nov-20	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	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ ~~Feb-23~~ Aug-23	~~Jul-22~~ ~~Feb-23~~ Nov-23	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 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 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. 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.
KS/890/09	Nov-20	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	KS/890/09_01	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 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.
BFS/KS/AMD/00106219	Apr-22	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	BFS/KS/AMD/00106219_002	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 delivey 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.
BFS/KS/AMD/00106219	Apr-22	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	BFS/KS/AMD/00106219_003	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 delivey 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.
BFS/KS/AMD/00106219	Apr-22	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	BFS/KS/AMD/00106219_005	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.
BFS/KS/AMD/00106219	Apr-22	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	BFS/KS/AMD/00106219_007	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 delivey plan for the site is to March 2025. Recommendation moved back from red to amber.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber	Progress update/Reason overdue
BFS/KS/AMD/001 06219	Apr-22	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	BFS/KS/AMD/001 06219_008	High	Item 4- R8. All door release devices (Including floor pneumatic release devices) should work in accordance with the relevant British standard: BS 7273-4:2015 actuation of release mechanisms for doors and comply with WHTM 05-02 Appendix C: Door Closers and Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. • Diabetic unit • This action should be carried out over the whole site and as part of the fire door survey mentioned in item 1 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22 Mar-24	~~Oct-22~~ Mar-24	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. This recommendation will be picked up in phase 1 as part of the EFAB funding for 2023/24. 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. Will be addressed in Phase 1. Completion date March 2024.
BFS/KS/AMD/001 06219	Apr-22	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	BFS/KS/AMD/001 06219_013	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.
BFS/KS/AMD/001 15940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/001 15940_001	High	R1. A fire door survey is required at the Tenby cottage hospital site due to a number of defects found at the time of inspection. The findings of this survey must be completed within the mentioned timescale. Fire resisting doors need to be fitted with: • A self-closing devices 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-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 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 completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. 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.
BFS/KS/AMD/001 15940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/001 15940_002	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). 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. WHTM 05-02 Chapter 5 and paragraph 5.12. 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.	~~Oct-22~~ ~~Mar-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 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 completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. 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.
BFS/KS/AMD/001 15940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/001 15940_003	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also 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.	~~Oct-22~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 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. Revised date of March 2024 provided and agreed by MWWFRS. Recommendation moved back from red to amber.
BFS/SM/AMD/00 107788	May-22	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	BFS/SM/AMD/001 07788_001	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.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	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. Detailed costs obtained for 106 repairable doors. Site review with NWSSP-SES to agree prioritisation of door replacements for EFAB funding. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 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 and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00 107788	May-22	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	BFS/SM/AMD/001 07788_003	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.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	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- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 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 and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00 107788	May-22	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	BFS/SM/AMD/001 07788_004	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	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- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 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 and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00 107788	May-22	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	BFS/SM/AMD/001 07788_005	High	R5. The cross-corridor doors in "Picu" was missing a self-closing device. A self-closing device is required on this door to ensure it closes fully into its rebate.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	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. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year. 15/12/2022- Head of Estates Risk & Compliance to confirm with GGH colleagues if this recommendation is now implemented. 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 and the revised date of March 2024. RAG status of recommendations changed back from red to amber.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
BFS/SM/AMD/00107788	May-22	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	BFS/SM/AMD/00107788_008	High	8. A hold open device (or alternative solution) is required on the "Step Down" kitchen door. 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.	~~Nov-23~~ Mar-24	~~Nov-23~~ ~~Oct-23~~ Mar-24	Amber	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- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 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 and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
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Admin - General/00329501	Jun-22	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	Admin - General/00329501_006	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.
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Admin - General/00329498	Jun-22	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	Admin - General/00329498_001	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 thay 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.
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Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_001	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/00329500) 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 of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
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Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	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/00329500) 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 of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
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BFS/KS/JEL/00115068	Sep-22	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	BFS/KS/JEL/00115068_001	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 05O2, 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.
BFS/KS/JEL/00115068	Sep-22	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	BFS/KS/JEL/00115068_002	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.
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NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_001	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jun-23	~~Jul-23~~ Mar-24	Amber	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_004	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ Jun-23	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).

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NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_005	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	Aug-23	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_006	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	Amber	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_007	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	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_008	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	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_009	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	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_010	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	Amber	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_011	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	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_015	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	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_021	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ Sep-23	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).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_022	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	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).
PR_RCR0616	Jun-16	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	PR_RCR0616_001	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	Ongoing	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
PR_HDUHBLR0120	Jan-20	Peer Review	Hywel Dda UHB Lung Report, issued January 2020	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	TBC	PR_HDUHBLR0120_003	N/A	R3. High 30 day mortality reported for SACT. The submission showed a 7.9% 30 day mortality for patients undergoing SACT. This is higher than the rest of Wales (0-3.6%).	The post Peer review business MDT agreed that at each business meeting 30 day mortality for SACT for each oncologist would be presented and discussed.	N/K	N/K	Red	
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_004	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External	03/05/2022 - Health Board are still awaiting receipt of the standardised national template. Unable to progress the recommendation until received, therefore status amended to External. 30/06/22 no update to position- template awaited. However, access to "Cardiobase" for Cardiff- based cases has now been formally secured for all HD PECs 18/08/2022 - standard national template still awaited 30/11/2022 - no further progress or update since last review

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule,	Progress update/Reason overdue
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_009	N/A	Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health	Job plan review	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ Oct-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - every cardiac clinic has a PEC when held, and covers all sites. Further clarification on job plans required and a revised timescale. 30/06/22- all clinicians actively participate within the network and work in collaboration with the tertiary consultants. Job planning activity yet to be completed but will now be revisited following appointment of new clinical lead. Job planning will also support the development of formalised honorary contracts. 18/8/2022 - Awaiting job planning & honorary contract 30/11/2022 - Job plans to be completed (in progress) during Q4 2022/23- 1 honorary contract arranged. 04/04/2023 - 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.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ Oct-23	Red	30/11/2022 - Initially unable to agree additional Echo technician capacity due to existing constraints in capacity- however, discussions and solutions are being revisited with Echocardiology team and Cardiology SDM. Unable to assign a date at this time. 19/01/23 - Discussion under way with Cardio-Respiratory department who would need to identify resources. Potential revised date to be identified after this discussion. 04/04/2023 - No capacity available at this time. Discussions are ongoing. Potential requirement for funding and recruitment.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_021	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- 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. Pathway to UHW remains intact.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_022	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- 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. Pathway to UHW remains intact.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_023	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment.	Response requested from lead officer.	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - Given patient/service user cohort sits within maternity services, request made to Head of Midwifery for an update on current provision.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	~~Mar-22~~ ~~Jan-23~~ Oct-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - discussions have commenced with the dental pathways, awaiting further response to progress the recommendation. 30/06/22- HB Dental leads continue to review the process- update requested from deputy director today 18/08/2022 - Awaiting update 30/11/2022 - Paeds service still awaiting update from HB Dental service- SDM has chased. 25/01/2023-AMD- Dental has identified a pathway in SBUHB and is assessing whether this is a primary pathway that would be accessed by HDUHB patients. 09/03/2023 - Discussion with DoN at the IT meeting to clearly identify what sits outside of our direct influence/ responsibility- this may be one as dental services have their own management structure. Update on issues in relation to dental risks from a patient-facing perspective: all patients at risk are advised to have good dental care and see a dentist regularly. Difficulty accessing NHS dentists is a potential contributor to increased risk. SM to provide an update on the timeline for the coding rollout if any available.Including advice on dental and other IE prophylaxis now every clinic letter. 04/04/23 Update on issues in relation to dental risks from a patient-facing perspective: all patients at risk are advised to have good dental care and see a dentist regularly. Difficulty accessing NHS dentists is a potential contributor to increased risk. Tertiary colleagues however, have access to specialist dental input if indicated. HD pathway is being defined by AMD (Dental) but no update receved from AMD at time of this submission.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_001	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	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. Approach is via ARCH. 24/08/2022 - DB to update PR. 22/02/2023 - Debra Bennett 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.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_002	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	Red	12/05/2022 – peer review was presented at May OpQSE, and SDM is currently updating the action plan with service leads and in process of obtaining revised completion dates for outstanding recommendations. 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 Barringtom to cover the LGI Oncology service within HDUHB. 22/02/2023 - Currently working with Swansea Bay on Strategic Business Case. This piece of work is included. Relooking at whole Oncology service for whole S.Wales. Within next 12 months, single-handed Oncologist is going to have review of work plan and build better clinical governance into her practice up north - details TBC.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_001	N/A	R1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as oneHealth Board and not hospital by hospital.	Awaiting management response.	N/K	May-23	Red	22/06/2022 - SBAR prepared for Operational Quality Safety and Experience Assurance Committee to consider the finding and recommendations outlined within the GIRFT report and support the establishment of an Orthopaedic Steering Group to oversee and progress actions in respect of recommendations highlighted, to be report via the Operational Planning & Delivery Group structure 18/04/2023 - Steering Group is being set up with first meeting before end of June 2022.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_002	N/A	R2. Review the detail of the Orthopaedics Action Plan at Annex A which includes recommendations about identified unwarranted variation	Awaiting management response.	N/K	May-23	Red	18/04/2023 - Annex A Action plan being discussed with clinical lead.

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RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_007	N/A	R7. Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient's home prior to admission. For emergency admissions (e.g. fracture neck of femur), these should be assessed early on during their admission to agree their likely support package, which can be tweaked if the patient's condition changes. Currently, a Social Services assessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficient use of valuable beds, thereby reducing elective surgical admissions. We need a risk share between the hospitals and Social Services as elective patients are disadvantaged due to lack of bed availability.	Awaiting management response.	N/K	Jun-23	Red	30/06/2022 - Process for elective and emergency admissions is currently being reviewed by the Occupational Therapy Service to remove variation in practice across counties. Pre-covid process was that Furniture Height Forms were completed by all the elective hip/ revision replacement patients prior to Preadmission appointment and returned at that appointment. This was forwarded to the OT department for assessment, and they arranged equipment delivery prior to admission or alternatively OTs contacted patients on advice of impending admission date to capture this data. Knee replacement patients were managed similarly, but only those identified by the pre-assessment service as requiring support. Early discussions have taken place with Social Services in Pembrokeshire regarding a pilot to refer surgical patients, on being listed for surgery (potentially at prehabilitation) to Reablement so that immediate assessments can be undertaken to identify aids, physio and third sector support that can be offered to the patient whilst they await surgery. Social Services are also keen to earlier support for emergency patients Currently existence of 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 staff shortfalls. An MDT (multidisciplinary team) approach in managing revisions and complex admissions requiring referral from WGH, BGH (Bronglais General Hospital) and community facilities to these surgeons for treatment at GGH is in the planning phase, which will also consider the total pathway of care for these patients 18/04/2023 - Equipment being delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_008	N/A	R8. Carry out a review of PROMS data collection and usage and the processes used to ensure data accuracy. We found inconsistencies in the way PROMS data is recorded and used across all Health Boards.	Awaiting management response.	N/K	Jun-23	Red	30/06/2022 - The T&O Management team and service work very closely with the VBHC (Value Based Health and Care) team in the implementation and collection of PROMS (Patient Reported Outcome Measures). This is collected at Pre-admission and for all post-operative arthroplasty patients and is also being utilised in the Upper limb pathways. Collection at prehabilitation is also being considered currently. We would wish to extend the use of PROMs further, but this is constrained by resource. The VBHC (Value Based Health and Care) team are working with WG (Welsh Government) and the Welsh Value in Health Centre on data standards. 30/09/2023 - Following receipt of GIRFT's specific concerns this recommendation addressed more fully by the Steering Group 18/04/2023 - PROMS is collected for all arthroplasty patients at prehabilitation stage and one year post-surgery. Currently reviewing further collection at joint school (approx 3 months before surgery). Consultant views also being sought.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_010	N/A	R10. Each hospital site must keep accurate robust data around their SSI rates for all procedures, especially arthroplasty of both upper and lower limbs. Hub sites should aim for deep infection rates of 0.5% or less. Regular reviews of infected cases should be undertaken for learning and SSI rates should be reported to the Executive Team.	Awaiting management response.	N/K	~~Aug-22~~ Jun-23	Red	30/06/2022 - SSi have been captured historically in Carmarthenshire for: •All arthroplasty – hip and knee replacement procedures and submitted nationally •All other joint replacement work and procedures associated with joints (unreportable) Bronglais has always captured SSI rates for hip and knee arthroplasty surgery only and reported nationally. Withybush General Hospital – no historical SSI data capture within clinical team. 31/08/2022 - To date, deep infection rates at all sites who collect are below the suggested levels. Since restarting all elective IP procedures in the South at PPH, all arthroplasty and non-reportable joint related procedure SSI data is being collected. SSI levels are monitored within the Infection, Prevention and Control structure at DGH and Health Board wide level. Procedure for capture and review of SSI data to be reviewed by Clinical Team
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012e	N/A	R12e. 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: Develop a strategy to release some of the unscheduled care beds to re-establish this as an orthopaedic pathway.	Awaiting management response.	N/K	Jun-23	Red	30/06/2023 - Health Board Transforming Urgent & Emergency Care Programme launched June 2022.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012f	N/A	R12f. 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: Develop an enhanced recovery unit operated 24 hours a day, seven days a week, that allows upskilled nurses to provide care and assessment to the sickest and most vulnerable patients. The service is to be delivered by experienced critical care trained nurses and led by an advanced nurse practitioner.	Awaiting management response.	N/K	~~Jul-22~~ Jun-23	Red	30/06/2022 - A Project Group is being reestablished to reintroduce and standardise all the principles of ERAS within T&O.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012g	N/A	R12g. 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: Upskill and empower therapy staff to undertake greater roles.	Awaiting management response.	N/K	~~Aug-22~~ Jun-23	Red	30/06/2022 - Further to on-going discussions with AHP services, a Situation Background Assessment Report is currently being drafted identifying the gaps in service required to support short to medium term T&O service provision taking these points into consideration, to encompass: Elective service; Trauma; MDT (multidisciplinary team) elective clinics for complex and revision patients; Prehabilitation
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012h	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.	Awaiting management response.	N/K	Jun-23	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.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012i	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.	Awaiting management response.	N/K	Jun-23	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)

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RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012j	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	Awaiting management response.	N/K	~~Jul-22~~ Jun-23	Red	30/06/2022 - Pre-operative assessment pathways subject to current review in line with NHS Wales IP&C guidance
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012k	N/A	R12k. 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: Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	Awaiting management response.	N/K	Jun-23	Red	30/06/2022 - Service delivery planned in accordance with HVLC programme principles.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012l	N/A	R12l. 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: Where there is recognised "good practice" in other Health Boards this must be adopted at pace rather than trying to reinvent the wheel. Learning and collaboration from others will be essential.	Awaiting management response.	N/K	Jun-23	Red	30/06/2022 - Health Board is fully engaged with NHS Wales Planned Care Programme.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012m	N/A	R12m. 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: Review emergency and urgent pathways to improve patient flow.	Awaiting management response.	N/K	Jun-23	Red	30/06/2023 - Health Board Transforming Urgent & Emergency Care Programme launched June 2022.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012p	N/A	R12p. 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: Review patients with high BMI and weight management services and identify improvement strategies and how to best respond to patients wanting surgery with high BMI.	Awaiting management response.	N/K	~~Mar-22~~ Jun-23	Red	The Screening service will contact all patients who we plan to treat by 31/3/22 to make initial health assessments before the patients attends full surgical preassessment in advance of surgery. For those patients not deemed fit a plan will be made on optimising these patients so that unnecessary further delays to surgery can be mitigated
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_013	N/A	R13. Create and implement a workforce plan both short, medium, and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.	Awaiting management response.	N/K	Jun-23	Red	30/06/2022 - As our theatre capacity increases we shall gradually appoint into the Consultant vacancies. AHPs - SBAR prepared to highlight staffing priorities to meet T&O service demands. There is a plan to increase theatre capacity which captures theatre staffing required to support.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_001	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_002	N/A	R2. There appears to be creep in the system whereby calls are being subdivided into county queues. This is occurring with the professional calls. Action: Review the subdivision of calls and the need for separate county queues. Revert to a single undifferentiated queue to promote Health Board wide working.	County queues have already been removed (May-22) although many GPs continue to deal with cases from their local area without cognisance of priority. Emphasis of the importance of cross-border working in the GP OOHs service is accepted and constantly reinforced by the management team but further work is required to change historic attitudes at the treatment interface. It is also accepted that there needs to be better management of patient expectation and support will be needed to achieve this.	Mar-23	Mar-23	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_003	N/A	R3. There appears to be lack of clarity on shift regarding business continuity and escalation. Action: Develop an escalation plan with clear routes and methods of escalation. Communicate this with all operational staff.	Existing escalation plans will be reviewed such that they are tailored to meet the localised needs across each of the three counties and will embrace the SOPs already developed and in service. Pre shift escalation systems are already in place with the new rates of remuneration for sessional doctors (Jan-23) which includes flexibility to increase capacity in targeted way as has been seen over Bank Holiday periods and during the Adastra outage. This includes the application of targeted rates along with shift bundling.	Sep-23	Sep-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_004a	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.

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PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_004b	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_004c	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 opportunities for joint working with South Pembs Urgent Primary Care and expansion of the model into weekend working.	The service will review any service opportunities with the service management team overseeing South Pembs Urgent Primary Care.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_005a	N/A	R5. There is still an issue with shift fill on weekends however there appears to be over staffing mid- week when the demand is low. Actions: Review demand and capacity across the week. Engage with CTM and the Peer Review Team for support with this.	Demand and capacity has commenced via the internal analytics team with the consequence of a more reactive distribution of locum rates being offered presently. The Primary care Power BI dashboard is being adapted to support the OOHs service and will support the timely and accurate supply of data.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_005b	N/A	R5. There is still an issue with shift fill on weekends however there appears to be over staffing mid- week when the demand is low. Action: urgent review of demand and capacity on weekends should be undertaken with executive support and input FROM THE National Team and CTM	Capacity is largely influenced by preferences and habits in the sessional GP workforce who can to a significant degree opt when to work. In recognition of this work has commenced to start a joint working arrangement with WAST which was been supported by the Health Board's DoN. It is anticipated with the cooperation of WAST that the challenges presented when an overprovision of AP time exists can be rebalanced and tailored to match demand.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_006	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_007a	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_007b	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 UPC framework – continued development of this is in place.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_008	N/A	R8. Staff advised that they don't have protected time to undertake clinical supervision. Action: Review provision of protected time for supervision activity	Management team identifying opportunities to facilitate protected time for supervision whilst accepting majority of doctors are sessional/ locum and so will require additional payment for such sessions.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_009	N/A	R9. Staff were positive about the Journal Club that had been set up but they commented that there were no other forums organised for them to raise concerns about service pressures. Action: Consider setting up a regular staff forum for staff to raise concerns.	The established journal club is set to continue and its scope will be the subject of review	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_010a	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	Dec-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_010b	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: Recruitment of GPs to be moved away from medical recruitment and placed within OOH.	Review arrangements which involves risk considerations will be undertaken and a preferred approach which works for the HB will be established.	Dec-23	Dec-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012a	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012b	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 scopes and compared with opportunities and needs.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012c	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012e	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.

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PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_013a	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_013b	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_014	N/A	R14. The number of datix incidents reported appears low compared to the number of contacts seen in OOH. Staff report that they don't report because of lack of feedback when they do. Action: consider taking action to support staff to improve reporting. Develop mechanisms for feedback (this could link with a staff form)	Promotion efforts escalated and subject of Journal Club agenda in Apr-23. Additionally features as a central part of the conversations with all as an action of the internal service review.	Jun-23	Jun-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_015a	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_015b	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_016	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_017	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	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_001	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	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 furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_002	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	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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_003	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	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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_004	N/A	R4. The local TB service has improved but still has inadequacies. In particular, cross-cover arrangements need to be in place for annual, sick and study leave in order to prevent delays in treatment. Pharmacy and administrative support needs improvement. Succession planning for the TB Specialist Nurse also needs to be clear	Development of a resilience plan for both future outbreaks and maintaining current TB case management. Agree a plan for Pharmacy, administrative and Specialist nursingsupport required for TB management.	Jun-23	Jun-23	Amber	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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_005	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	TBC	TBC	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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_006	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	TBC	TBC	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.

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PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	TBC	Medical Director	PHW_LTOER_1222_007	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.	TBC	TBC	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.
PSOW_202003189	Sep-22	Public Service Ombudsman (Wales)	202003189	Open	N/A	Nursing	Nursing	Sian Passey Helen Dawkins	Director of Nursing, Quality and Patient Experience	202003189_003	N/A	R3. Develop a TNP care plan/template for clinical staff to complete so that there is evidence to demonstrate that a consistent approach has been given to the therapy from all disciplines.	Action plans held with Ombudsman Liaison Manager.	Dec-22	~~Dec-22~~ N/K	Red	13/12/22 - Request to PSOW for an extension to the deadline. Awaiting response 02/03/2023 - Update received from Ombudsman Case Manager: still awaiting response from PSOW regarding the requested extension. 02/05/2023 - Draft care plan template sent to PSOW, still awaiting ratification. PSOW have asked for a copy of the final agreed care plan once in has been through this process.
PSOW_202100369	May-23	Public Service Ombudsman (Wales)	202100369	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Primary Care, Community and Long Term Care	PSOW_202100369_001	N/A	R1. Apologise to Mr A for the failings identified in this report.	Action plans held with Ombudsman Liaison Manager	Jun-23	Jun-23	Amber	
PSOW_202100369	May-23	Public Service Ombudsman (Wales)	202100369	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Primary Care, Community and Long Term Care	PSOW_202100369_002	N/A	R2. Provide the Ombudsman with evidence that it has shared this report with the Practice staff and clinicians involved in this case for the purpose of reflection in the context of their continual professional development.	Action plans held with Ombudsman Liaison Manager	Jun-23	Jun-23	Amber	
PSOW_202100369	May-23	Public Service Ombudsman (Wales)	202100369	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Primary Care, Community and Long Term Care	PSOW_202100369_003	N/A	R3. Review the information provided to patients regarding the SAR process, ensuring that clear, consistent information is provided both on its website and in writing and that this information is in accordance with current best practice.	Action plans held with Ombudsman Liaison Manager	Aug-23	Aug-23	Amber	
PSOW_202100369	May-23	Public Service Ombudsman (Wales)	202100369	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Primary Care, Community and Long Term Care	PSOW_202100369_004	N/A	R4. Ensure that Practice staff understand the purpose and reach of its zero tolerance approach, including the appropriate use of placing warnings on patient records, how these warnings are monitored and reviewed.	Action plans held with Ombudsman Liaison Manager	Aug-23	Aug-23	Amber	
PSOW_202100369	May-23	Public Service Ombudsman (Wales)	202100369	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Primary Care, Community and Long Term Care	PSOW_202100369_005	N/A	R5. Review its procedure for requesting the removal of patients from its GP's lists. This should include clear guidance regarding mediation, patient notification and accurate, robust record keeping.	Action plans held with Ombudsman Liaison Manager	Aug-23	Aug-23	Amber	
PSOW_202101488	May-23	Public Service Ombudsman (Wales)	202101488	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101488_001	N/A	Apologises to Mr L for the failings identified in this report.	To note the finding of the Ombudsman's investigation report and draft an appropriate apology letter.	Jun-23	Jun-23	Amber	
PSOW_202101488	May-23	Public Service Ombudsman (Wales)	202101488	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101488_002	N/A	Carries out an audit of arterial cannula management to ensure nursing staff in the ITU are reviewing arterial cannulas at the intervals specified in the Workbook and documenting them accurately and provides evidence that it has done so.	Action plans held with Ombudsman Liaison Manager	Aug-23	Aug-23	Amber	
RCP_VYBGH0919_001	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	~~Mar-21~~ ~~Mar-23~~ N/K	Red	23/03/2022- GM working closely with other sites of the Health Board to ensure safe services, e.g. through channels such as the senior Ops team meetings. Good collaboration between community and acute services. GM looking at scheduled care elements. Real challenges in terms of tertiary level pathways and getting the right patient in the right place for the right clinical supervision. Exploring joint consultant posts with Powys and Betsi, however progress has been significantly hampered due to Covid. This is in the recovery phase and the UHB has restarted this process with neighbouring Health Boards post Covid. Clinical advisory group for Mid Wales in place which started pre-Covid. Working with Powys to establish optimal flow for their patients using Hywel Dda services, and how to work together to deliver care. This is less developed with Betsi. GM is hopeful to make significant progress and have a programme of work in place by March 2023. 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 - Quarterly commissioning meetings in place with Powys to develop pathways, and the Mid Wales Clinical Advisroy Group in place which explores joint appointments with Powys, surgical pathways and identify improvements. The site also works collaboratively with other Health Board sites, and links with clinical groups and peer reviews. Site lead advising that recommendation can be closed from the Lead Executive. 20/04/2023 - BGH would need more resources if further work would be required for this, especially in terms of the Scheduled Care pathways and Commissioning. Recommendations to be presented to the Director of Operations for approval to close.
RCP_VYBGH0919_001	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.2 Improve networking and collaboration with other sites and health boards	Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid.	Mar-21	~~Mar-21~~ ~~Mar-23~~ 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.
RCP_VYBGH0919_001	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_001	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	Mar-24	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.

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RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_004	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility.	Dec-20	~~Dec-20~~ N/K	Red	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.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	~~Sep-22~~ N/K	Red	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training. 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 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting this recommendation to be closed as lack of funding does not allow this recommendation to be fully implemented. There is however a designated RESUS officer just for Ceredigion, which has helped provide more RESUS training dates. Due to lack of funding BGH are discussing opportunities to access training space through the University Medical School. 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth |University. Both developments will include clinical skills facilities.	Sep-22	~~Sep-22~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 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 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed as no funds available at this time with the intention to be part of the Capital plan. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. The original management response in this report was made on the assumption that funds were available which was incorrect. 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close, once 'mini' paper has been produced.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	RCP_VYBGH0919_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	~~Dec-21~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 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 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed. BGH are part of ongoing discussions for the postgraduates build which requires WG Capital investment. However, it is felt that this is not achievable in the current conditions. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. BGH feel the risk for not having this will impact in poor training and will be reflected in not doing enough to support activities. A major issue is the lack of space for teaching and meetings. BGH have 3 available rooms which are fully booked all the time. This will affect the trainees' satisfaction. This impact to be incorporated into the existent BGH Datix risk (1586-Harm associated with lack of space). 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close, once 'mini' paper has been produced.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	WLC_PCTWL_002	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.
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_001	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	Amber	11/05/2023 - The existing policy has been given a formal extension by CWCDG until 10/08/2023, whilst the review is undertaken.
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_002	N/A	R2. Update the information provided on the consent intranet page about the new ESR consent training.	Ensure that the information on the intranet is accurate and up to date.	Apr-23	Apr-23	Red	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_003	N/A	R3. Develop a formally approved procedure setting out the organisation's governance process in relation to the development and approval of local procedure specific consent forms.	Set out the existing process in a Produce document for approval by the Mental Capacity and Consent Group.	Jun-23	Jun-23	Amber	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_004	N/A	R4. Implement a requirement for all clinicians who take consent from patients to complete a recognised training programme. It is recommended that the frequency of this should be at least once per revalidation cycle for the relevant professional group, it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.	Discuss this recommendation with the Medical Director, Director of Nursing, Quality and Patient Experience, and the Director of Therapies and Health Science to determine the most appropriate approach.Implement agreed approach.	TBC	TBC	Red	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_005	N/A	R5. Finalise the review of the Policy for Production of Patient and Carer Information.	Policy to be reviewed and updated by the Listening and Learning Sub-Committee.	May-23	May-23	Amber	11/05/2023 - Formally extended until 14/05/23 by QSEC on 20/02/23 whilst the review is finalised.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber	Progress update/Reason overdue
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_006	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	Jun-23	Amber	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_007	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	Oct-23	Amber	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_008	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.	TBC	TBC	Red	
WRP_NRCETSNHSW_0323	Mar-23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Nursing	Mental Health & Learning Disabilities	TBC	TBC	WRP_NRCETSNHSW_0323_009	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.	TBC	TBC	Red	

Reports closed on the Audit Tracker since ARAC April 2023

Report name	Lead Executive/Director
Counter Fraud Authority: Covid-19 Post Event Assurance Report of findings for Hywel Dda University LHB	Director of Finance
Delivery Unit: All Wales Cardiology to Cardiac Surgery Transfer Point Assurance Review	Director of Operations
HIW: Quality Check: Morlais Ward	Director of Operations
HIW: Ty Bryn	Director of Operations
HIW: Nuclear Medicine Department, Withybush General Hospital	Director of Operations
Internal Audit: Medical Staff Recruitment	Director of Operations
Internal Audit: Follow up: Overpayment of Salaries	Director of Workforce & OD
Internal Audit: Non-Clinical Temporary Staffing Follow Up	Director of Workforce & OD
Peer Review: Out of Hours Peer Review, issued November 2019	Director of Operations
PSOW: 202004109	Director of Operations
PSOW: 202102801	Director of Nursing, Quality and Patient Experience
PSOW: 202100614	Director of Nursing, Quality and Patient Experience

Reports opened on the Audit Tracker since ARAC April 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
Audit Wales: Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Director of Operations	6	Audit and Risk Assurance Committee
Delivery Unit: Review of Psychological Therapies in Wales	Director of Operations	7	Quality, Safety and Experience Committee
HEIW: General Internal Medicine Bronglais Hospital	Director of Operations	12	People, Organisational Development and Culture Committee
HEIW: Obstetrics and Gynaecology Glangwili Hospital	Director of Operations	7	People, Organisational Development and Culture Committee
HIW: Mental Health Discharge Review	Director of Nursing, Quality and Patient Experience	40	Quality, Safety and Experience Committee
Internal Audit: Patient Experience	Director of Nursing, Quality and Patient Experience	3	Audit and Risk Assurance Committee
Internal Audit: Safety Indicators – Pressure Damage & Medication Errors	Director of Nursing, Quality and Patient Experience	4	Audit and Risk Assurance Committee

Internal Audit: Fitness For Digital - Use of Digital Technology	Director of Finance	9	Audit and Risk Assurance Committee
Internal Audit: Regional Integration Fund	Director of Finance	2	Audit and Risk Assurance Committee
Internal Audit: Service Reset and Recovery	Director of Operations	1	Audit and Risk Assurance Committee
Internal Audit: Withybush General Hospital - Fire Precautions Phase 1	Director of Operations	10	Audit and Risk Assurance Committee
Internal Audit: Records Digitisation	Director of Finance	4	Audit and Risk Assurance Committee
Internal Audit: Job Planning	Medical Director & Director of Clinical Strategy	7	Audit and Risk Assurance Committee
Peer Review: Out of Hours Peer Review , issued April 2023	Director of Operations	17	Quality, Safety and Experience Committee
Peer Review: Hywel Dda UHB Lung Report	Director of Operations	3	Quality, Safety and Experience Committee
PSOW: 202100369	Director of Primary Care, Community and Long Term Care	5	Listening and Learning Committee
PSOW: 202101488	Director of Nursing, Quality and Patient Experience	2	Listening and Learning Committee
Welsh Risk Pool: A National Review of Consent to Examination & Treatment Standards in NHS Wales	Director of Operations	9	Operational Quality and Safety Experience Sub-Committee
Total		**148**	

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Medicines Management in Acute Hospitals (June 2015)	1 External	June 2016	1 External – awaiting funding confirmation from Welsh Government	Medicines Management	One 'external' recommendation relating to electronic prescribing/discharging. Welsh Government (WG) have provided some funding for a small pre-implementation team that is now in place to develop a 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 is approved a mini-procurement process will be undertaken to secure the most appropriate system for the Health Board.
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board (October 2021)	2 (1 External)	December 2022	1 External – awaiting national system roll out 1 - awaiting service confirmation for closure	Director of Operations	Directorate Improving Together Sessions established in January 2023. Assistant Director of Assurance and Risk and Head of Assurance and Risk to meet with Director of Operations in June 2023 to confirm if the recommendation can be closed in relation to Governance arrangements. 1 'external' recommendation relates to the roll-out of the All-Wales Datix risk management system, the date of which has not yet been confirmed. A risk has been added to Datix in relation to the implementation of the new risk management system.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Structured Assessment 2022	2	March 2023	2 - original completion dates lapsed since previous meeting	Governance	Recommendations relate to the Health Board being required to set out expected outcomes for all its planning objectives set out in its Annual Plan, and currently awaiting progress updates from a supporting service, and revised completion dates where required.
Community Health Council - Accident & Emergency Departments in the Hywel Dda Health Board area (November 2022)	3	March 2023	2 - original completion dates lapsed since previous meeting 1 - awaiting service confirmation	Nursing	Assurance and Risk Team are clarifying with the service if these recommendations have been implemented, or if revised completion dates are required.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Community Health Council - Eye Care Services in Wales, issued March 2020	1 External	June 2022	1 External – awaiting national system roll out	Scheduled Care	Completion of this recommendation relies on the national rollout of an Electronic Patient Record (EPR) system. The supporting lead in Digital has highlighted concerns with the system at a local level and work continues with Information Governance, Ophthalmology and the national project team in readiness for transition of project governance at a national level from Cardiff & Vale University Health Board to Digital Health and Care Wales (DHCW) in Quarter 3 2023/24.
Delivery Unit - All Wales Review of progress towards delivery of Eye Care Measures (September 2019)	3	October 2020	2 – investment challenges 1 – workforce challenges	Scheduled Care	An SBAR on service fragility was presented at the ARAC meeting in April 2023 by the Service Delivery Manager for Ophthalmology. 2 of these recommendations are unlikely to progress without central investment in Estates, Infrastructure and Workforce to develop a sustainable service. The other recommendation is proving to be a challenge due to a national shortage of Consultant Ophthalmologists. A risk has been added to Datix highlighting the difficulty in progressing these recommendations (Risk ref 1664 – Ophthalmology service fragility).

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Delivery Unit - Focus on Ophthalmology: Assurance Reviews (January 2016)	2	November 2022	1 – awaiting approval from a supporting service within the Health Board to proceed 1 – workforce challenges	Scheduled Care	The Ophthalmology service are unable to confirm a timescale for completing 1 of the recommendations on this report as awaiting approval from the Health Board's Information Governance (IG) team to progress with the Ophthalmic Diagnostic Treatment Centre (ODTC). The sign-off of a Data Protection Impact Assessment (DPIA) allowing the sharing of patient information is critical to the implementation of this pathway. The other recommendation continues to prove difficult to implement due to the challenges of increased demand, reduced capacity and balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients, which presents a conflicting priority to the service. A risk has been added to Datix highlighting the difficulty in progressing this recommendation. (Risk ref 1664 – Ophthalmology service fragility).
HEIW - General Internal Medicine Bronglais Hospital	12	January 2023	12 - Awaiting formal presentation of report to PODCC to confirm timescales	Unscheduled Care (BGH)	This is a new report added to the tracker since April 2023, with 12 open recommendations for which management responses are being presented to People, Organisational Development and Culture Committee (PODCC) in June 2023, after which the tracker will be updated along with recommendation owners and timescales, and RAG statuses revised as required.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HEIW - Obstetrics and Gynaecology Glangwili Hospital	7	January 2023	7 - awaiting formal presentation of report to PODCC to confirm timescales	Women and Children's Services	This is a new report added to the tracker since April 2023 with 7 open recommendations for which management responses are being presented to People, Organisational Development and Culture Committee (PODCC) in June 2023, after which the tracker will be updated along with recommendation owners and timescales, and RAG statuses revised as required.
HIW - Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	1	April 2023	1 - original completion date lapsed since previous meeting	Women and Children	Progress updates are currently being sought for these recommendations from the Quality Assurance and Safety Team (QAST) team, with updates to be reflected to ARAC in August 2023.
HIW - Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	1	March 2023	1 - revised completion date lapsed since previous meeting	Mental Health & Learning Disabilities	Work is underway to install appropriate observation mirrors. Revised timescale for the recommendation is being requested via the QAST team.
HIW - Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	1	March 2023	1 - original completion date lapsed since previous meeting	Unscheduled Care (GGH)	Awaiting clarification from the service, via the QAST Team, that the recommendation has been implemented, or if a revised completion date is required.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - Glangwili – Maternity Services 28 - 30 November 2022 (Publication date 02 March 2023)	2	March 2023	2 - original completion dates lapsed since previous meeting	Women and Children's Services	Progress updates are currently being sought for these recommendations from the QAST team, with updates to be reflected to ARAC in August 2023.
HIW - National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	4	April 2023	4 - revised completion dates lapsed since previous meeting	Acute Services	Revised timescales are being requested via the QAST Team.
Internal Audit – Discharge Processes (December 2021)	5 (3 External)	June 2022	3 – external 2 - change in timescales of IA follow up	Primary Care, Community and Long Term Care	The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been delayed and pushed back to be completed by end of Quarter 3 2023/24, with follow up date to be confirmed by Internal Audit.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit – Discharge Processes (December 2021)	5 (3 External)	June 2022	3 – external 2 - change in timescales of IA follow up	Primary Care, Community and Long Term Care	The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been delayed and pushed back to be completed by end of Quarter 3 2023/24, with follow up date to be confirmed by Internal Audit.
Internal Audit - Fitness For Digital - Use of Digital Technology	2	February 2023	2 – original completion date lapsed since previous meeting	Digital and Performance	The Health Board will be developing a business case for the movement of data from on-premises to the cloud. The Assurance and Risk Team are currently in the process of ascertaining with the service whether the timeline outlined in the management response is achievable, and to obtain revised completion dates.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Glangwili General Hospital Fire Precautions Works: Phase 1	1	April 2023	1 - original completion date lapsed since previous meeting	Estates	Awaiting confirmation from the service that the recommendation relating to reporting of project changes has been implemented.
Internal Audit - Safety Indicators – Pressure Damage & Medication Errors	2	April 2023	2 - original completion dates lapsed since previous meeting	Nursing	Recommendations recently lapsed at the time of reporting. Progress updates including revised completion dates are currently being sought from the service.
Peer Review – Respiratory Cancer (June 2016)	1	July 2016	1 – workforce challenges	Unscheduled Care (PPH)	A risk regarding fragility of service has now been added to Datix due to a single handed consultant delivering lung cancer health board wide (risk ref 1655 – Fragility of Lung Cancer Service). This reflects the current challenge of a sustainable service model which the recommendation refers to.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Hywel Dda UHB Lung Report, issued January 2020	1	January 2020	1 – workforce challenges	Unscheduled Care (PPH)	A risk regarding fragility of service has now been added to Datix due to a single handed consultant delivering lung cancer health board wide (risk ref 1655 – Fragility of Lung Cancer Service). In addition there is no consistent Pathology diagnosis due to significant staffing issues, resulting in a lack of pathology input at Multi-Disciplinary Team (MDT) meetings, which this recommendation refers to.
Peer Review - Congenital Heart Defect Provider (October 2021)	1 External	October 2022	1 – awaiting national roll outl	Women and Children's Services	The ability to fulfil this recommendation relates to the development and roll-out of a national template when children and young people are transferred across or between networks, to ensure the they are accompanied with high quality and accurate information.
Peer Review – Getting It Right First Time (GIRFT) Orthopaedic Review	7	May 2022	7 - awaiting formal presentation of report to ARAC to confirm timescales	Scheduled Care	Management responses are being presented to the ARAC in June 2023 and timescales to be confirmed.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
PSOW - 202003189	1	December 2022	1 - Awaiting confirmation from PSOW to close the rec.	Nursing	The recommendation relates to developing a care plan for clinical staff to complete to ensure consistency. Draft care plan template sent to PSOW, still awaiting ratification. PSOW have asked for a copy of the final agreed care plan once it has been through this process. Once PSOW have ratified the plan, this recommendation will be closed.
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	3	September 2022	3 - awaiting service update	Unscheduled Care (BGH)	A meeting was held in April 2023 between the Assurance & Risk Team, General Manager and Hospital Services Manager. It was confirmed that a paper would be written on the Postgraduate education centre, to be presented to the Director of Operations with the purpose of establishing whether any recommendations can be closed.
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	3	May 2023	3 - new report awaiting timescales to be confirmed by the service.	Director of Operations	This is a new report with 9 recommendations of which 3 are awaiting timescales to be confirmed by the service. Ownership of this report is also being clarified by the Assurance and Risk Team.
Total number of N/K Recs	**69**				