Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 April 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

Asesiad / Assessment

The attached report and supporting appendices will aim to provide assurance on the progress in respect of the implementation of recommendations from audits and inspections, since the previous report presented to ARAC in February 2024.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

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

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

	concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CHC – Community Health Council DU – Delivery Unit GGH – Glangwili General Hospital GIRFT – Getting It Right First Time HEIW – Health Education and Improvement Wales HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IRMER – Ionising Radiation (Medical Exposure) Regulations MH&LD – Mental Health & Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience PHW – Public Health Wales PPE – Post Project Evaluation

	PPH – Prince Philip Hospital PODCC – People, Organisational Development & Culture Committee PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SDM – Service Delivery Manager UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance/Board Secretary

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

Introduction

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

All reports from audits, reviews and inspections carried out across the Health Board are logged onto the Health Board central tracker, and progress regarding the implementation against each recommendation is monitored. The Audit Tracker utilises a traffic light system in relation to the timeframes to implement recommendations. The criteria for this system is as below:

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

Utilisation of the Audit Management and Tracking System (AMaT)

Since the report was last presented to ARAC in February 2024, work has commenced on the feasibility of utilising the Audit Management and Tracking (AMaT) system instead of the current Audit and Inspection tracker, to monitor all recommendations across the Health Board from a central data repository. The Assurance and Risk Team are liaising with colleagues in the Quality, Assurance and Safety Team (QAST) and the Effective Clinical Practice Team to understand system capabilities, and any impact this would have on providing assurance to Committees on implementation of recommendations from auditors, inspectorates and regulators. It is proposed that initial focus would be on all operational services' reports be transferred to AMaT during Q1 of 2024/25, who are already utilising the system in order to monitor progress of HIW activity, with corporate functions to be transferred later in 2024/25. This will allow services to update progress against all recommendations via one system to alleviate operational pressures, and ensure consistency in approach with regards to processes and reporting.

An impact assessment and project plan will be presented to ARAC in due course once the feasibility assessment has been completed.

Progress Since February 2024

Since the previous report, 17 reports have been closed or superseded on the Audit Tracker, and 19 new reports have been received by the Health Board, as detailed in Appendix 3.

As of 11 March 2024, the number of open reports has increased from 134 to 136. 51 of these reports have recommendations that have exceeded their original completion date, a slight decrease from the 52 reports previously reported in February 2024.

There is a decrease in the number of recommendations where the original implementation date has passed since the previous meeting, from 230 to 205.

The number of recommendations that have gone beyond six months of their original completion date has increased from 66 to 114, as reported in February 2024, primarily driven by current operational demands, and services focussing on work to support the submission of the Annual Plan to Welsh Government (WG).

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

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

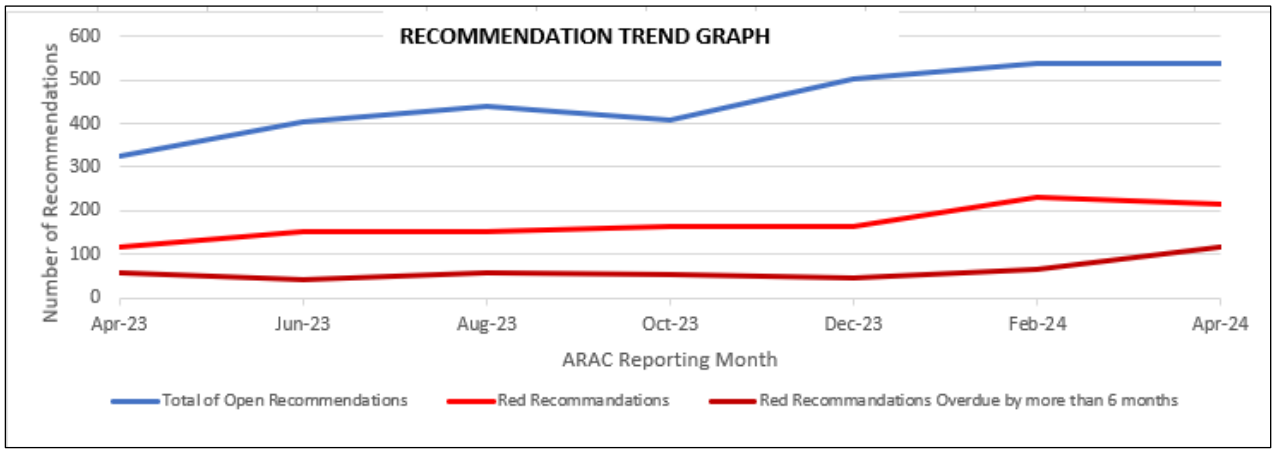
Summary of open reports per Inspectorate / Regulator

Inspectorate / Regulator	Open reports at ARAC February 24	New reports since February 24	Closed reports since February 24	Open reports at ARAC April 24	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	7	2	0	9	6	12	7
HEIW	2	0	0	2	1	3	2
HIW	14	1	0	15	10	61	27
Independent Review	1	0	0	1	0	1	0
IA	28	4	8	24	12	33	26
Internal Review	0	0	0	0	0	0	0
Llais[3]	5	0	0	5	3	7	4
MWWFRS	43	5	0	48	3	11	1
Natural Resources Wales	2	0	2	0	0	0	0
NHS Wales Cyber Resilience Unit[4]	1	0	0	1	0	9	9
NHS Wales Executive[5]	8	0	0	8	4	12	6
Peer Reviews	10	1	1	10	8	47	29
PSOW - S21	8	5	6	7	0	0	0
PHW	1	0	0	1	1	0	0
Royal Colleges	1	0	0	1	1	2	2
Welsh Risk Pool	2	0	0	2	1	7	1
WLC	1	0	0	1	1	0	0
Welsh Government	0	1	0	1	0	0	0
TOTAL	**134**	**19**	**17**	**136**	**51**	**205**	**114**

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

There are currently **531 open recommendations** (a slight decrease from the 539 reported in February 2024) on the audit tracker and detailed in Appendix 2, and split per service / directorate for ease of reference. The appendix includes the 68 recommendations that are considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation. These recommendations are marked as 'External' in the RAG status column.

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



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

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

There are **107 recommendations that do not have revised timescales** (where the original date has passed and not known (N/K) is reported), a reduction from 140 as presented to ARAC in February 2024. These recommendations are included in Appendix 4, and details the date at which recommendations became N/K, and the reason why they are N/K.

The 107 N/K recommendations are comprised of:

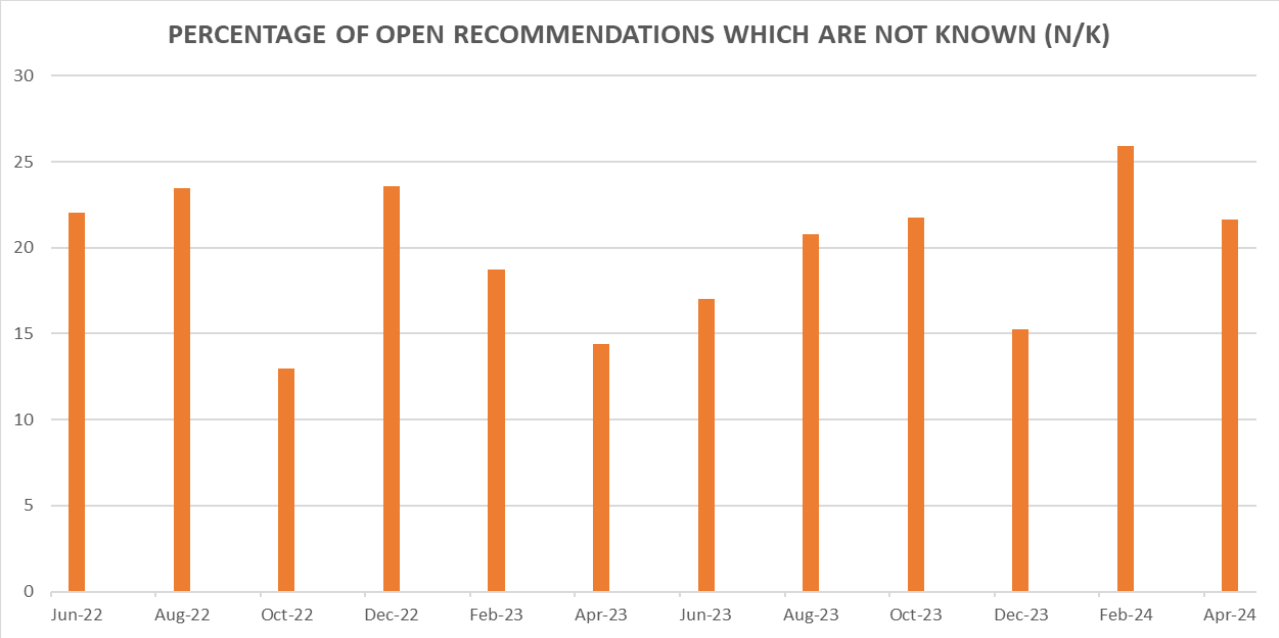
- 8 recommendations which have recently lapsed to N/K status since the previous report;
- 66 recommendations where the revised completion dates have lapsed to N/K status prior to the previous meeting, and awaiting revised completion dates from the services;

- 16 recommendations noted as 'external', and
- 2 recommendations which have been re-opened since the previous meeting from AW Structured Assessment 2022; and
- 15 recommendations from the HIW MHLD Discharge Process which the QAST team are supporting the Directorate with in relation to AMAT system queries.

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

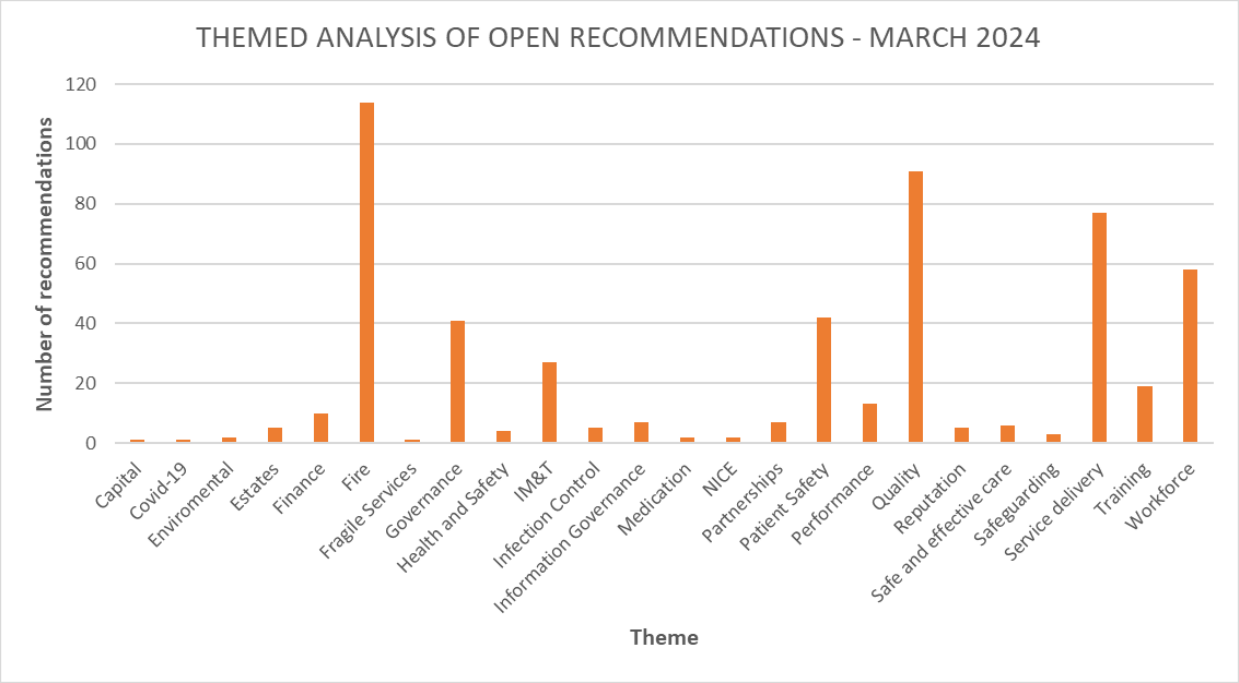
N/K recommendations overdue by	Overdue N/K recommendations at March 2024	Overdue N/K recommendation at January 2024	Trend since previous meeting
1 month	14	40	↓
2 to 3 months	41	22	↑
4 to 5 months	9	21	↓
6 months and over	43	57	↓
Total**	**107**	**140**	↓

Below is a chart detailing the percentage of open recommendations that do not have revised timescales (N/Ks) from June 2022 to this Audit tracker paper.



The Assurance and Risk team continue to liaise directly with services, and review the status of reports monitored via AMaT, to obtain progress updates and revised completion dates where applicable.

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



Audit Tracker Summary Per Service / Directorate

A snapshot of the audit tracker activity split by service/directorate as at 11 March 2024 is included from page 6 onwards, including trends since the last report to ARAC in February 2024 (please note trends are not yet available for 'Overdue reports by more than 6 months' as this is the first report this data is being reported by service). Issues and nil responses from services are escalated to the appropriate Lead Executive/General Manager. Where services are identified as an area of concern for two consecutive reports, the service will be escalated to ARAC. The following Services/Directorates do not currently have any open reports on the audit tracker:

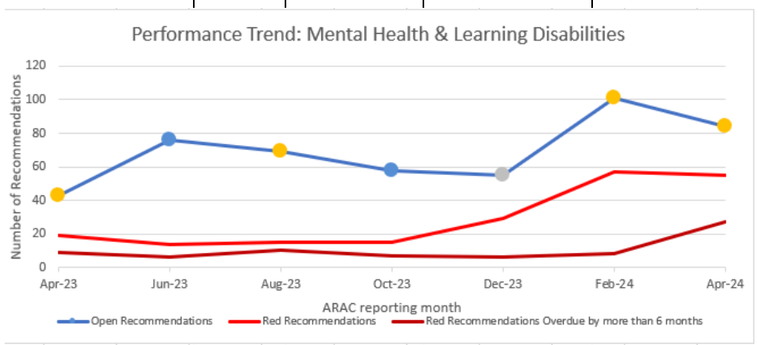
- Cardiology;
- Carmarthenshire;
- CEO Office (Welsh Language)
- Pathology;
- Performance;
- Pembrokeshire; and
- Therapies

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

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

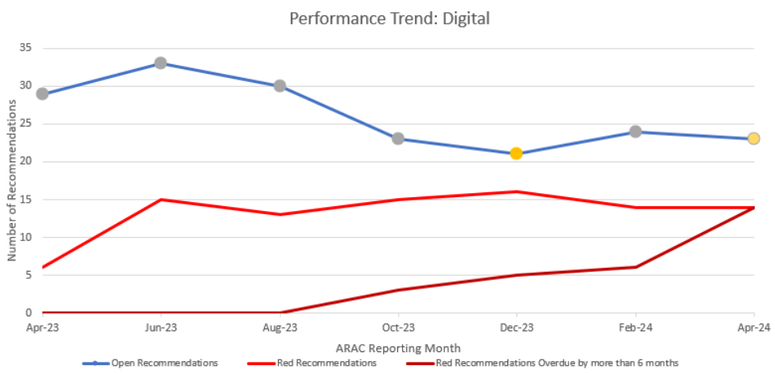
Service of Concern at March 2024

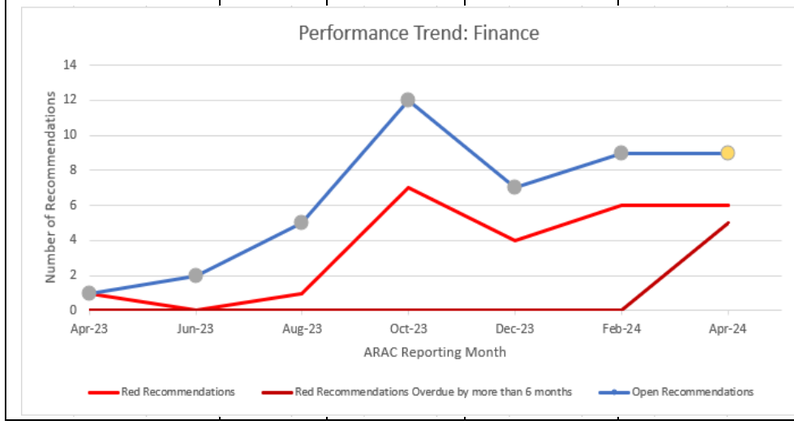
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Mental Health and Learning Disabilities		Reports: 17 ↑ Recs: 87 ↓	Reports: 6 ↑ Recs: 55 ↓	Reports: 4 Recs: 27 ↑	Since the previous report, the total number of open recommendations has reduced from 101 to 87, 55 of which are overdue (February 2024:57). 27 recommendations are noted as being overdue by more than 6 months, which is a significant increase from the 6 previously report (20 of these recommendations are from the HIW Mental Health Discharge Review report). The number of overdue recommendations without revised timescales (N/Ks) has increased from 34 to 43. Of the 55 overdue recommendations, 30 relate to the HIW Mental Health Discharge Review. The Assistant Director of Nursing MH&LD is currently determining revised timescales with support from the Interim Director Nursing, Quality & Patient Experience. Of these 30 recommendations, the service are being supported by the QAST team with AMAT system queries relating to 15 of these. Whilst there is good engagement with the service, this is not resulting in improving performance. The Assurance and Risk team continue to work closely with service leads to obtain progress updates and revised completion dates. A monthly meeting with the Assistant Director of Nursing MH&LD and service leads has been set up to further strengthen this process. This is the fourth time MHLD have been called out as a service with a concerning variation since April 2023 due to the number of overdue (red) recommendations, recommendations overdue by more than 6 months, and number of overdue recommendations without revised timescales (N/Ks). It is noted that the service is being highlighted as one with a concerning variation for the second consecutive time, therefore meeting the criteria to be considered as a Service of Concern for this report. However it is recognised that there have been significant operational demands on the service as we approach the end of the financial year and the submission of the Annual Plan to WG, as well as 10 overdue recommendations requiring support from Estates to fully implement.



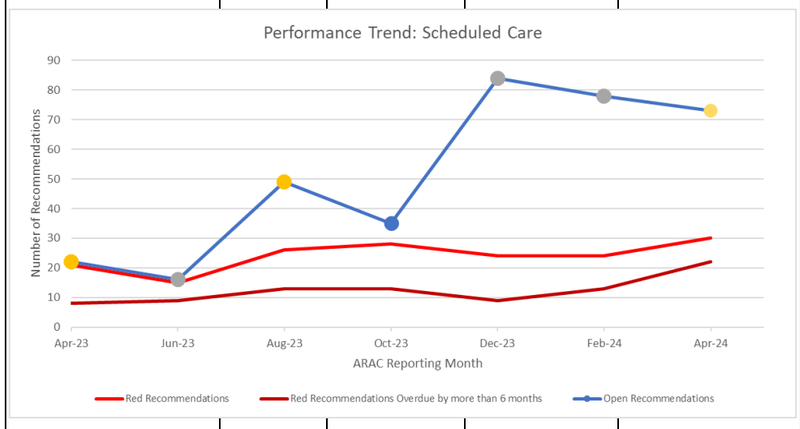
Services with a Concerning Trend at March 2024

Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Digital		Reports: 5 → Recs: 23 ↓	Reports: 1 → Recs: 14 →	Reports: 1 Recs: 14 ↑	Since the previous report presented to ARAC in February 2024, the number of overdue recommendations has remained at 14, all of which are now overdue by more than 6 months. The number of overdue recommendations without a revised timescale (N/K) remains at 3. 4 additional recommendations are due to lapse at the end of March 2024. Reasons as to why these recommendations are unable to be fully implemented include optimistic completion dates included within initial management responses, those which are reliant on the completion of other recommendations in order be progressed, and a lack of capacity within the service to prioritise the range of workstreams currently being undertaken by the service. Overall there is good engagement with the service, however this has diminished in the period since the last report was presented to ARAC as a result of operational demands and availability of key staff. There is an outstanding recommendation raised in the Internal Audit report "Fitness for Digital", issued in March 2023 with an overall completion date of March 2024, for which no updates have been received to date. Internal Audit have recently requested an update on this recommendation. There are 3 recommendations which have an 'external' status as they are reliant on input from NWSSP, and currently outside the gift of the Health Board to complete. A full review of all recommendations on the Audit and Inspection tracker will be undertaken in April 2024 following the scheduled launch of the ARMIS asset management and security system. Digital services have advised that this will address at least 8 recommendations between the IA report on "IT Infrastructure" and NHS Wales Cyber Resilience Unit "Cyber Assessment Framework Report". The Assurance and Risk Team will continue to work with the service to report an improved trend at the next ARAC meeting in June 2024.
Finance		Reports: 5 → Recs: 9 →	Reports: 4 ↑ Recs: 6 →	Reports: 2 Recs: 5 ↑	Since the previous report presented to ARAC in February 2024, the number of overdue recommendations has remained at 6, 5 of which are now overdue by more than 6 months, and 4 without revised timescales. It is noted that 4 additional recommendations are due to lapse at the end of March 2024. There has been a minimal level of engagement with the service, resulting in a lack of progress updates and revised completion dates against the outstanding recommendations. However, it is recognised that many of the recommendations rely on support from the Strategic Development and Operational Planning team to progress, and that there are significant demands on both directorates as we approach the end of the financial year and the submission of the Annual Plan to WG. The Head of Assurance and Risk is due to meet with the Assistant Director of Finance in April 2024 to obtain progress updates post financial year-end, and the Assurance and Risk Team will continue to request updates and revised timescales for these reports in order to report an improved position to the next ARAC meeting in June 2024.



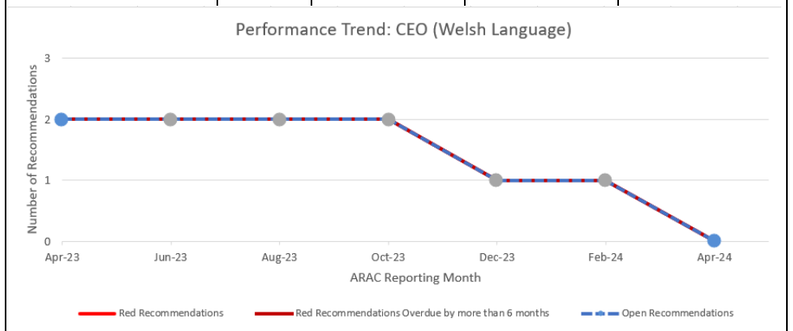


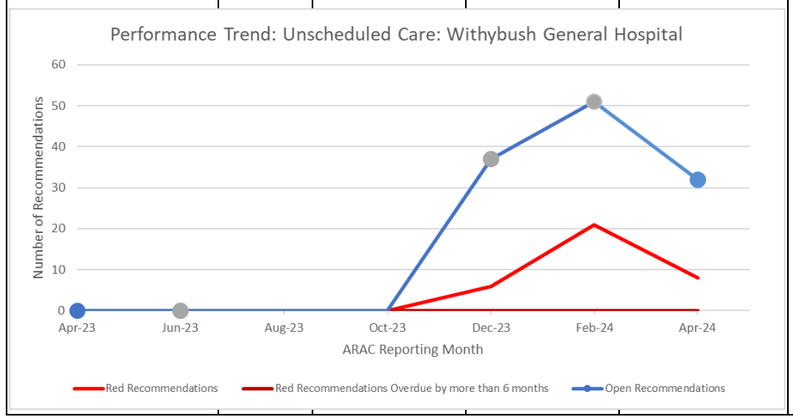
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Scheduled Care		Reports: 9 Recs: 73 	Reports: 6 Recs: 30 	Reports: 5 Recs: 22 	Since the previous report presented to ARAC in February 2024, there has been a decrease in the number of open recommendations for Scheduled Care from 78 to 73. However, the number of recommendations that are overdue has increased from 24 to 30, with 21 of these now being overdue by 6 months or more. The number of recommendations overdue by 6 months or more are attributed to: • 12 on the Getting It Right First Time (GIRFT) report on General Surgery, • 1 recommendation carried over on the Follow-up IA report on “Theatre Loan Trays & Consumables”, • 1 recommendation from a HIW report on “Thematic Review of Ophthalmology”, • 2 from a CHC report on “Eye Care Services in Wales”, • 3 from a DU report on “All Wales Review of progress towards delivery of Eye Care Measures”, and • 2 from a DU report on “Focus on Ophthalmology: Assurance Reviews”. There is good engagement with the service, with regular progress updates received and revised completion dates obtained for all recommendations in readiness for this report. However, the number of overdue recommendations continues to rise. Reasons behind the inability to fully implement these recommendations are varied but include workforce pressures such as sickness and difficulty recruiting into specialities, a lack of funding, demand and capacity issues, RAAC-related challenges, challenges associated with developing new pathways, delays in the rollout of national electronic platforms such as E-consent and OpenEyes, and a lack of interest from external providers in the community. It is noted that since the data was extracted for this report, further progress updates have been obtained in relation to the GIRFT report on General Surgery, with one recommendation confirmed as implemented, and revised completion dates obtained for the remaining open recommendations. This progress will be reflected in the next paper to ARAC in June 2024.



Services with an Improving Trend as at March 2024

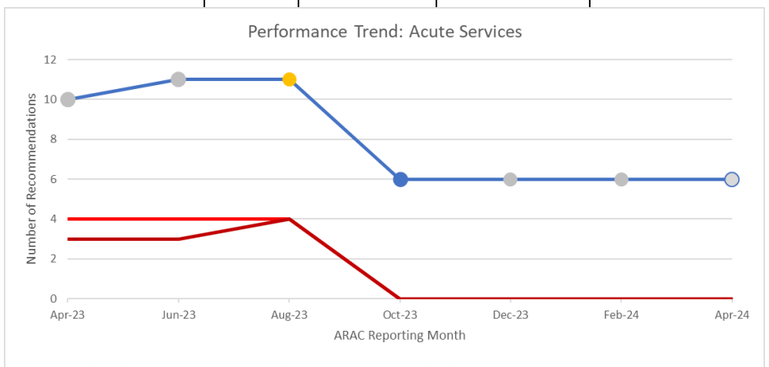
Service	Trend - March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
CEO Office (Welsh Language)		Reports: 0 ↓ Recs: 0 ↓	Reports: 0 ↓ Recs: 0 ↓	Reports: 0 Recs: 0 ↓	IA report on Welsh Language Standards has been closed since the previous report presented to ARAC in February 2024, which previously had 1 recommendation overdue by more than 6 months.
Unscheduled Care: Withybush General Hospital		Reports: 4 ↑ Recs: 32 ↓	Reports: 0 → Recs:8 ↓	Reports: 0 Recs: 0 →	Despite the addition of 1 new PSOW report since the previous report presented to ARAC in February 2024, the service have demonstrated a significant improvement in performance, with the number of open recommendations decreasing from 51 to 32, and the number of overdue recommendations decreasing from 21 to 8. There has been good engagement with the service and the improved position can be attributed to several recommendations being completed on all existing reports, notably 12 recommendations on the HIW "Emergency Department, Withybush General Hospital" report and 5 on the HIW "National Review of Patient Flow – a journey through the stroke pathway" report. All recommendations have now been completed on the Llais "West Wales Region Engagement Report", with 1 remaining action awaiting approval by QAST to close the report.

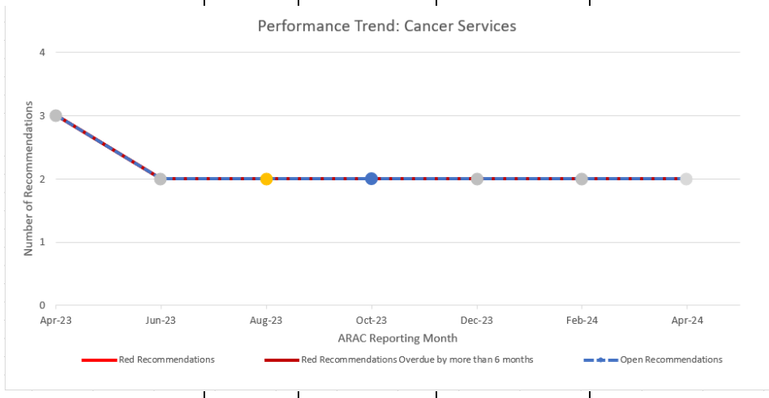




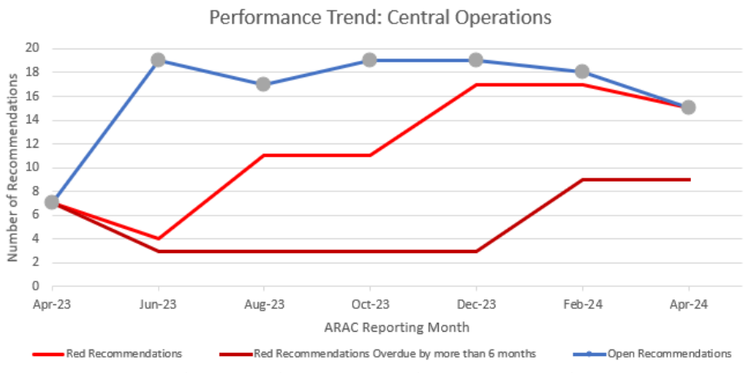
Services with Usual Trend at March 2024

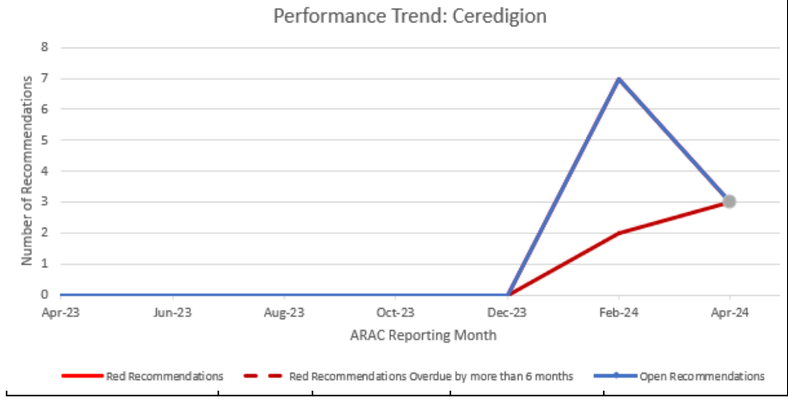
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Acute Services		Reports: 1 → Recs: 6 →	Reports: 1 → Recs: 0 →	Reports: 1 Recs: 0 →	The HIW National Review on WAST remains open with 6 recommendations of 'External' status as they are for WAST consideration. Progress updates have been received from the service for those recommendations which were in the gift of the Health Board to implement and confirmed as completed. These are currently awaiting final confirmation to close the report from the Interim Director of Nursing, Quality and Patient Care.
Cancer Services		Reports: 1 → Recs: 2 →	Reports: 1 → Recs: 2 →	Reports: 1 Recs:2 →	There are 2 recommendations outstanding on the Colorectal Cancer (Third Cycle) peer review issued in January 2022 which became overdue in March 2022. One recommendation has been given a revised timescale of January 2025, however the recommendation relating to the cover for the single-handed Oncologist in Bronglais Hospital, is due to surpass its revised completion date March 2024.



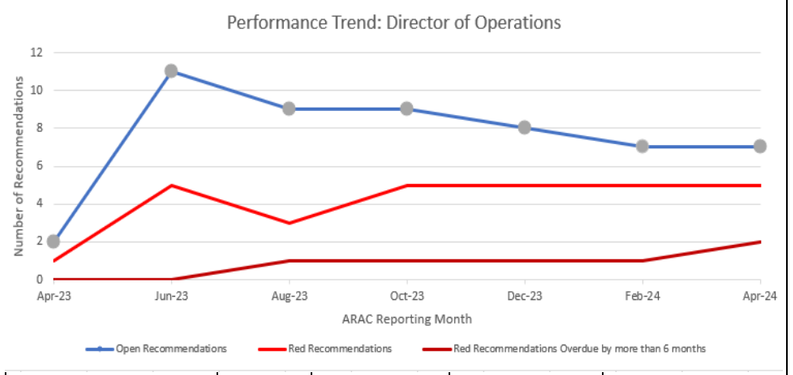


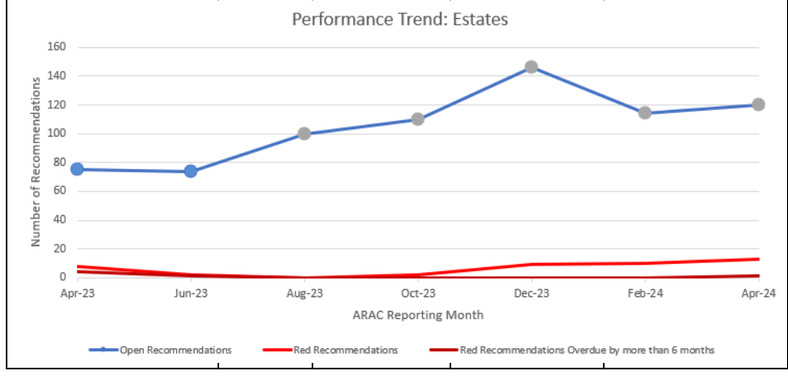
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Central Operations		Reports: 3 → Recs: 15 ↓	Reports: 3 → Recs: 15 ↓	Reports: 1 Recs: 9 →	There is good engagement with the service, however the ability to fully implement some recommendations raised within the Out of Hours Peer Review is dependent on the outcomes of the restructure of Acute Services. Changes to the WAST front end Clinical Assessment programme have also impacted on the ability to progress other recommendations included in this report to closure. The report has 10 overdue recommendations, 5 of which are overdue by more 6 months. For the IA Records Management 2019 report, Internal Audit have confirmed they will discuss the 2 overdue recommendations, which are overdue by more than 6 months, with the service as part of year-end processes, in the hope that they may be able to confirm implementation and subsequent closure. The IA Records Digitisation 2023 report has two overdue recommendations which have recently lapsed into being overdue by more than 6 months, with revised dates of March 2024 provided.
Ceredigion		Reports: 1 ↓ Recs: 3 ↓	Reports: 1 ↓ Recs: 3 ↓	Reports: 1 Recs: 0 ↓	There has been steady progress completing recommendations on the CHC report on Palliative and End of Life Care, with 3 outstanding recommendations noted as 'overdue' on AMaT. The QAST will be seeking further updates and revised timescales for these actions, to be reflected in the report to the next ARAC in June 2024. Since the previous report, PSOW report 202200883 has been closed.



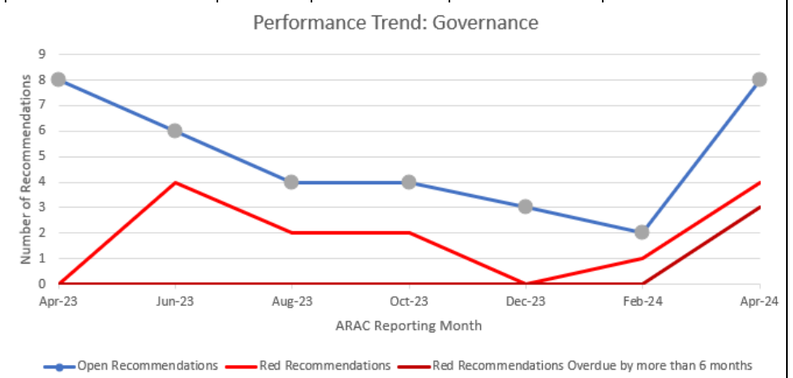


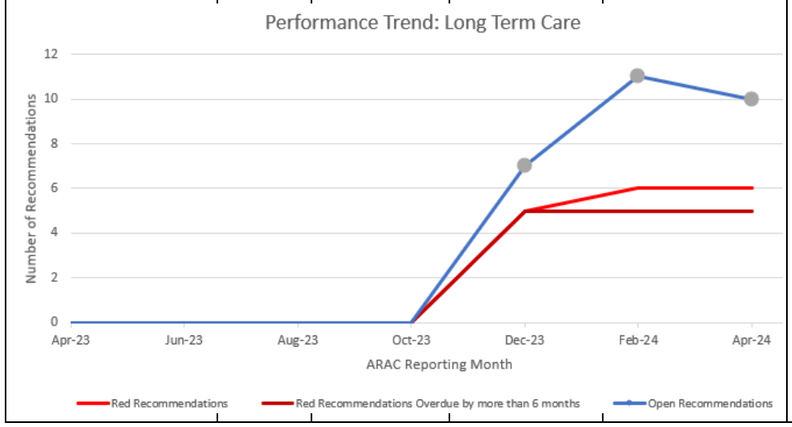
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Director of Operations		Reports: 2 → Recs: 7 →	Reports: 2 → Recs: 5 →	Reports: 2 Recs: 2 ↑	The AW Review of Quality Governance Arrangements report has 1 'external' recommendation and 1 overdue recommendation by more than 6 months with a revised timescale of September 2024. The WRP National Review of Consent to Examination & Treatment Standards in NHS Wales report has 1 'external' recommendations and 4 overdue recommendations with revised timescales of March 2024, 1 of which has become overdue by more than 6 months since the previous report to ARAC in February 2024.
Estates		Reports: 50 ↑ Recs: 120 ↑	Reports: 4 ↓ Recs: 13 ↑	Reports: 1 Recs: 1 ↑	There is good engagement from the Directorate. There has been an increase in the number of open reports and recommendations as a result of the receipt of 5 new Letters of Fire Safety Matters (LOFSMs) with a combined total of 50 recommendations, with varying dates of completion from March to August 2024. Of the 13 overdue recommendations, 2 are without revised timescales (N/K), with the service awaiting confirmation from IA that they can now be closed. The remaining 11 overdue recommendations all have revised completion dates ranging between April and October 2024. The recommendation overdue by more than 6 months relating to a replacement fire door is due for completion in June 2024. The service is currently liaising with MWWFRS to agree the amended dates against these recommendations All MWWFRS reports are overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting.



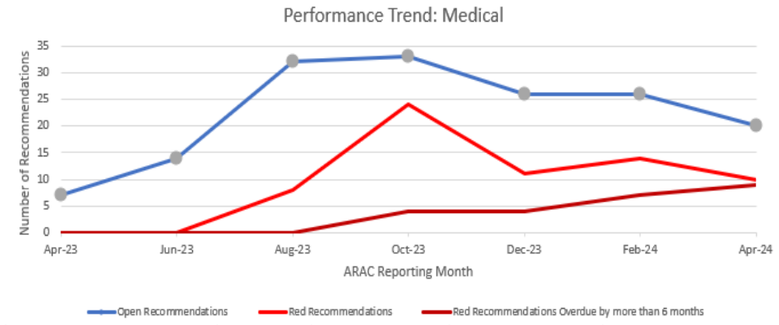


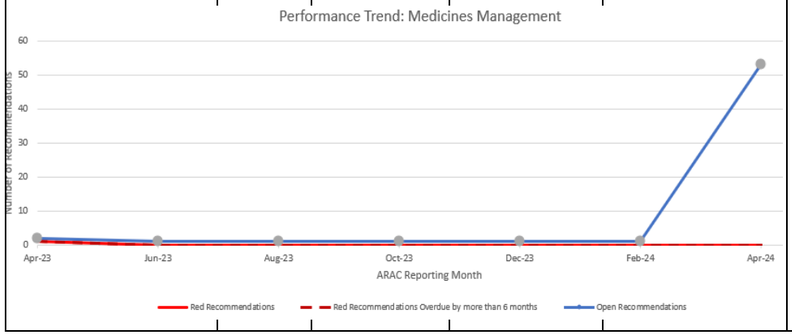
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Governance		Reports: 2 ↑ Recs: 8 ↑	Reports: 1 ↑ Recs: 4 ↑	Reports: 1 Recs: 3 ↑	Since the previous report presented to ARAC in February 2024, one new report has been received from AW on Structured Assessment 2023, with 5 recommendations raised. The Structured Assessment 2023 also reviewed progress made against recommendations raised in previous Structured Assessment reports, which has resulted in 3 recommendations being re-opened previously reported to ARAC as completed in 2023, and are therefore overdue by more than 6 months. The Executive Director of Strategy and Planning is noted as the Responsible Owner for 2 of these recommendations, with the Director of Finance noted as the Responsible Owner for the other. It is noted that since the data was extracted for this report, further progress updates have been obtained from the Executive Director of Strategy and Planning and the Director of Finance in relation to the recommendations raised in the Structured Assessment from 2022, and these will be reflected in the next paper to ARAC in June 2024.
Long Term Care		Reports: 2 → Recs: 10 ↓	Reports: 1 → Recs: 6 →	Reports: 1 Recs: 5 →	Since the previous report presented to ARAC in February 2024, the total number of recommendations has decreased from 11 to 10, with the number of overdue recommendations, and those overdue by more than 6 months, remaining the same as previously reported. The IA Discharge Processes report has 5 recommendations overdue by more than 6 months without revised timescales (N/Ks). An IA report incorporating a review of all recommendations from the IA Discharge Processes report will be presented at the April 2024 ARAC. Updates will be reflected in the next Audit Tracker report to ARAC in June 2024. Overdue recommendation from the IA Deprivation of Liberty Safeguards (DoLS) report being discussed for closure with IA colleagues. *The performance trend graph data for Long Term Care is available from December 2023 onwards only. Prior to this Long Term Care figures were included within the Primary Care service data.*



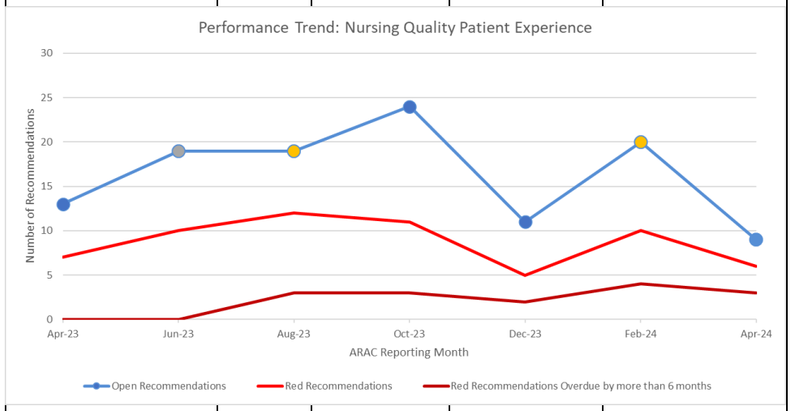


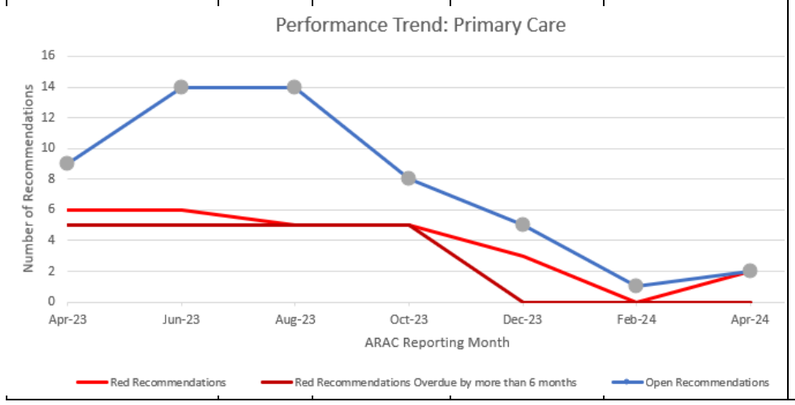
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Medical		Reports: 6 ↓ Recs: 20 ↓	Reports: 4 ↓ Recs: 10 ↓	Reports: 3 Recs: 9 ↑	The IA NICE Guidelines report has been closed since ARAC in February 2024. Since the previous report presented to ARAC in February 2024, the number of recommendations has reduced from 26 to 20. The number of overdue recommendations has decreased from 14 to 10, whilst those overdue by more than 6 months has increased from 7 to 9. Of the 10 overdue, 5 are without revised timescales (N/Ks). The Head of Assurance and Risk is supporting the Assistant Director of the Medical Directorate to obtain updates on these recommendations, which will be reflected to ARAC in June 2024.
Medicines Management		Reports: 2 ↑ Recs: 53 ↑	Reports: 1 → Recs: 0 →	Reports: 1 Recs: 0 →	Since the previous report presented to ARAC in February 2024, 1 new report on Welsh Government Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales has been added to the tracker. The report has 52 recommendations with timescales ranging from September 2024 to April 2029. There is one “external” recommendation from the AW report on Medicines Management in Acute Hospitals. The recommendation relates to electronic prescribing/discharging. Systems have been approved on a national framework and is currently awaiting confirmation of funding. This is reflected in risk 1171 – Risk of avoidable medication related patient harm due to no e-prescribing and electronic medication administration system, which has a current risk score of 16 as at February 2024.



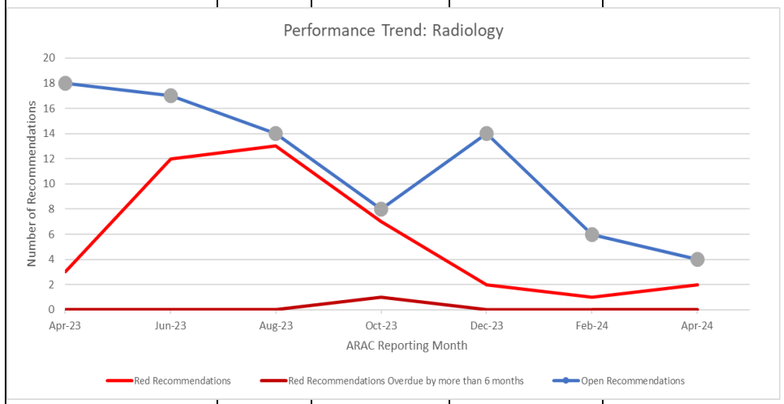


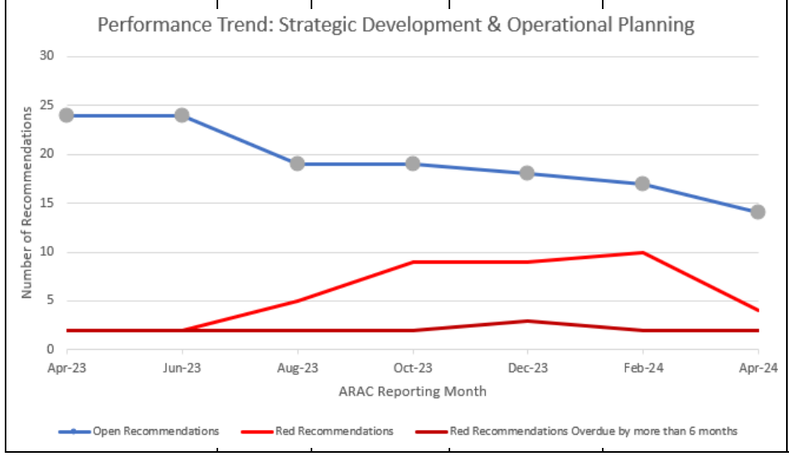
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Nursing, Quality and Patient Experience		Reports: 7 ↓ Recs: 9 ↓	Reports: 3 ↓ Recs: 6 ↓	Reports: 2 Recs: 3 ↓	The service was highlighted in the previous report to ARAC in February 2024 as one with a concerning trend. Progress received since the previous meeting has demonstrated a reduction in the number of open reports and recommendations, with 1 PSOW report closed and 4 of the 7 open reports noted currently awaiting formal approval for closure by PSOW and IA. Of the 3 recommendations overdue by more than 6 months, 1 has lapsed since the previous meeting, and the remaining 2 have progressed but both are due to lapse and it is unlikely they will be completed by their revised dates of March and April 2024. 1 recommendation relates to digital communication screens in waiting rooms, whilst the screens are in place there is ongoing difficulties with security/compatibility between screens and resource issues. The other recommendation relates to the Falls Strategy work which is currently on hold following discussions with the new Executive Director of Therapies and the Interim Director of Nursing, Quality and Patient Experience, as it is anticipated that the Falls Strategy may form part of a frailty strategy. The Assurance and Risk team have good engagement with the Service to obtain progress updates and request revised completion dates.
Primary Care		Reports: 2 ↑ Recs: 3 ↑	Reports: 2 ↑ Recs: 2 ↑	Reports: 2 Recs: 0 →	1 new report issued by AW Primary Care Follow-up Review was presented to ARAC in February 2024, with 2 recommendations raised for which management responses and completion dates due to be provided to ARAC at its meeting in April 2024. The tracker will be updated to reflect the management response and completion dates. *The performance trend graph for Primary Care includes Long Term Care reports up until October 2023, after which Long Term Care has been split as a separate service for the purpose of this report.*



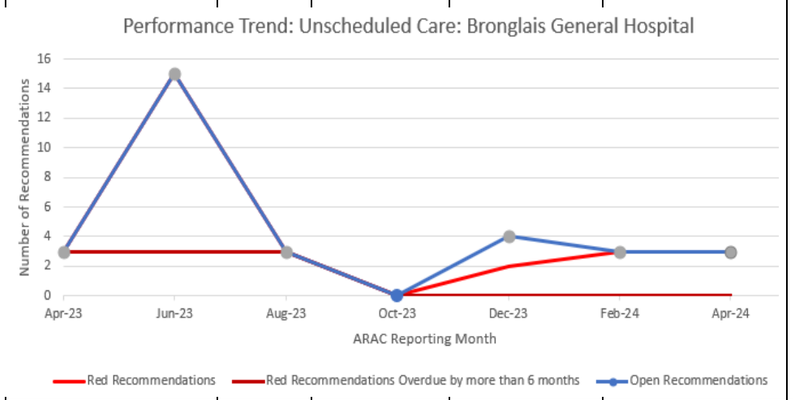


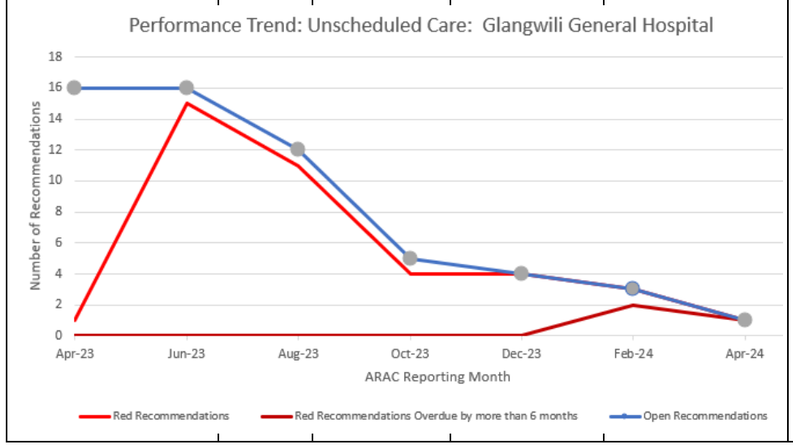
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Radiology		Reports: 2 ↓ Recs: 4 ↓	Reports: 1 → Recs: 2 ↑	Reports: 0 Recs: 0 →	1 new PSOW report has been added to the tracker since the previous meeting in February 2024 with 2 outstanding recommendations, 1 of which is overdue without a revised timescale (N/K). The Public Ombudsman Case Manager will be seeking an update on this report in readiness for the next ARAC meeting in June 2024. 1 recommendation remains incomplete on the HIW IRMER report for GGH issued in February 2023, which was due for completion in September 2023. The recommendation relates to sourcing a document control system to improve the ratification process for locally produced documentation. This recommendation was escalated in an exception report to the Operational Quality, Safety and Experience (OQSE) Sub-Committee in January 2024 and has a risk associated on Datix (Risk 1399- Non-compliance with IR(ME)R standards and governance requirements and associated patient safety risks. Current risk score 16) This report is monitored via AMaT. 2 Natural Resource Wales reports issued in September 2023 have been completed and closed on AMaT since the previous report presented to ARAC in February 2024. There is good engagement with the service.
Strategic Development & Operational Planning		Reports: 4 → Recs: 14 ↓	Reports: 3 → Recs: 4 ↓	Reports: 1 Recs: 2 →	1 AW report on Structured Assessment 2021 (Phase 1 Operational Planning Arrangements) has 2 recommendations which have been re-opened on the tracker since the previous report presented to ARAC in February 2024, as a result of the review of the recommendations undertaken as part of the Structured Assessment 2023. Both recommendations are overdue by more than 6 months, with revised completion dates of March 2024. 1 Peer Review report on Planning Arrangements in Hywel Dda University Health Board has 2 recommendations overdue with revised completion dates of March 2024. There is an improved position on both the IA reports. The IA report on A Healthier Mid & West Wales Programme has 8 of the 16 recommendations noted as complete with 8 recommendations noted as External (until Welsh Government have made a decision on the submitted Strategic Outline Case, as agreed with Internal Audit). The IA report on Decarbonisation has 2 of the 4 recommendations noted as complete with 2 recommendations on schedule (completion dates of March and April 2024).There is good engagement with the service.



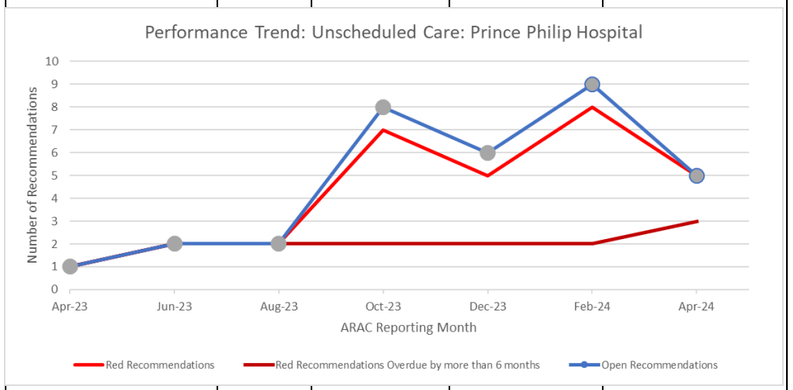


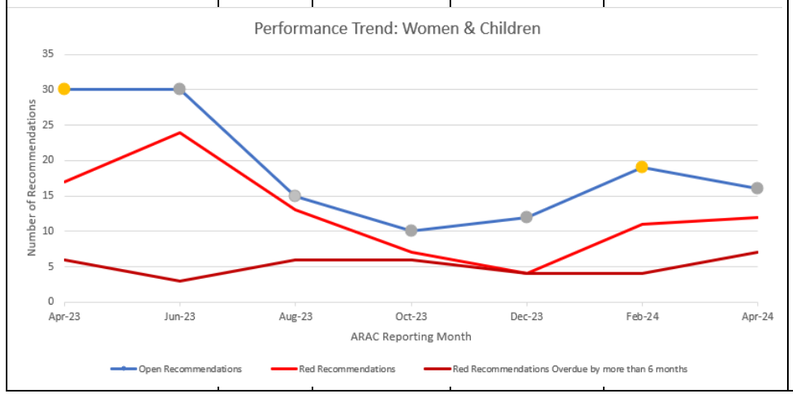
Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Unscheduled Care: Bronglais General Hospital		Reports: 1 → Recs: 3 →	Reports: 1 → Recs: 3 →	Reports: 0 Recs: 0 →	The follow-up IA report on Bronglais General Hospital Quality & Safety Governance has superseded the original report on the tracker, with 3 overdue recommendations that have revised completion dates ranging between April and August 2024. Recent engagement with the service has been good. The Assurance and Risk Team will be seeking updates for these recommendations in readiness for the next ARAC meeting in June 2024.
Unscheduled Care: Glangwili General Hospital		Reports: 1 → Recs: 1 ↓	Reports: 1 → Recs: 1 ↓	Reports: 0 Recs: 1 ↓	Since the previous report presented to ARAC in February 2024, the number of open recommendations has reduced from 3 to 1. The remaining recommendation as raised in the HIW report on the Emergency Unit relating to the refurbishment of staff changing rooms, shower facilities and toilets is overdue by more than 6 months, with a revised completion date obtained of March 2024. There is good engagement with the service.



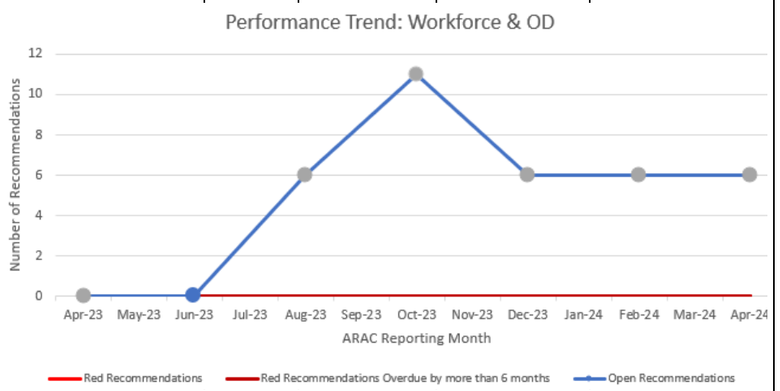


Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Unscheduled Care: Prince Philip Hospital		Reports: 3 ↓ Recs: 5 ↓	Reports: 3 → Recs: 5 ↓	Reports: 3 Recs: 3 →	There is good engagement with the service, with a reduction in the number of open reports, open recommendations, and overdue recommendations since the previous report. The 1 remaining recommendation as raised in the Peer Review; Hywel Dda UHB Lung Report relating to the absence of Pathologist in some MDTs, is overdue by more than 6 months. Respiratory service to agree with Pathology that the outstanding recommendation should be re-assigned to them. The 1 remaining recommendation as raised in the Peer Review report; Respiratory Cancer Review relating to the Health Board's strategic review of services where sustainability of current service model is challenging, is overdue by more than 6 months. The Head of Assurance & Risk to confirm with the Director of Operations if this outstanding recommendation can be closed. This has been the position of both Peer Review reports since reporting to ARAC in February 2024. Both reports are being actively monitored by the Assurance and Risk team and progress updates will be reflected to ARAC in June 2024. The 3 remaining recommendations (February: 6) as raised in the HIW report on PPH Minor Injuries Unit, are all without a revised timescale, with 1 of these recommendations now overdue by more than 6 months. This report is monitored via AMaT. The QAST will be seeking further updates and revised timescales for these actions, to be reflected in the report to the next ARAC in June 2024. 1 PSOW report has been closed since the previous report to ARAC.
Women and Childrens		Reports: 4 ↓ Recs: 16 ↓	Reports: 2 → Recs: 12 ↑	Reports: 1 Recs: 7 ↑	Since being noted as a service with a concerning trend in the previous report to ARAC in February 2024, the total number of open recommendations has decreased from 19 to 16 and 1 PSOW report has been closed. However, it is noted that the number of overdue recommendations has increased slightly from 11 to 12 driven primarily by 2 reports. There are 5 overdue recommendations on the HIW report on Bronglais Hospital Maternity Unit which is monitored via AMaT, 4 of which do not a revised timescale (N/K). There are 7 overdue recommendations on the follow-up Congenital Heart Defect Provider Report which are overdue by more than 6 months due to the overdue recommendations as raised in the original report issued in 2021 report being carried over. All actions raised the Llais West Wales Maternity Services report are fully complete and approved on AMaT, with the report awaiting formal approval for closure. There is good engagement with the service, with updates provided for reports monitored via the tracker and on AMaT, however the number of recommendations overdue by more than 6 months has increased from 4 to 7 since the previous report presented to ARAC in February 2024.





Service	Trend – March 2024	Open reports and recommendations – March 2024	Overdue reports and recommendations – March 2024	Overdue reports and recommendations more than 6 months – March 2024	Analysis
Workforce & OD		Reports: 1 → Recs: 6 →	Reports: 0 → Recs: 0 →	Reports: 0 Recs: 0 →	The service have 1 AW open report on the Review of Workforce Planning Arrangements, with 6 open recommendations with varying timescales to April 2025.



Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved	N/A – for WAST consideration	N/A	N/A	External	
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	N/A – for WAST consideration	N/A	N/A	External	
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	N/A – for WAST consideration	N/A	N/A	External	
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	N/A – for WAST consideration	N/A	N/A	External	
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	N/A – for WAST consideration	N/A	N/A	External	
Sep-21	2021/22	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	High	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	N/A – for WAST consideration	N/A	N/A	External	

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Jan-22	2021/22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ ~~Mar-24~~ Jan-25	Red	22/02/2023 - Cancer Services Delivery Manager has met with MDT lead and update sent to Mr Rao. Response said this is part of their Pathology program, building central facility in Morriston. FBC will be signed off in next 3-12 months - no progress expected until after this. 22/08/2023 - Update from the ARCH programme: The Programme is currently in Outline Business Case(OBC) phase working towards submitting the OBC to Welsh Govt in Jan/Feb 2024 work is currently ongoing to draft and cost the OBC. Building plans are due to go to the Programme Board in a few weeks time for its approval. Work is ongoing to determine what the desired regional service model should be for laboratory medicine/blood sciences Engagement on this will take place with representatives from hospital and primary care across both UHBs over the summer to help develop a preferred option. The timescale for completion has been revised to 2025. 19/12/2023 - Service confirmed that there has been no change since the previous update. 23/02/2024 - Update from the ARCH programme: An initial set of building plans for the proposed new Pathology Hub building were produced in July 2023. However, these plans are being revised following the subsequent publication of new Welsh Government guidance on the scope & cost of business cases. A revised Schedule of Accommodation has been produced, reducing the scale of the proposed Hub, and making more extensive use of the existing Pathology building at Morriston. The location of the proposed Hub building on the site is also being revised, in order to reduce build costs and timescales. Architects are currently working on a revised set of building plans, which will be made available to staff across Pathology disciplines after Easter for consideration and review. The work to establish a regional Pathology Service (via an Operational Delivery Network) is continuing. Subgroups have been established to take forward the workforce planning, finance & commissioning, and digital arrangements, processes and infrastructure needed to create a regional Pathology service. Current priorities include recruiting a senior leadership team for the service, creating a legal & governance framework to support regional decision-making, and preparing for the implementation of the new LIMS system across the region. The second set of staff engagement workshops have been held in January/February across the region (with sessions already held at GGH, Bronglais, PPH, Withybush, Princess of Wales and Singleton, and the final session set to be held in Morriston on 19th Feb). The sessions focused on identifying areas of good practice that could potentially be spread between sites, as well as common challenges that regionalisation may be able to help address.
Jan-22	2021/22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ Mar-24	Red	22/08/2023 - Currently working with SBUHB to update the Oncology Strategy that was put in place in 2015. This will include the BGH Oncology service. Cover is currently provided by Dr S Gwynne, SBUHB along with CNS support/ Telephone advice for Dr E Jones/CNS when away. SBUHB have now also appointed Dr C Barrington to cover the LGI Oncology service within HDUHB.The work on the updated strategy is still ongoing. 19/12/2023 - Service confirmed that there has been no change since the previous update. 23/02/2024 - Currently working with SBUHB to update the Oncology Strategy, this will include the BGH Oncology service. Scoping the possibility of support from HBs in the North for oncology in order to provide sustainable service. Working with SBU under the SPC to provide support to Bronglais in order to provide a sustainable service in the long term.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red-behind schedule, Amber- on schedule	Progress update/Reason overdue
Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	Medium	R4. Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.	As identified in the recommendation above following a report reviewed by the non-pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of the scoping working the groups will be required to identify any records outside of retention guidance and the relevant costs of destruction. As clarified above this work will be progressed early in the new year.	Mar-19	~~Jul-21~~ ~~Nov-22~~ ~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The Health Board continues to operate with the imposed UK government destruction embargo in situ, meaning no patient records can be destroyed. The relevant inquires could be completed early in 2023 and destruction processes can immediately go back into operation. The review of the offsite and private storage facilities, continues as part of the IG work programme and is identifying various records held at the localities. Work has also commenced in terms of returning Hywel Dda records to the central health records storage facilities, from private storage. Relocating records to one central management team will ensure retention and destruction schedules are followed diligently. 28/03/2023 - Each service area has an identified Information Asset Owner (IAO), who has responsibility for the management (including the destruction of the records). Following the lease of a new offsite storage facility the plan for the project moving forward will be to identify those services with greatest need of support from various viewpoints.Following this a plan will be agreed how the services implement strict records management arrangements, agree if there is a requirement to relocate records to the health records storage facility and ensure robust destruction procedures are implemented. 29/11/2023 – Since 2015 the Health Board has been under a destruction embargo, as a result of two national inquires. Fortunately the Health Board has recently received notification that they can now recommence destruction, however this must be completed in line with the Welsh Government, Records Management Code of Practice (COP). The COP has introduced some new retention timeframes which have previously only be utilised in England and discussions are ongoing if they are relevant or a legal requirement to follow in Wales. With this in mind services within Hywel Dda have started to destroy deceased records only, which provided easier review and assurances in terms of compliance. As discussions continue nationally, the Health Board has started to relocate various records types to the two health records storage facilities. Records are being recalled from private storage providers and from inappropriate internal storage locations so they are centralised at one secure locality, ready for review. This project will include a considerable number of records and a wide range of records type, which currently we are unable to accurately quantify. This project will take a sustained period of time to complete and we are only in the early stages. We envisage this being a 3 year project for completion. In conjunction with the relocation of records the Health Board Retention & Destruction Policy was approved in February 2023 and circulated across the Health Board and will be utilised to support the destruction process. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. As at January 2024, 308,000 acute patient records have been scanned, with another batch ready for distribution before the end of the financial year and to date 6,538 boxes (each containing a varied number of service records) and 16 filing cabinets have been transferred to the centralised storage facilities in Dafen and Llangennech, from both private storage providers and other internal Health Board storage locations. This allows for improved oversight of the identification and subsequent decision making where destruction or alternative courses of action of health records is concerned and is in line with Welsh Government Records Management Code of Practice and improved adherence to Information Governance requirements. The pace of the destruction of records can also now increase as a result of the lifting of both destruction embargoes arising from two national inquiries. Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.
Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	High	R6, section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The IG work programme to review storage facilities is ongoing and to date 4 locations have been reviewed, including 2 private providers (Lloyd & Pawlett and Logic Document) and the health records storage facilities based at Dafen and Llangennech in Llanelli. Concerns remain in regards the private storage providers and an SBAR was presented to the Executive Team in October 2022 proposing that the management and storage of all Hywel Dda records be examined to one Executive lead. Clearly this is a considerable project to undertake and complete and it will require significant support from a wide range of services and identified IAO's. Work has commenced in terms of developing a project plan and schedule of work, but initial progress has been made by relocating A&E and pharmacy records, with other services to follow. Once all records are relocated to the Health Board storage facilities this will negate any concerns. 28/03/2023 - As the knowledge centre of the organisation where record management is concerned the change would not be severe for the health records service and would simply be an extension of the business model currently operated for the acute patient record, to accept wider record types. This work has already commenced with the relocation of A&E cards for GGH and PPH and Pharmacy records and others will follow over the next 12 months as the digital records project is progressed. 29/11/2023 – As the IG team continue to undertake their review of both external private storage facilities and internal storage facilities the health records service has been extremely proactive in terms of continuing the relocation of records to its secure centralised storage facilities. Through proactive dialogue, with various service leads, across a wide range of Directorates including: Scheduled Care, Unscheduled Care, Therapies, Community, Women & Child Health, the health records service has already supported the Health Board in relocating approximately 136,950 records, 5800 boxes from A&E and Pharmacy (too many records in a box to equate) and also various boxes of charts and theatre registers and 12 filing cabinets, to ease storage pressure and relocate records to an appropriate and secure location. The services already located include: Dietetics, Physiotherapy, Maternity, Mental Health, Maternity, A&E, Long Term Care, District Nursing, Community Nursing, Pharmacy and Oncology. Further dialogue is ongoing with other services and will continue in the future. Again without a full inventory of all records held within these and other services we are dealing with an unknown quantity and the completion of the project will be a few years down the line, but already from the considerable piece of work undertaken in a relatively short timeframe the Health Board is already witnessing the benefits. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. As at January 2024, 308,000 acute patient records have been scanned, with another batch ready for distribution before the end of the financial year and to date 6,538 boxes (each containing a varied number of service records) and 16 filing cabinets have been transferred to the centralised storage facilities in Dafen and Llangennech, from both private storage providers and other internal Health Board storage locations. This allows for improved oversight of the identification and subsequent decision making where destruction or alternative courses of action of health records is concerned and is in line with Welsh Government Records Management Code of Practice and improved adherence to Information Governance requirements. The pace of the destruction of records can also now increase as a result of the lifting of both destruction embargoes arising from two national inquiries. Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.
Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	High	R6, section2. Management should establish what information is stored with the third party storage providers and that the retention and destruction of information is being undertaken in line with the Welsh Government arrangements.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non-pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – Please see update provided for recommendations R4 and R6 section 1. The SBAR presented to the Executive Team in October 2022 proposing to move the management, handling, scanning and destruction of all Hywel Dda records to one Executive lead and retained within the health records storage facilities will ensure all storage, governance, destruction issues are fully resolved. 28/03/2023 - identified what records (an other items) are being held in private storage, how we intend to relocate them back into the Health Board, under on service/lead and how destruction processes will be implemented. 29/11/2023 – As the IG team continue to undertake their review of both external private storage facilities and internal storage facilities the health records service has been extremely proactive in terms of continuing the relocation of records to its secure centralised storage facilities. Through proactive dialogue, with various service leads, across a wide range of Directorates including: Scheduled Care, Unscheduled Care, Therapies, Community, Women & Child Health, the health records service has already supported the Health Board in relocating approximately 136,950 records, 5800 boxes from A&E and Pharmacy (too many records in a box to equate) and also various boxes of charts and theatre registers and 12 filing cabinets, to ease storage pressure and relocate records to an appropriate and secure location. The services already located include: Dietetics, Physiotherapy, Maternity, Mental Health, Maternity, A&E, Long Term Care, District Nursing, Community Nursing, Pharmacy and Oncology. Further dialogue is ongoing with other services and will continue in the future. Again without a full inventory of all records held within these and other services we are dealing with an unknown quantity and the completion of the project will be a few years down the line, but already from the considerable piece of work undertaken in a relatively short timeframe the Health Board is already witnessing the benefits. All the records returned to the centralised storage facilities will be fully reviewed, inventoried into appropriate sections (ready for destruction/retain for agreed period before destruction/retained & scanned/scanned immediately) and ultimately destroyed in line with the Health Board's Policy and National Code of Practice. 29/01/2024 - Since the original Internal Audit report was produced in February 2019, there have been significant developments with the arrangements in place across the Health Board in relation to records management due to the commencement of digitalisation project enabling schemes, such as: •Relocation of records from private storage providers to centralised health records storage facilities in Dafen and Llangennech; and •Implementation of an electronic document records management system) Digitisation project work continues across the Health Board, with effective communication between the Health Records team and relevant service leads; the project is currently due for completion by March 2027 with the proviso that the back records held will be either scanned or destroyed by that time. 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Work undertaken to date on the relocation and digitisation of A&E cards has produced a cost avoidance of approximately £60-70,000 annually for the Health Board; this money will be reinvested into furtherance of the digitalisation project. It is noted that the Health Board have a corporate risk in relation to the ongoing project (1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure) which is regularly updated to reflect developments, and presented to Executive Risk Group monthly and reported to Board three times a year, and scrutinised at Sustainable Resources Committee (SRC). A planned follow up to the original internal audit is scheduled for Q4 2023/24. At the Directorate Improving Together Sessions for Central Operations held on 19th January 2024, Executive confirmation was sought that the original recommendations could be closed due to the developments as noted above. 16/02/2024 - IA will discuss this recommendation with Health Records and in an end of year mop up exercise for potential closure.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R1. Clinical leadership within the OOH service requires expansion to include leadership at system wide level and on- shift. Action: Review leadership roles and recruit to expand both at system level and operational level.	This is accepted as an area requiring attention. Exploration of the capacity of leadership is now the subject of discussion within the senior team along with at the Improving Together sessions recently instituted by executives. Limited numbers of GPs with an interest in OOHs remains a challenge so longer term development opportunity may be needed. The operating relationship with leads in TUEC and UPC opens up further reconciliation needs.	Jun-23	~~Jun-23~~ ~~Aug-23~~ ~~Mar-24~~ Jun-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Paper drafted outlining transitional plan to institute the changes required, addressing the system-wide which will potentially reduce the on-shift requirement. Paper requires sign off by Deputy Director of Operations prior to being presented to the Executive Director of Operations. Resilience work is being done regarding the on-shift element, and may require additional time to implement compared to the in-hours role. 16/08/2023 - 1 WTE clinical lead in place, and currently formalising arrangements in terms of restructuring of the OOH senior management team. However review required for the rest of the structure given current Health Board financial constraints. 04/12/2023 - Clinical Lead continues to work Monday-Friday as previous information. There has been no progress in formalising this to extend the contracted hours to a WTE and so additional days are remunerated at sessional rates with the precedent set at hourly rates paid in HB Managed Practice. The value of Clinical Leadership and associated achievements can be expalined during the DITS session. 05/03/2024 - Clinical Lead continues to work up to 1.0 WTE with conversations open with the support of Senior Workforce colleagues to establish permanently. The OCP may have an impact on how this is continued is not being allowed to be a rason not to progress.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review options for consolidation of bases.	Bases have been consolidated overnight from five to three since 2020 in the interests of patient safety and better management of expectation. This temporary service change remained under review as the underlying intention remains to operate from five bases. Latterly shift fill has not shown any significant improvement. Key to improving this is to develop the MDT model such that the interested medical parties in the numbers available can be spread across five centres.	Sep-23	~~Sep-23~~ ~~Mar-24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - a more balanced shift fill has been noted by the service, however due to financial constraints, review of bases are still ongoing. 04/12/2023 - Shift fill has improved over recent months and will continue to be evaluated. Christmas rotas are improved when compared to 2022 however there are significnat levels of reduced capacity due to the dominant locum workforce availability. 05/03/2024 - Rota stability on the whole remains improved with few base closures over the past 12 months compared to previous years. The bases that were closed overnight temporarily in 2020 remain closed during these periods however the clinical cover during the evenings and weekend/BH daytime periods is relatively stable. The OCP may influence direction of travel for these bases and the OOH service as a whole.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review rural models in operation in Cumbria with a view to implementation in the West.	The TUEC Director has made arrangements to pilot a model which is based on the Airedale service which is soon to commence in the Carmarthenshire area and will offer support to the residential care sector. In addition the OOHs team will seek to understand the arrangements specific OOHs impacts as a result of the Airedale model's operation in Cumbria.	Jun-23	~~Jun-23~~ ~~Dec-23~~ ~~Mar-24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model, and if it's feasible to be implemented within Carmarthenshire. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. The implementation of Salus may cause further delay (expected November 2023), therefore proposed revised timescale of December 2023. 16/08/2023 - work is ongoing by service leads who are due to meet with colleagues in Cumbria OOH services to identify areas of good practice which can be shared with the Health Board. In Carmarthenshire, a trial period is scheduled in terms of implementing a model similar to Airedale currently under the auspices of TUEC . 04/12/2023 - The proposed Airdale project has not yet commenced within HDUHB (as updated from USC Lead). A visit to assess the rural model in Cumbria has not been possible and so revised date provided to allow time to do so and integrate this where possible into the OOH delivery. 05/03/2024 - No further update available - beyond sphere of influence
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts. Action: Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ Jun-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - due to management structure chanegs at WAST, and several APPs leaving, this has delayed the full implementation of the recommendation, however improvements beginning to be noticed and a new cohort of APPs are currently embedding. Ongoing financial constraints are also impacting on the ability to fully implement this recommendation as at August 2023 04/12/2023 - There has been a prolonged period of reduced APP shift fill that is being addressed by WAST with the assurance that shift fill is set to improve imminently. 05/03/2024 - Shift fill did improve however not sustained. This may be linked to the same APPs being used in other areas of the HB despite OOHs funding two WTE. Assessment of the sustainability and resilience of the APP relationship with WAST is being considered and a decision will be reached in Q1 24/25. This again may be influenced by the decision reached through the OCP.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: OOH and UPCC to work collaboratively on development of a workforce plan for increasing the MDT	Collaborative working with WAST and other teams within HDUHB has commenced with a view to developing the model.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - conversations ongoing and impacted by current financial position. Revised completion date noted. 04/12/2023 - Work ongoing to integrtae with other systems utilising ACPs but plans needed to ensure OOHs are able to develop a MDT with these colleagues 05/03/2024 - Work will be continuing but no progress to report at this time. Linked to outcome of OCP.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: UPCC to utilise the UPC Framework to expand scope of practice of practitioners	OOHs Clinical Lead sits on national group discussing UPC framework – continued development of this is in place.	Jun-23	~~Jun-23~~ ~~Sep-23~~ ~~Mar-24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Paper being presented at All Wales Urgent Primary Care Conference on 28/06/2023, with progress to be provided at next recommendation review meeting 16/08/2023 - work is ongoing, and impacted by current financial position. Revised completion date noted. 04/12/2023 - There was to be a UCP presentation at the Al Wales OOH Forum last week but this has been deferred until the new year whilst work is ongoing partly due to concerns of GP workforce. 05/03/2024 - Work is continuing but no further update at this time. Linked to outcome of OCP
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R10. The service relies mainly on sessional GPs to provide shift cover. Consideration needs to be given as to how to attract new GPs to the role. There is an opportunity to work collaboratively with UPCC to create salaried, rotational posts. In addition on-boarding of GPs willing to work in OOH has been hampered due to this being managed by Medical recruitment. Action: Workforce plans need to be developed for OOH and UPCC increasing the number of salaried/ rotational posts.	Development of a broader workforce plan which incorporates PC/ UPCC	Dec-23	~~Sep-23~~ ~~Mar-24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - conversations ongoing with relevant leads and Executives in order to promote recruitment and OOH and Primary Care for co-working, and developing rotational portfolios with areas such as SDEC to make the opportunities more attractive. However current financial constraints are limiting the ability to progress this recommendation at pace, therefore timescale moved to Mar-24 to reflect. 04/12/2023 - Renewed conversations and inclusion with ongoing TUEC/UPC work. 05/03/2024 - Workforce plan being developed. Expect to have in useful shape by the end of Q1 24/25. This action is also linked to outcome of OCP and involvement with the UPC work which is currently being reviewed.

Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review utilisation of HCSW in base and in cars, link with CTM to understand how they deploy their HCSW.	Promoting further use of HCSW in OOHs is active. As part of Internal Service Review all JDs being discussed as 1:1 and emphasis being made to using skills. CTUHB will be approach on this arrangement also	Sep-23	~~Sep 23~~ ~~Mar 24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further update on the further development and integration of HCSWs in to the OOH MDT. 05/03/2024 - Reviewing the job roles and where possible developing a single role within the OOH service to allow HCSW trained colleagues to work in this capacity on a frequent basis to support the service and maintain their skills
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation of HCSW in bases in the West could support a rural model of care.	Explore with CTUHB. Ties in with TUEC programme work Skill set to be scopes and compared with opportunities and needs.	Jun-23	~~Jun 23~~ ~~Dec 23~~ ~~Mar 24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. Interaction with Salus may cause further delay, therefore proposed revised timescale of December 2023. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further progress to date. 05/03/2024 - Those trained as HCSW are being encouraged to utilise their skills. Clinicians are being encouraged to support such colleagues and feedback has been positive. As the number of face to face consultations continues to increase these opportunities should also be more frequent. Evaluation of the role will be ongoing. All new recruits to the OOH operational team will be trained as HCSW through the Skills to Care programme.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation and training of HCSW in community hospitals could support medicines administration, link with Pharmacy and Social Services.	Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared to opportunities and needs Engagement to facilitate better understanding of the need and to establish what opportunities might exist whilst remaining a compliant approach to care.	Dec-23	~~Dec 23~~ ~~Mar 24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023- There is no further progress to date as invite to visit CTM had to be cancelled due to work pressures. There has also been a change of clinical leadership in CTM with a greater focus on GPs. 05/03/2024- Conversation with colleagues in other HBs including CTM have been rekindled and opportunities to undertake visits are being sought with a view to understanding other models and bringing back examples that would suit the HDUHB model.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Consider training for staff in VoD and management of catheters.	Requires wider engagement with DN /ART to assess frequencies and demand profiling to inform workforce modelling.	Sep-23	~~Sep 23~~ ~~Mar 24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - No change to OOH structure with no opportunity to explore this further. 05/03/2024 - Support or DN/ART teams has reduced the demand for catheter and VoD in the OOH service and so the need is not so apparent at this time. If service redesign progresses there may be need to review this action again and ensure OOH HCSWs are supported to learn and maintain the appropriate skills.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Consider a workshop bringing together UPCC, Clusters and OOH to work on an integrated plan	Being led by TUEC Programme Director.	Sep-23	~~Sep 23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures. 04/12/2023 - work recently reconvened following move of previous lead and restructure of leads in this domain. 05/03/2024 - OOHs is included in the submission to the Six Goals programme later in March. Likely will be influenced by the outcome of the OCP
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Review use of dedicated slots for UPC offered in GMS, consider whether any slots can be utilised by OOH.	To discuss with PC, Cluster and UPC leads	Sep-23	~~Sep 23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures. 04/12/2023 - conversations are underway with Primary Care colleagues to find a way to constructively interact with the wider systems 05/03/2024 - This is being discussed within the HB through the Primary Care Leads forum and UPC working group. Consideration will be needed to allocate this action to a new lead and this may also be influenced by the OCP.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: develop policies that support clinicians to undertake tasks related to remote prescribing.	Remote prescribing being received with excessive caution on the part of OOH clinicians. DMD supporting the development of a compromise.	Sep-23	~~Sep 23~~ N/K	External	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - this links to electronic prescribing which is driven nationally. The Health Board await national guidance, and will update policies in light of these requirements. Recommendation status amended to External. 04/12/2023 - It is understood the newest version of Adatsra is capable of remote prescribing however this will require a national implementation. 05/03/2024 - Remote prescribing is a national initiative and so is outside of the direct influence of the OOH service. Within HDUHB options are being considered to make prescribing and communication with pharmacies more efficient. Discussion with Community Pharmacy colleagues is underway to jointly explore solutions to improve prescribing opportunities which will allow clinicians to choose the most appropriate pharmacy for the patient they are dealing with and improve efficiencies within the OOH service.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: Review policy for booking F2F slots to allow remote clinicians to book slots	Some negative feedback received from clinicians and DMD supporting a compromise.	Sep-23	~~Sep 23~~ ~~Dec 23~~ ~~Mar 24~~ Sep-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - Policy has been reviewed, and compromise discussions are ongoing with workforce and clinical lead with communications sent in August 23. 04/12/2023 - compromises have been reached to ensure HDUHB OOH service can function safely and efficient however there is a continued drive from 111 to allow direct booking into treatment centres without any limitation which continues to be a source of concern to the OOH medical workforce and DMD/AMD. 05/03/2024 - Arrangement remains in place to good effect although there is little appetite to allow 111 to book patients into any OOH Treatment Centre without minimum communication. Presently being monitored
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R16. Clinicians raised concerns about the appropriateness of calls sent across from 111, which could have been closed by 111. Action: Consider a table top review of calls sent across by 111 deemed inappropriate	Data gathering has continued with the recent restoration of Adastra and its concentrator. Analysis of call profiles to be undertaken and interpretations to be compared.	Sep-23	~~Sep 23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Continues to be challenged nationally by all HBs. Professor Mark Lawrence has undertaken a survey to be published in the new year. Upwards of 60% of calls are passed as priority 1 (Emergency in general practice) however les than 1% of these maintain that level of priority following medical triage. 05/03/2024 - Regular feedback to 111 about the appropriateness of calls and disproportionately large numbers of Priority 1 calls. This is also a factor in the above action. The report by Professor Mark Lawrence has recently been shared and is being reviewed nationally. WAST are due to have a replacement for their front end Clinical Assessment programme and this will allow some changes including a change to some triage categories which may see the sensitivity reduced and less calls being categorised at Priority 1.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R17. Clinicians were concerned about calls being held on the 111 advice queue from early afternoon and then being passed to OOH at 6:30pm on weekdays. Action: Gather data to determine the extent of this issue and raise via Joint Operational group.	Similar data profile noted above to be gathered to assess validity of claim	Sep-23	~~Sep 23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Data gathering continues but reliable cooperation with frontline clinicians is poor to gather timely and accurate detail rather than anecdote. Work continues nationally on this subject also. 05/03/2024 - Continual gathering of information and feedback to 111 is in place. Reinforcing the need to use the Datix system when near miss incidents occur and adverse incidents linked to this recommendation
May-23	2022/23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	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.	Jun-23	~~Jul 23~~ ~~N/K~~ ~~Jan 24~~ ~~N/K~~ Mar-24	Red	11/07/2023 - Regular meetings are held to look at suppliers and solutions. 11/09/2023 - A meeting was held between Digital Director and Central Ops. It was agreed that the recommendations on this report are to be reassigned to Ops Directorate with Digital noted as a supporting service. 15/12/2023 - All Programme doumentation is being finalised complete with governance structure and consituent project plans. 20/12/2023 - IA confirmed that a follow up audit is due to take place in Q4 (Jan 2024 to March 2024) 16/02/2024 - Follow up report to be presented at April 2024 ARAC. 27/02/2024 - follow-up audit interviews took place with Health Records staff and Programme Manager February 2024.
May-23	2022/23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	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~~ ~~N/K~~ ~~Jan 24~~ ~~N/K~~ Mar-24	Red	11/09/2023 - A meeting was held between Digital Director and Central Ops. It was agreed that the recommendations on this report are to be reassigned to Ops Directorate with Digital noted as a supporting service. 15/12/2023 - Work in progress but on track pending forecasts/costs associated with establishment of Scanning Bureau. 20/12/2023 - IA confirmed that a follow up audit is due to take place in Q4 (Jan 2024 to March 2024) 16/02/2024 - Follow up report to be presented at April 2024 ARAC. 27/02/2024 - Finance BPM is preparing a full costings excercise for the Programme - Health Records information was submitted 23/02/2024.
May-23	2022/23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Medical	Deputy Director of Operations	Director of Operations	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~~ ~~Feb 24~~ Sep-24	Red	11/09/2023 - A meeting was held between Digital Director and Central Ops. It was agreed that the recommendations on this report are to be reassigned to Ops Directorate with Digital noted as a supporting service. 15/12/2023 - The Programme Manager will maintain oversight, but this is heavily reliant on clinical input and therefore ownership is extended to the medical directorate. Further UAT planned and currently on track. 20/12/2023 - IA confirmed that a follow up audit is due to take place in Q4 (Jan 2024 to March 2024) 16/02/2024 - Follow up report to be presented at April 2024 ARAC. 27/02/2024 - Full clinical UAT to commence on move to EDRMS Production Environment - current expectation in Q2/3 2024/25. UAT with Health Records staff is ongoing as staff are currently using the system to access legacy records.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R2b. The Health Board needs to provide assurance that case reviews are carried out to see what can be learned from individual cases as the Health Board seeks to implement and monitor its strategy.	Implement a recommendations from the Palliative and EOL Strategy to establish a monthly Health Board wide peer review.	Sep-23	N/K	Red	Update taken from AMaT = Overdue (no revised date provided)
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R3b. The Health Board needs to consider whether the initial discussions with patients, carers and loved ones are as comprehensive as they can be in terms of decision-making and communication.	To ensure all patients and relatives are reached, the Health Board is contributing to the digitalisation of an All Wales Advance and future care plans.	Sep-23	N/K	Red	Update taken from AMaT Sept 23 - Hywel Dda representative on the All-Wales AFCP Group. Feedback is given via the Hywel Dda Palliative and End of Life Group bimonthly meetings. All Wales digitalisation work is ongoing. Update 16/02/24 Hywel Dda representative on the All-Wales AFCP Group. Feedback is given via the Hywel Dda Palliative and End of Life Group bimonthly meetings. All Wales digitalisation work is ongoing.
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R3e. The Health Board needs to consider whether the initial discussions with patients, carers and loved ones are as comprehensive as they can be in terms of decision-making and communication.	Following Welsh Government guidelines, the Palliative care & EOL service to contribute to the implementation of the All Wales Advance and Future Care Planning when it is finalised.	Sep-23	N/K	Red	Update taken from AMaT Sept 23 update All Wales work ongoing to develop a digital AFCP. Hywel Dda Specialist Palliative Care Team promote the use of all Wales recommended AFCP documents and websites.
Mar-23	2022/23	CHC	Palliative End of Life Care	Open	N/A	Ceredigion	Ceredigion	Jill Paterson	Director of Primary Care, Community and Long Term Care	N/A	R4b. The Health Board needs to ensure that the needs of an effective palliative care model are consistently met by local GP/Out of Hours services	To ensure access to nursing support is available across Hywel Dda 24/7. In addition to the Nursing support Specialist Palliative Consultants are available Out of Hours (OOH) as well as the provision of a separate telephone advice line for Patients and their families and Health Care Professionals requiring OOH GP support.	Sep-23	N/K	Red	18/01/2024 - AMaT - overdue (no revised date provided)

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jun-23	~~Jul-23~~ ~~Mar-24~~ Mar-26	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ ~~Jun-23~~ ~~Mar-24~~ Mar-25	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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Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ Jan-25	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ Jun-24	External	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
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Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Low	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	~~Aug-23~~ ~~Jul-24~~ Oct-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ ~~Dec-23~~ Oct-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
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Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	Mar-24	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).
Feb-22	2021/22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital	Digital	Digital Director	Director of Finance	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Jun-23~~ Mar-24	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).
Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	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~~ N/K	Red	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 occurring to undertake all the tasks associated with the asset workstream of our cyber programme. 21/09/2023 - A revised timescale cannot be provided at present due to the involvement of multiple service leads however progress is being made. 22/12/2023 - (Update from IA) Recommendation can be considered for closure. Launch of ARMIS will supersede this management reponse and ideally be monitored via a specific group/sub committee.
Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	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~~ ~~Oct-23~~ N/K	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 at present. 21/09/2023 - The assurance process is expected in October 2023. 22/12/2023 - (Update from IA) Launch of ARMIS may supersede this management reponse if the project is monitored via a specific group/sub committee.
Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Medium	R4a. All network management tools should be correctly configured so as to be able to identify and categorise alerts by importance/severity, and to assist with capacity management.	The Asset Management workstream will be integrating the Solarwinds Network Management tool with FreshService. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur.	Feb-23	~~Feb-23~~ ~~Jul-23~~ ~~Aug-23~~ May-24	Red	16/01/2023 - Work in progress. On track. 17/05/2023 - The integration of Solarwinds with FreshService is underway with requirements being scoped. 11/07/2023 - Regular meetings are currently being held around FreshService which incorporates asset management 02/11/2023 - Change to management response: The infra team will be configuring the Solarwinds and CISCO ISE Network Management to provide sufficient alerts and events for proactive problem mgt. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur. Revised date - May 24. 22/12/2023 - (Update from IA) Launch of ARMIS may supersede this management reponse if the project is monitored via a specific group/sub committee.

Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	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~~ May-24	Red	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. 11/07/2023 - Current figures to be updated 02/11/2023 - Legacy desktop 758, server 152 - Increased as further legacy dates being met across the estate. Work is ongoing as a project workstream to capture the legacy estate and provide mitigations. 22/12/2023 - (Update from IA) Launch of ARMIS may supersede this management reponse if the project is monitored via a specific group/sub committee.
Nov-22	2022/23	Internal Audit	Cyber Security	Open	Substantial	Digital	Digital	Digital Director	Director of Finance	Low	R2. A central mailbox for all alerts should be created and used for their management. A routine procedure should be created, documented and followed for the management of the mailbox and clearance of the notifications	The Infrastructure Team are working through the arrangements of having a centralised mailbox, and the business continuity of this approach. Associated with this will a standard operating procedure (SOP) of the management of the mailbox, and the clearing of notifications.	Dec-22	~~Dec-22~~ ~~Dec-23~~ N/K	Red	16/01/2023 - Recommendation has been completed. Internal Audit have now been contacted. 11/08/2023 - Update from Internal Audit: The Central Mailbox has been established, but a standard operating procedure has yet to be produced (likelihood of completion by end of the year). 02/11/2023 - Alert systems need to be pointed towards central mailbox which is ongoing. SOP to detail the setup also needs to be created. On target for end of year.
Mar-23	2022/23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital	Digital	Digital Director	Director of Finance	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~~ ~~Aug-23~~ N/K	Red	11/07/2023 - Paper has been completed. Head of Digital Business & Engagement to get more information from Digital Director. 11/09/2023 - Head of Digital Operations to pick up with Digital Director 02/11/2023 - No further update. Drafted paper to be located and reviewed.
Mar-23	2022/23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital	Digital	Digital Director	Director of Finance	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 case will be the case for change, which will outline the proposed plan. Timeline: • Case for Change / Business Case – September 2023	Sep-23	~~Sep-23~~ N/K	Red	11/09/2023 - Head of Digital Operations to pick up with Digital Director. 02/11/2023 - No further update. Dependent on R1a Strategic Options Appraisal delivery first.
Mar-23	2022/23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital	Digital	Digital Director	Director of Finance	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	Mar-24	Mar-24	Amber	11/09/2023 - Head of Digital Operations to pick up with Digital Director. 02/11/2023 - No further update. Dependent on R1a Stratgeic Options Appraisal and R1b Business Case delivery first.
Nov-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Low	R5. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	May-24	Amber	
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	High	R1. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	May-24	Amber	
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Medium	R2. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	May-24	Amber	
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	High	R3. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	Mar-24	Amber	
Dec-23	2023/24	Internal Audit	Technical Resilience Final Report	Open	Reasonable	Digital	Digital	Digital Director	Director of Finance	Medium	R4. Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	May-24	May-24	Amber	

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	~~Dec-23~~ Nov-24	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- update to ARAC provides revised date of December 2022 for the implementation of the new risk management system. This is an All Wales system therefore the implementation date is outside the gift of the Health Board. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 10/07/2023 – Fundamental issues with the new Datix risk system have come to light in respect of its functionality and reporting, which have led to the All Wales Datix Team agreeing with RLDatix that the current Datix risk module will remain in place until November 2024. At present, RLDatix are developing a roadmap for the work needed to address the issues with the new risk system for the NHS Wales Risk Group to consider and inform decision-making about proceeding with the new Datix Risk module or exploring other options. 14/11/2023 - discussions are continuing on an All Wales level with Datix, and outcomes awaited from Programme Board meeting scheduled for November 2023 to determine next steps
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	~~Jul-22~~ Nov-24	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 21/03/2022- this recommendation has been delayed due to the Omricon variant. Revised date July 2022. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience. Head of Assurance and Risk to obtain clarification from Board Secretary. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 21/11/2022 - Assistant Director of Assurance and Risk with the Deputy Director of Operations to establish a revised process and timescale for implementation for the recommendation. 24/11/2022 - Recommendation changed from red to external as implementation will be dependent on the implementation of the new Datix system 23/03/2023 - no further progress or timescales. Risk raised to reflect the situation - 1607 - Risk that the UHB will not have a fit for purpose risk management system after 31Mar24 10/07/23 – Whilst waiting for the new risk system, the Operational Risk Report to Operational Quality, Safety and Experience Sub-Committee will now include a more detailed analysis, which will include grouping of similar risks. The Directorate Improving Together sessions provide high level oversight, identification and discussion of key risks and issues experienced by Directorates and Services. Work is also progressing to define 'fragile services' which will help the identification of increased risks in particular services. 14/11/2023 - discussions are continuing on an All Wales level with Datix, and outcomes awaited from Programme Board meeting scheduled for November 2023 to determine next steps
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ Sep-24	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 23/03/2023 - Directorate Improving Together Sessions commenced in January 2023, which now supersede the operational risk review meetings, of which the generated TOAs are monitored via DITS, as we as via Senior Operational Business Meetings. To confirm with Director of Operations in April 2023 that the recommendation can now be closed. 01/08/2023-Directorate Improving Together Sessions established in January 2023. Assistant Director of Assurance and Risk and Head of Assurance and Risk have requested confirmation from the Director of Operations in June 2023 to confirm if the recommendation can be closed in relation to Governance arrangements. 28/12/2023 - an OCP has been issued to operational teams in December 2023, with a consultation preiod extending in to 2024 following which further engagement may be required. A phased approach is being applied and that a new structure will be ready for implementation by 1st April 2024. Once the structure has been agreed and individuals appointed and in post, a review can then be undertaken on Datix to ensure it reflects the revised structures.
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R1. Complete the review of the Transfusion Policy.	Confirm that the Transfusion Policy has been reviewed, updated and approved by the Transfusion Committee.	Aug-23	~~Aug-23~~ ~~Oct-23~~ Mar-24	Red	11/05/2023 - The existing policy has been given a formal extension by CWCDG until 10/08/2023, whilst the review is undertaken. 15/06/2023- lead officer has contacted Consultant Haematologist for an update. 07/09/2023- This policy sits with Pathology.The Chair of the Blood Transfusion Committee has responded to say that they are working on the update and hope to get it approved at the Blood Transfusion Committee meeting in October 2023. 28/09/2023- Ownership of this policy sits with the Blood Transfusion Committee. The policy was given a formal extension by CWCDG until 10/08/2023, whilst a review was undertaken, however this timescale was overrun due to the need to prioritise the update of the more clinically urgent Major Haemorrhage Procedure. Chair of the Blood Transfusion Committee has provided assurance that the policy remains fit for purpose. The review and update are in progress and the intention is for the revised policy to be approved at the October meeting of the Blood Transfusion Committee. On track for revised date of October 2023. 26/10/2023- The latest review of this policy is still in progress, the task and finish group tookmplace prior to the BTC meeting on 26/10/2023 but with it being a 90 page document with several new national guidelines to reflect, the work is ongoing. It has been decided to take out the Emergency Blood Management Plan to form a separate document, for which we are awaiting an all Wales policy, which should minimise further delays. We had discussions around the irradiated products appendix and linking notifications to chemocare and are awaiting final arrangements around issue of andexanet alpha which is a new product. The current version is fit for purpose. Blood transfusion manager is leading on this review and will be progressing things over the next few weeks. The next meeting of the BTC has not been scheduled yet so we do not have a definite date for approval. 20/12/2023- Work on updating the Transfusion Policy is ongoing. A decision has been made regarding Andexanet Alfa therefore the Blood Transfusion Manager is liaising with pharmacy re the procedure for its prescription and issue. The Blood Transfusion Manager is not able to provide a date of publication at this stage. 27/02/2024- updated policy planned to be approved by the Blood Transfusion Committee in the meeting in March 2024.
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R6. Develop a database of patient information leaflets used within the consent process.	Convert the EIDO audit spreadsheet into a database.	Jun-23	~~Sep-23~~ ~~Dec-23~~ ~~Feb-24~~ N/K	External	15/06/2023- lead officer provided revised date of September 2023, as they hadn't anticpiated how long their phased return would be. 07/09/2023- at the next meeting of the MCA & Consent Group on the 25/09/23, the Head of Consent and Mental Capacity will be requesting an extension to December 2023, as they won't have time to complete this before the meeting. 28/09/2023- changed to 'external' rec. The MCA & Consent Group (25/09/23) was informed that WRP are currently working with EIDO to extend their patient information system into a central repository where each health board can store any locally produced patient information leaflets. Currently awaiting a response from WRP as to whether this negates the need for this recommendation. 20/12/2023- WRP have confirmed (03/10/23) that they are developing a new EIDO platform which will enable the health board to develop its own searchable database of local procedure specific consent leaflets. The health board will be required to advise WRP of local information leaflets used in the legal consent process that need to be uploaded so that this database can be developed. WRP hope that all Health Bodies in Wales will have migrated to the new platform by the end of February 2024.
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R7. Put a process in place to comply with the 'Criteria for use of Procedure Specific Patient Information Leaflets following publication of RMA2020-01 namely – Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk.	Write that required procedure and take to Mental Capacity and Consent Group for approval.	Oct-23	Mar-24	Red	07/09/23- At the next meeting of the MCA & Consent Group on the 25/09/23, the Head of Consent and Mental Capacity will be asking for an extension to December 2023, as the Group doesn't meet again until the December 2023, therefore approval will not be received by October 2023. 28/09/2023- The MCA & Consent Group (25/09/23) recommended the timescale is updated from October 2023 to March 2024 to take account of the required development time, and MCA & Consent Group and CWCDG approval timescales.

Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R8. Undertake a peer review of the organisation's consent process using the All Wales peer review tool. In addition to monitoring the organisation's consent process it will enable compliance with requirement No. 6 of WRP RMA2020-01 Consent to Treatment –monitoring compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of provision of procedure specific patient information leaflets.	Consult with the Deputy Medical Director regarding appropriate timing. Discuss process for audit with relevant clinical leads. Plan and schedule the audit.	Dec-23	Mar-24	Red	15/06/2023- lead officer confirmed December 2023 implementation date. Meeting held with Mark Henwood and Owain Ennis 15/06/23 to commence planning process. 07/09/2023- This is on track. Arrangements for this Welsh Risk Pool national peer review audit are well underway, with the plan to complete the data collection in September/October 2023, and report the findings to the MCA & Consent Group on 08/12/23. 28/09/2023- This action is on track. Arrangements for this Welsh Risk Pool National Peer Review Audit are well underway. A randomised sample has been generated for each specialty and issued to the clinical lead so the data collection can commence. However, as the data collection timescale set by WRP is until 31st December 2023, and the All Wales Consent to Treatment Group has reported that other health boards are finding clinical engagement in the audit challenging, the MCA & Consent Group (25/09/23) recommended the timescale is updated from December 2023 to March 2024 to allow for any delays in data collection due to clinical engagement issues, plus data analysis and production of the audit report.
Mar-23	2022/23	Welsh Risk Pool	A National Review of Consent to Examination & Treatment Standards in NHS Wales	Open	Reasonable	Director of Operations	Mental Health & Learning Disabilities	Head of Consent and Mental Capacity	Director of Operations	N/A	R9. Continue to monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets.	Hold discussions with Scheduled Care, Women and Children's Directorate and Radiology to ensure processes are in place to monitor and assess shortfalls in use, provision and documentation of patient information leaflets.	Dec-23	Mar-24	Red	15/06/2023- lead officer confirmed December 2023 implementation date. 07/09/2023-No progress made with this action as yet, but should be on track for December 2023. 28/09/2023- Should be on track for December 2023. The peer review audit (recommendation 8) will provide up to date data on use of patient information which will facilitate the monitoring and assessment of use of patient information leaflets. 20/12/2023-Email sent to the relevant service leads. The Head of Radiology has confirmed that a process is currently being put in place by their Lead Radiology Nurse who will set up a procedure, including audit, by which compliance can be checked. This issue has been added to their Governance meeting agenda as a standing item.Response awaited from Scheduled Care and Women and Children's Services. The peer review audit (recommendation 8) will provide up to date data on use of patient information which will facilitate the monitoring and assessment of use of patient information leaflets. Revised date of March 2024 provided.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Feb-20	2019/20	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	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22. 20/12/2022- A programme completion date will be developed as the above BJC work is progressed to encompass the work content and complexity of this Phase 2 project. Early indications are that due to the multiple Decant needs of Ward areas the programme may need to be extended as part of the due diligence work within the Business Case. As this becomes more developed, MWWFRS will be fully involved in these discussions so that appropriate changes can be made to the Phase 2 Enforcement dates. This matter has been discussed with MWWFRS who appreciate that a revision may be required to this programme should the nature of the works dictate that an extension to this timeline becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2025 date. 26/04/2023- the UHB has recently presented a reduced scope of works for Phase 2, which the MWWFRS are considering, with a decision likely to be received the second week of May 2023. Subject to this being approved, there will be a significant reduction in cost. 06/12/2023- Completion date moved to October 2025, MWWFRS informed 10/11/2023. MWWFRS to write to confirm their agreement.
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Jul-24	~~Jul-22~~ ~~Feb-23~~ ~~Nov-23~~ ~~Jan-24~~ Jul-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/08 to be completed by 31/07/2022 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. 20/12/2022- A revised completion date of November 2023 has now been accepted by the Project Management Team following all their due diligence checks. This programme update has been fully reported to the MWWFRS in a formal meeting held on 08/12/2022 and they fully accept the need for this adjustment. MWWFRS have noted that they will look to revisit the UHB prior to the currently set end date (February 2023), so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms they presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is November 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 31/08/2023- MWWFRS letter confirms extension to 31/01/2024. 06/12/2023- delays with contractor, to be discussed with MWWFRS. Timescale now possibly late 2024. 08/02/2024- Timescale being confirmed. 14/02/2024- extension letter received from MWWFRS confirming extension of KS/890/08 to 31 July 2024. Recommendation therefore turned back from red to amber.
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	Jun-25	~~Aug-24~~ Jun-25	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid-November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme, should the nature of the works dictate that an additional period of time becomes necessary. 20/12/2022- It is important to note that Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Regular discussions continue with MWWFRS, including a formal meeting held on 08/12/2022, who appreciate that a revision may be required to the FEN dates should the nature of the works dictate that an additional period of time becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2024. 26/04/2023- it is unlikely this works will be completed by August 2024 due to the scope reduction and complexity of the works. MWWFRS are fully briefed on the UHB position and will consider an official extension when the works programme is presented to them. The business case is currently being drafted. 06/12/2023- awaiting new agreed dates from MWWFRS. 14/02/2024- extension letter received from MWWFRS confirming extension of KS/890/09 to 30th June 2025.
Feb-22	2021/22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	Apr-24	External	11/11/2022-Progress to be requested in early 2023 to ensure this is on track. 27/04/2023- Senior Environmental Officer confirmed Waste Policy on track for update by October 2023. 12/10/2023- The UHB have been given a 6-month extension to update the Waste Policy as the HTM 07 01 is being updated in Wales and this is the key piece of guidance that informs the Waste Policy. Recommendation changed to 'external' whilst HTM 07 01 is being updated at an All Wales level.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivery plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.

Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/0010621 9	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivery plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/0010621 9	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. All remaining doors under future phasing Overarching delivey plan for the site is to March 2025.Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/0010621 9	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Overarching delivery plan for the site is to March 2025. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/0010621 9	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	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.	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. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/0010621 9	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/0010778 8	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	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. 05/12/2023- Update to MWWFRS on 10/11/2023 states timescale date to be agreed.

May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	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.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
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Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	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/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	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: - •~~T~~op of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R8. An assessment should be undertaken to ensure all Internal and external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Dec-25	Dec-25	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion December 2022. 10/01/2023- Head of Estates Risk & Compliance to check if this has been implemented. 13/01/2023- A scheme has been completed to address all vertical escape routes with new emergency lighting, all remaining areas of the block will be considered as part of the main firecode scheme as agreed with MWWFRS. Revised date of December 2025 provided to encompass all works at the BGH site. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to December 2025. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG. 06/12/2023-update to MWWFRS on 10/11/2023 states completion phase 1-2 combined February 2029. MWWFRS to write back shortly to confirm this date.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.

Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms this will be completed by November 2023.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
Jan-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 24 - Diabetes Research Clinic, West Wales General Hospital, Dolgwili, Carmarthen. SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Keep waste material in suitable containers before it is removed from the premises. If bins, particularly wheeled bins, are used outside, secure them in a compound to prevent them being moved to a position next to the building and set on fire. They should normally be a minimum of 6 metres away from any part of the premises.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	06/12/2023- on track.
Jan-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 24 - Diabetes Research Clinic, West Wales General Hospital, Dolgwili, Carmarthen. SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. Provide a staff/general fire routine notice stating in concise terms, the action to be taken upon discovering a fire or on hearing the fire alarm. A copy of the notice should be exhibited in the vicinity of each fire alarm actuation point.	Full action plan held by Estates.	Nov-24	Nov-24	Amber	06/12/2023- on track.
Jan-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 24 - Diabetes Research Clinic, West Wales General Hospital, Dolgwili, Carmarthen. SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement	Full action plan held by Estates.	Jan-24	~~Jan-24~~ Apr-24	Red	06/12/2023- on track. 08/02/2024: Revised date needed April 24 to agree with the Fire Brigade the exact scope.
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, (Elderly Services & Mynydd Mawr ward), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • Id 1164a & 1164b • Id 1170a & 1170b Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 1.4)	Full action plan held by Estates.	Sep-23	~~Mar-24~~ Jun-24	Red	20/10/2023- More work is needed to address defect. Doors are not repairable. Revised date March 2024. 05/12/2023-update to MWWFRS on 10/11/2023 states identified new doors needed to be changed with Fire Door scheme starting in January 2024. 14/02/2024 - Subject to funding being provided. 29/02/2024 - Date of completion revised to June 2024 due to delays with specific doors.
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 27, (Brynhaul Day Hospital & Bryngolau), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173908	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Mynydd Mawr. The opening in the ceiling located in • Switchgear Room should be in filled to achieve the same fire resistance as the rest of the floor/ceiling. The fire separation should conform to a relevant standard e.g. WHTM – 05-02 Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 1.6)	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS on 10/11/2023 confirms March 2024 deadline.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Surgical Day unit, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF. NE/BFS/00337255	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified: • Water Plant room. (Transportation Weep Hole pipes still in situ in floor). 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 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms March 2024 date and under warranty.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Surgical Day unit, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF. NE/BFS/00337255	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	06/07/2023- Service to check if this has been implemented. 05/12/2023- update to MWWFRS 10/11/2023 confirms March 2024 date and under warranty.

May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Surgical Day unit, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF. NE/BFS/00337255	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following 30-minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •~~D~~F55 Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms March 2024 date and under warranty.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Surgical Day unit, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF. NE/BFS/00337255	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. During the inspection the self-closing devices on the doors located at; •~~D~~F 06 •~~D~~F 01 •~~D~~F 15 •~~D~~F 22 Were found to be ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms March 2024 date and under warranty.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Templates 8 & 9,(Wards 3 & 4, Wards 6 & 5), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00141802	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •~~2~~160 •~~2~~176 •~~2~~170 The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.8)	Full action plan held by Estates.	Sep-23	~~Mar-24~~ Jun-24	Red	20/10/2023- More work is needed to address defect. A new door is required for item 2170, this will now be March 2024 as doors are not repairable. 05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024. 14/02/2024 - Subject to funding being provided. 29/02/2024 - 2160 and 2176 completed. 2170 to be completed 01/06/2024.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Templates 8 & 9,(Wards 3 & 4, Wards 6 & 5), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00141802	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •~~D~~35 Fire resisting doors need to be fitted with •~~A~~ self-closing device •~~I~~ntumescent strips and smoke seals. •~~T~~hree brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.5).	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Templates 8 & 9,(Wards 3 & 4, Wards 6 & 5), Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00141802	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •~~2~~241 Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.7)	Full action plan held by Estates.	Mar-24	Mar-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms identified new doors needed to be changed with Fire Door Scheme starting in January 2024.
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Confirmation of the fire resistance of panels within Fire Resisting doors should be provided. Any Panels within the door should provide a similar degree of fire resistance as the door. Fire resisting doors need to be fitted with •~~A~~ self-closing device •~~I~~ntumescent strips and smoke seals. •~~T~~hree brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Jan-24	~~Jan-24~~ May-24	Red	01/03/2024 - Revised date needed May 24 to agree with the Fire Brigade the exact scope.
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement.	Full action plan held by Estates.	Jan-24	~~Jan-24~~ Apr-24	Red	08/02/2024: Revised date needed April 24 to agree with the Fire Brigade the exact scope.

Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01	Full action plan held by Estates.	Apr-24	Apr-24	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Charging of battery devices must not be done within the means of escape, remove all charging items into a suitable room with a fire door. The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Apr-25	Apr-25	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - 50% completed. Operational demands in one or two wards have prevented relocation. Ward 4 future copier room enhanced fire stopping to be part of 2nd phase fire improvements. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The storage and use of electrical equipment/devices within the means of escape is not permitted, remove all electrical devices into a suitable room with a fire door. • Fridge (behind the nurse station WD1) • Photocopier. (next to the nurse station WD3 & 4) • Laptop charging units (noted mounted in various ward corridors / department corridors).The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Apr-25	Apr-25	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - Ward 1 fridge relocated. Ward 3 copier relocated, see above re ward 4 copier, laptop charger units 50 % completed. Operation demands have prevented relocation in some areas. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. During the inspection breaches in compartmentation were identified within the endoscopy storeroom which houses the photocopier and a large air conditioning unit. The breaches in compartmentation would not support the existing evacuation strategy.In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. Compliance with this or an equivalent standard will normally satisfy the requirement. I am happy for this to item to be address in the Phase 2 enforcement works Scheme.	Full action plan held by Estates.	Apr-25	Apr-25	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - This forms part of phase two fire improvement works. Schedule to be confirmed. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Provide an emergency lighting system (which is to be independent of all other systems), to illuminate • Block 4 LGF Kitchens On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority. This system is to be designed and installed in accordance BS5266-1:2016 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Feb-24	Oct-24	Red	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - Emergency lighting system to be installed during RAAC emergency work.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel.This was noted in rooms SF176 & SF166 but applies to any of this type of system fitted to a fire rated door within the means of escape where the room it is fitted to contains a fire risk.The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement	Full action plan held by Estates.	Feb-24	Apr-24	Red	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - Originally part of phase two fire improvement works, now scheduled to be completed as part of RAAC remediation.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. A fire door should be installed providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance in the following location: • Between the sluice room and electrical room within Ward 4 Fire resisting doors need to be fitted with • A self-closing device • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Apr-25	Apr-25	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 05/03/2024 - Head of Estates Risk & Compliance confirmed that this recommendation forms part of Phase 2 main FIRECODE work at WGH. 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. Reduce the risk within this area to as low as practicable by: Either reconfigure the area by moving the kitchen into the staff room or make up the corridor so it provides adequate fire resistance to allow the relevant person to effect a safe exit.	Full action plan held by Estates.	Apr-25	Apr-25	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track. 01/03/2024 - This forms part of phase two fire improvement works 08/03/2024 - Phase 2 to be completed by April 2025. Agreed with Fire Brigade (letter to follow).
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, (Out Patients, Cardio & Respiratory) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Switch rooms to be cleared of all storage and kept locked shut when not in use.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	04/12/2023- Update to MWWFRS on 10/11/2023 confirms December 2023 date.

Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, (Out Patients, Cardio & Respiratory) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The opening in the ceiling located in •Switchroom R10 •Darkroom R30 •Storeroom R98 •Staff Room R17 should be in filled to achieve the same fire resistance as the rest of the floor/ceiling. The fire separation should conform to a relevant standard e.g. WHTM – 05-02 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	04/12/2023- Update to MWWFRS on 10/11/2023 confirms March 2024 date.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, (Out Patients, Cardio & Respiratory) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	04/12/2023- Update to MWWFRS on 10/11/2023 confirms March 2024 date.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, (Out Patients, Cardio & Respiratory) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. If a door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	04/12/2023- Update to MWWFRS on 10/11/2023 confirms March 2024 date.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The opening in the wall in the following location: •From R45 into Service Duct should be in-filled with non-combustible materials, to provide 60 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Aug-24	Aug-24	Amber	03/01/2024- Head of Operations to check with Head of Estates Risk & Compliance if this recommendation has been completed. 08/01/2024- Head of Estates Risk & Compliance confirmed this has been agreed with MWWFRS this forms part of the main GGH fire Project. 08/02/2024- to be checked if this forms part of phase 1 or phase 2. 01/03/2024 - Head of Estates Risk & Compliance has advised that this recommendation forms part of Phase 2 to be completed August 2024 (letter awaited).
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The opening in the ceiling located in: •R12 •R13 •B48 should be in filled to achieve the same fire resistance as the rest of the ceiling. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Jun-24	Jun-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms June 2024 date.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, (X-Ray & External Plant Room) Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement	Full action plan held by Estates.	Jun-24	Jun-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms June 2024 date.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The storage and use of electrical equipment/devices within the means of escape is not permitted, remove all electrical devices into a suitable room with a fire door. •Fridge (Cadog Ward) The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	

Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •3037 •Store R30 Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. During the inspection the self-closing devices on the doors located at; •R08a •Stairwell (R40) to Corridor (R61) Were found to be missing/ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •3028 •To R55 The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R1. The UHB should ensure that all sites have appropriate surveys in accordance with the five-year recommended cycle. These surveys should be undertaken by individuals who are appropriately skilled to ensure that the estimated cost of remedial works is appropriate to inform the EFPMS.	Accepted – Noting financial pressures, the UHB will risk assess each site to evaluate survey requirements prior to approaching the market.	Apr-24	Apr-24	Amber	03/01/2024- Head of Property Performance confirmed this is on track. 07/03/2024- Head of Property Performance confirmed this action is on hold pending the outcome of the above NWSSP – SES exercise on the 6 facet survey approach including a view on how surveys will be funded, given current constraints on finances. Head of Property Performance concerned how this action will be addressed with continued pressures on finances. Awaiting response from Internal Audit.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R3. The Property Asset Strategy should be enhanced to include items such as performance measures, RAAC issues and to further align with the Welsh Health Building Note 00- 08 2018 (cross-referencing other key documents as required).	Accepted – Management will ensure a review and alignment of existing documents to Estatecode requirements.	Apr-24	Apr-24	Amber	03/01/2024- Head of Property Performance confirmed this is on track. 07/03/2024- Head of Property Performance requested clarity from Internal Audit on how this recommendation can be closed.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R5. A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity based on the current configuration of the estate - pre any redevelopment. Following this, a clear financial model for the revenue support needed in the estate should be developed.	Accepted - Management will undertake a review of its workforce based of the current estate configuration.	Jul-24	Jul-24	Amber	03/01/2024- on track.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Future estate workforce reviews will be aligned with the 'A Healthier Mid and West Wales Transforming our Hospitals Programme Business Case' or associated interim service plans,to ensure capability, capacity, and future requirements of the service are met.	Accepted - Management will look to review its workforce based on the future configuration of the estate.	Jul-24	Jul-24	Amber	03/01/2024- Report notes timescale as 'future assurance'. On track.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R7. The UHB should review the risk categorisation within the EFPMS and engage with NWSSP SES to ensure consistency in approach when applying risk categories to the estate backlog maintenance figures.	Accepted – The UHB will engage with NWSSP: SES to ensure consistency in approach and risk categorisation.	Mar-24	Mar-24	Amber	03/01/2024- Head of Property Performance confirmed this is on track. 07/03/2024- Head of Property Performance believes this recommendation closed as matter of Backlog and risk categorisation linked to EFPMS reporting raised with NWSSP SES and included as agenda item 4 as an NWSSP group. Awaiting response from Internal Audit.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Estates	Rob Elliott	Director of Operations	Medium	R2. The UHB should engage with NWSSP SES to ensure the programme of surveys were appropriately detailed, noting the need for a consistent All-Wales assessment of the estate.	Accepted – The UHB will engage with NWSSP: SES to ensure that the UHB are applying a consistent methodology	Jan-24	~~Jan-24~~ N/K	Red	Internal Audit to check if this recommendation can be closed. Regular engagement is taking place at an All Wales Group which is discussing the consistent methodology to be applied. 07/03/2024- minutes from the all-Wales Estate group meeting item 5 provided to Internal Audit to evidence this is raised and being progressed by NWSSP SES. Awaiting response from Internal Audit that this recommendation can be closed.
Nov-23	2023/24	Internal Audit	Estates Condition	Open	Limited	Estates	Strategic Development and Operational Planning	Rob Elliott	Director of Operations	High	R8. The Board will be provided with assurances on the effectiveness of the identified controls to reduce the principal risk associate with the "Insufficient investment in facilities/equipment/digital infrastructure".	Accepted - The BAF is actively monitored and will be reviewed to provide assurance that the controls (and proposed actions) identified in risk 1196 are effective or going to help reduce/mitigate the risk of not being able to provide safe, sustainable, accessible, and kind services. Following this a Board level discussion may be required on the appetite of risk around the estate and what it may be having to accept.	Dec-23	~~Dec-23~~ N/K	Red	06/12/2023-on track. Final report to be presented at ARAC December 2023 meeting. 20/12/2023- requested updated from Head of Capital Planning by 10/01/2024. 17/01/2024- emailed Internal Audit for clarification if this recommendation can be closed or any further information required.
Nov-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ashgrove Medical centre, Thomas Street, Llanelli. SA15 3JH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The opening in the ceiling located in: •Boiler room •Corridor adjacent to pharmacist office (above ceiling tile) should be in filled to achieve the same fire resistance as the rest of the ceiling. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Feb-24	~~Feb-24~~ Mar-24	Red	29/02/2024 - Order placed awaiting contractor date – completed by end of MARCH (confirmed)

Nov-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ashgrove Medical centre, Thomas Street, Llanelli. SA15 3JH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The openings around the door frame of the: •Expansion Space (1st Floor) should be in-filled with non-combustible materials, to provide 30 minutes standard of fire resistance. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Feb-24	~~Feb-24~~ Mar-24	Red	29/02/2024 - Order placed awaiting contractor date – completed by end of MARCH (confirmed)
Nov-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Ashgrove Medical centre, Thomas Street, Llanelli. SA15 3JH	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. Ceiling access hatches located should be able to achieve the same fire resistance as the rest of the ceiling. The hatches should also be locked shut. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Feb-24	~~Feb-24~~ Mar-24	Red	29/02/2024 - Order placed awaiting contractor date – completed by end of MARCH (confirmed)
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified: •Switch Room R 05(Ground floor) •Store Rooms R 29 & R 30 (Ground Floor) The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Wedges, hooks and any other devices in use at the present time throughout the block on all floors as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following Server cupboards to be cleared of all storage and kept locked shut when not in use. •R02	Full action plan held by Estates.	Mar-24	Mar-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Extend the existing fire detection and warning system by providing automatic smoke detectors in the following areas: •Storerooms R29 & R30. All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The following fire resisting door was found to be damaged. This door must be replaced. •B016B (GF) Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	May-24	May-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. An Assessment should be undertaken throughout the building to ensure: - All openings in the walls, floors, partitions, and ceilings throughout the premises that are provided for the passage of service piping, ducts, or cables, are to be sealed or bushed to at least 30-minute standard of fire resistance. (e.g., Dental storage – First Floor). All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard (e.g. Appendix A including table A/1, A/2 of Approved Document B volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Awaiting quotation from fire stopping contractor	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.

Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. A number of doors should be replaced with fire doors providing the relevant fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. (e.g., Laser correction room – Ground floor, Dental practice – rooms containing cylinders and storage rooms containing high levels of combustible materials). Fire resisting doors need to be fitted with: - • A self-closing device. • Intumescent strips and smoke seals. • Three Brass/steel hinges. Fire doors should confirm to a relevant standard e.g. Appendix B (including appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214 timber-based fire door assemblies code of practise.	Adjust self-closing devices and fit smoke seals. Hazard rooms to be reviewed by MG	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. An assessment is required to be undertaken to ensure that both internal andexternal routes are illuminated by emergency lighting that will operate if the local lighting circuit fails.	New smart emergency lighting system to be installed.	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R13. • A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure that they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm. • Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so that the doors close completely into their rebates. • All self-closing devices are to be regularly inspected and maintained and records kept. • Wedges are not to be used to keep fire doors open.	Review current fire doors and repair as necessary. Review current hazard rooms	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Door from R07 to corridor (1st Floor) •Door 3003 Radio Studio (3rd Floor) Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement	Engaging with contractor for a quote to replace	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The following doors should be reinstated with a fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Room 04 Printer room (1st floor) Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement	Engaging with contractor for a quote to replace	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. 'Fire Door - Keep Shut' signs should be provided on the outside face of each fire door located: •Common room (3rd floor).	FSA to address.	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. All drapes and curtains withing the Radio Studio should be of inherently flame-retardant material or be treated in accordance with a relevant standard. E.g.BS 5867-1:2004 Textiles and textile products – curtains and drapes general requirements and BS 5867-2:2008 Specification for fabrics for curtains or drapes flammability requirements. Compliance with this or an equivalent standard will normally satisfy the requirement.	To be addressed by Hotel Services.	Apr-24	Apr-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The routes to emergency exits from premises must be kept clear and free of obstruction at all times to allow persons to evacuate the premises as quickly and safely as possible.The following items must be removed from the corridors •Ironing boards and irons (2nd & 3rd Floors) •Large linen trolleys (2nd & 3rd Floors) •Recycling bags of Waste paper in stairwell (1st Floor)	To be addressed by Hotel Services.	Apr-24	Apr-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024.

Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The inner room situation located •Room 15 (GF) is unacceptable, one of the following must be provided: •Provide a smoke detector in the outer room, capable of initiating a warning of fire to the occupants of the inner room. The detector should be linked into the existing fire alarm system; or •Clear glazed vision panels should be provided so that the people occupying the inner rooms can see into the outer rooms from their normal working position. •The enclosures (walls or partitions) of the inner room should be stopped at least 500mm below the ceiling; This work should be done to conform to a relevant standard e.g. Approved Document B Volume 2 Buildings other than dwelling houses. All work involving the fire alarm should be carried out in accordance with BS5839-1:2017 Compliance with this or an equivalent standard will normally satisfy the requirement.	Merlin fire Improvement works identified	Aug-24	Aug-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of August 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided; •In Stairwells Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.	FSA to address.	Mar-24	Mar-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of March 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •Door 1013 A / B The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Carry out improvement works.	Apr-24	Apr-24	Amber	07/02/2024- Head of Estates Risk & Compliance provided timescale of April 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The existing windows located in (Dental corridor – first floor) should be re-glazed with the appropriate fire resisting glazing to a minimum period of fire resistance in accordance with the manufacturer's instructions. The glazing should conform to a relevant standard. Table A4 Approved Document B Volume 2 Buildings other than dwelling houses.	Not a Fire boundary. This was an old compartment line	Mar-24	Mar-24	Amber	07/02/2024- being clarified with MWWFRS if this needs to be actioned. 26/02/2024 - To be completed by 31/03/2024
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. A fire warning system must be provided. The scope and extent of the fire alarm system should be informed by the significant findings of your fire risk assessment. All work involving the fire alarm system should be carried out in accordance with BS5839. All changes should be carried out and commissioned by a competent person.		Jun-24	Jun-24	Amber	07/02/2024- Head of Estates Risk & Compliance confirmed this is being queried with MWWFRS as UHB believe the system is adequate. 26/02/2024 - Director of Estates, Facilities & Capital Management advised that order has been placed and contractor appointed - Completion June 2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.		Apr-24	Apr-24	Amber	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms April 2024 deadline against this recommendation, therefore turned back from red to amber.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. Establish procedures to be followed in case of fire and nominate people to put those procedures into effect.		Apr-24	Apr-24	Amber	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms Training scheduled 12/04/2024.
Jan-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. Ensure that sufficient numbers of employees are provided with adequate training to enable them to understand and interpret the fire alarm panel.		Apr-24	Apr-24	Amber	08/02/2024- action plan being finalised by Estates team and will be shared with Assurance & Risk team shortly. 14/02/2024- action plan from Estates confirms Training scheduled 12/04/2024.

Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 14, (Pathology, Mortuary), Prince Phillip Hospital, Dafen, Llanelli, SA15 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified: •Switchgear Room R19 •Switchgear Room R24 The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.		Mar-24	Mar-24	Amber	29/02/2024 - Order placed with contractor works done by end of MARCH
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 14, (Pathology, Mortuary), Prince Phillip Hospital, Dafen, Llanelli, SA15 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The intumescent strips and cold smoke seals on a number of sampled doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		N/K	N/K	Red	29/02/2024 - The Estates & Facilities department have asked the fire brigade to confirm what door this relates to, as R8 not included in our system – date TBA. (June 24?)
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Where a fire door is required to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel. The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with these standards will normally satisfy the requirement		Aug-24	Aug-24	Amber	01/03/2024 - Need to agree GGH phase that this is under - June 24 08/03/2024 - Head of Estates Risk & Compliance has advised that recommendation is due for completion August 2024 (Phase 2).
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following stairwells are to be cleared of all storage and combustibles: •R 16 & R 44: GF Teifi ward		Apr-24	Apr-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete April 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The following doors should be replaced with fire doors providing 30 minutes fire resistance. Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. •Day Room R08 (Teifi) •Office R36 (Picton) •Bathroom R21 (Picton) •Clinical Room R06 (Picton) Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following Fire doors fitted with automatic hold open devices do not close satisfactory upon actuation of the fire alarm. •Dayroom R09 (Derwen) Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors Fire doors should conform to a relevant standard e.g., Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01		Jun-24	Jun-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete June 2024.

Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. Extend the existing fire detection and warning system by providing automatic smoke detection in the following areas: •R21 (Preseli) •R18 (Derwen) All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017.		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided; •Indicating exit stairs in Corridor R45 (Derwen) •In both stairwells at eye level. Signs should be designed and installed in accordance BS 5499-4:20 Compliance with this or an equivalent standard will normally satisfy the requirement.		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •D006 A/B Stem corridor GF. •Store Room R34 Stem corridor GF Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R11. During the inspection the self-closing devices on the doors located at; •6 x Doors leading on to stairwells from GF, FF & SF. Were found to be missing and should therefore be installed and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.
Feb-24	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R12. Ceiling tiles in the following areas were found to be damaged, they should be repaired or replaced to provide or reinstated a 30/60 minutes standard of fire resistance. •Store/server room R44 (Picton) The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.		Aug-24	Aug-24	Amber	01/03/2024 - Head of Estates Risk & Compliance advised that recommendation is due to complete August 2024.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Apr-23	2022/23	Internal Audit	Regional Integration Fund	Open	Reasonable	Finance	Finance	Director of Finance	Director of Finance	High	R1. The UHB as "Host" for the RIF Finances, work with the Regional Partnership Board to ensure an agreed Memorandum of Understanding is in place explicitly setting out the Health Board and other key partners roles and responsibilities for the governance and accountability arrangements of RIF for the next financial year.	We will ensure that we work with the RPB to finalise the MoU which clearly sets out the key roles and responsibilities for the governance and accountability arrangements for RIF for the next financial year.	Jun-23	~~Jul-23~~ ~~Sep-23~~ N/K	External	11/05/2023 - Originally intended to be completed by 30/06/2023, but with it will need to be approved by the Board before it can be signed off (meeting scheduled for July 2023). 12/09/2023 - Linda Jones, who has been successful into the RPB Lead role, confirmed the remaining queries were being worked through with Ceredigion, who should look to provide their final views in late September 2023. 25/10/2023 - Action residing with RPB Lead, and response has been further requested for finalising and signing a MoU 20/12/2023 - IA to check if this recommendation has now been implemented. 21/12/2023 - The Memorandum of Understanding has been discussed at Decemeber IEG and reported to each Board meeting due to the delays. This recommendation is now awaiting for progress to take place with the Local Authority. Recommendation changed from 'Red' to 'External'.
Jun-23	2022/23	Internal Audit	Financial Management	Open	Reasonable	Finance	Finance	Senior Business Finance Manager (Corporate)	Director of Finance	Medium	R2. Management to review the current arrangement to ensure consistency in approach and level of documented actions.	Agree, document, and gain operational engagement and signoff for a framework that articulates a consistent agenda, frequency and action point outputs expected from all routine financial performance meetings. Ensure this approach is embedded within the Operational Delivery Framework - a Master Theme deliverable as part of Targeted Intervention led by the Executive Director of Operations.	Aug-23	~~Aug-23~~ ~~Oct-23~~ Mar-24	Red	25/09/2023 - Revised timeline committed to delivering all framework elements with the exception of full alignment to the Operational Delivery Framework which is pending completion. This will then be updated on a continuous basis as and when required. 25/10/2023 - Reviewed within Finance during September, with Finance Director review on 30th October. Operational Delivery Framework engagement will be sought once structural changes communicated. 12/12/2023 - Framework has now been completed, work will be refreshed once the Operational Structure changes are announced. 04/01/2024 - IA Update - Operational Delivery Framework has been drafted, but has yet to be implemented due to departmental restructure and work pressures.
Jul-23	2022/23	Audit Wales	Audit Wales ISA 260 and Letter of Representation 2022/23	Open	N/A	Finance	Finance	TBC	Director of Finance	High	R1. The Health Board should review the CHC closedown process to ensure that year-end liabilities are accurately classified and complete.	A revised process will be developed.	Mar-24	Mar-24	Amber	23/08/2023 - Option for alternative process agreed with Director of Finance and will be implemented for the 2023/24 year end process.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R1b: A formal process to convert opportunities into savings plans whereby identified opportunities are considered, agreed with Executive and operational leads before any savings targets are shared with the Board needs to be developed. Sufficient time needs be built in to undertake this process which needs to be agreed by the Board. This needs to be undertaken much earlier to allow time for realistic savings plans to be considered by Board as part of the Annual Plan.	An exercise to refresh the medium term financial outlook is underway and is reporting into Executive structure at regular points. This will include options for the Board on future trajectories, including financial breakeven. Having selected a trajectory an underlying annual and cumulative savings requirements, before further cost pressures, will be clearly spelt out.	Mar-24	Mar-24	Amber	31/07/2023 - In year the minimum savings requirement is £19.5m, as agreed via annual plan. Whilst progress made operational plans incomplete at this point and routinely communicated and escalated via Executive Team. Process outline shared with and approved by Executive Team June 2023. An update on progress against the recommendations will be presented to ARAC on 17 October 2023 25/10/2023 - In-progress still, and linked to the outstanding Finance Function action as part of Targeted Intervention. December closure date was proposed in the last quarterly TI meeting.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Strategic Development and Operational Planning	Executive Director of Finance	Director of Finance	N/A	R4b: Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 2. Support Structure Development (September - October 2023) Action - Develop a robust support structure that provides scheme leads with access to expertise in operational planning, finance, governance, and project management. This includes establishing clear communication lines and creating a comprehensive repository of resources and guidance.	Oct-23	~~Oct-23~~ N/K	Red	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1. Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2. The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Strategic Development and Operational Planning	Executive Director of Finance	Director of Finance	N/A	R4c: Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 3. Support Implementation (November 2023 - March 2024) Action - Implement the support structure and monitor its effectiveness throughout the planning and execution phases of the savings scheme, ensuring triangulation and assumptions are stress tested. This will involve regular check-ins with scheme leads and adjustments to the support provided as necessary.	Mar-24	Mar-24	Amber	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1. Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2. The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Strategic Development and Operational Planning	Executive Director of Finance	Director of Finance	N/A	R4d: Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 4. Continuous Review and Improvement (After March 2024 and ongoing) Action - Review the support provided regularly to ensure it continues to meet the needs of scheme leads and contributes effectively to the success of the savings scheme. This will involve gathering feedback from scheme leads and using this to inform improvements to the support structure. We are committed to ensuring our scheme leads have the resources and support they need to be successful, and we believe these actions will help us achieve that goal.	Mar-24	Mar-24	Amber	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1. Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2. The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Finance	High	R1. Develop a formal framework for the identification, scrutiny and approval of opportunities for strategic/transformation change and ensure sufficient evidence is maintained to demonstrate the journey from potential opportunity through to recognition as a formal programme.	A formal framework will be finalised to ensure that there is a clear trail from opportunity to acceptance as a formal programme.	Jul-23	~~Jul-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 Current Findings- An Opportunities Framework has been developed to formally guide the review of ideas and opportunities for savings and onward progression into formal savings plans. The process, requirements and governance arrangements are set out within a 'Principles and Process' document for each of the four stages of the framework (Enquire, Discover, Design, Deliver). Schemes will be recorded and recognised as follows: The processes have been worked through with the Finance Delivery Unit as part of the Targeted Intervention engagement. We were advised that to date, no additional strategic change programmes have been identified following the full audit undertaken in spring 2023. It has therefore not been possible to assess the application and effectiveness of the new framework and supporting principles and processes. Internal Audit Conclusion: Action Taken – further review required to assess compliance and effectiveness

Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Strategic Development and Operational Planning	High	R2. Strategic programmes should be managed as such from the outset, with appropriate programme management resource and a formal programme plan demonstrating alignment with the organisations objectives and setting out the aims, milestones and anticipated outcomes.	The strategic programmes of change within the Health Board are described by the Planning Objectives agreed annually by the Board. The Executive team will establish a formal process to assess the resource requirements for each and align corporate resources accordingly.	Jul-23	~~Jul-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 The Core Delivery Group was established in August 2023 as a sub-group of the Executive Team. As per the Terms of Reference, responsibilities include overseeing delivery of the Health Board's savings plan, including ensuring that clear processes are in place for capturing project plans consistently and ensuring that support is provided for each scheme from corporate functions as necessary. The savings process document provides guidance on the approach that should be followed within each stage of the framework, including a resource allocation review in the Discover phase to identify resources required to bring an idea into fruition, and a detailed project plan as part of the Design stage outlining clear milestones, deliverables and performance indicators. The Project Initiation Document template has been developed to ensure this detail is determined and captured as part of the planning process, including: • Project scope and drivers • Project team • Anticipated benefits and risks • Key milestones and tasks • Monitoring arrangements We were advised that to date, no additional strategic change programmes have been identified following the full audit undertaken in spring 2023. Internal Aduit Conclusion: Action Taken – further review required to assess compliance and effectiveness
Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Strategic Development and Operational Planning	High	R3. The programme plan should form the basis of monitoring programme delivery against milestones and achievement of identified aims and outcomes. This would encourage transparency, consistency and completeness in assurance reporting to the Board.	Linked to the ongoing Targeted Intervention work the Health Board will review its processes and documentation for managing programmes	Aug-23	~~Aug-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 As noted above, scheme delivery will be monitored through the Core Delivery Group. Arrangements for reporting delivery of anticipated savings are clear – via the savings tracker template with a Power BI dashboard to facilitate monitoring and reporting both within the organisation and externally (e.g. to Welsh Government). Arrangements for monitoring and reporting achievement of non-financial benefits (for example quality, safety and experience improvements) are more ambiguous at this stage – the PID template should facilitate this if completed and used as intended, although as no additional strategic change programmes have been identified following the full audit undertaken in spring 2023 we have been unable to assess this. Internal Audit Conclusion: Action Taken – further review required to assess compliance and effectiveness
Dec-23	2023/24	Internal Audit	Follow-up: Strategic Programme Governance	Open	Reasonable	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Finance	High	R4. Implement the recommendations arising from the Director of Corporate Governance/Board Secretary's review of the governance arrangements in place for Health Board savings schemes.	The recommendations of the review will be implemented in full.	Jul-23	~~Jul-23~~ N/K	Red	This follow up report Superseeds the previous report - Strategic Change Programme Governance - HDUHB-2223-37 The issues identified in the Savings Schemes Governance review were consistent with the findings of our original Strategic Programme Governance review and are therefore similarly addressed by the Opportunities Framework and savings process outlined above (although we have not sought to confirm implementation of the individual recommendations). Fundamentally: • a formal process to convert opportunities into savings plans whereby identified opportunities are considers, agreed with Executive and operational leads before any savings targets are shared with the Board (rec 1) • an agreed process for developing and agreeing savings plans/target (rec 3) • ensuring access to support for scheme leads including operational planning, finance, governance and project management (rec 4) • documented programme documentation setting out responsibilities, scope, milestones/trajectories, actions, risks and agreed savings targets (rec 5) • clear and consistent reporting into Executive Team (rec 6) The following recommendations will also be implemented as part of the 2024-25 savings cycle: • the process for identification of savings needs to commence earlier in the financial year (rec 2) • develop a positive culture in respect of accountability, ownership and delivery of saving schemes where lessons are learnt together to improve the Health Board's ability to deliver planned savings (rec 7 – due March 2024) • the Board should have clear and detailed saving plans presented within the annual plan which can be monitored throughout the financial year and reported to SRC and Board (rec 8) Progress is monitored via the recommendation tracker with updates to ARAC in August and October 2023. Internal Audit Conclusion: Action Ongoing

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Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Director of Operations	TBC	TBC	High	R2. While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgenc	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Dec-23	~~Dec-23~~ Sep-24	Red	06/06/2023 - Update to ARAC- A proposed revision to the operational governance structure has been developed which needs further sign off from a Governance and Executive Team perspective. The work on operational structure continues in line with the outlined timeframe. 28/12/2023 - an OCP has been issued to operational teams in December 2023, with a consultation period extending in to 2024 following which further engagement may be required. A phased approach is being applied and that a new structure will be ready for implementation by 1st April 2024. (Revised completion date of September 24 noted to reflect the period to embed the new structure) 09/02/2024: Audit Wales Structured Assessment Report 2023 has advised that this recommendation will be followed up through their review of operational governance.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	High	R3. While performance arrangements exist at an operational level, there is scope to bring these together into a holistic review of performance. Alongside the rollout of its Improving Together Framework, the Health Board should revisit its performance management arrangements to ensure that there is a joined‐up approach at an operational level.	Our Improving Together framework has been developed over the last 18 months and deployed within a number of pilot areas. Following this progress, the approach was agreed with the Executive Team in December 2022 for it be used for Directorate level performance management arrangements. The Framework aligns teams to our strategic objectives and what matters to us as a health board. It focusses on key improvement measures identified by the directorate and team and regular coaching style discussions around how we are performing and whether additional improvements need to be made. These discussions are supported by "Our Performance" and "Our Safety" dashboards which provide triangulated data sets from across quality and safety, performance, risk and finance. The Directorate level sessions are holistic, covering performance, safety, quality workforce, finance and planning. The Director of Operations will chair these sessions monthly and will be supported by the Executive Directors of Finance (with executive responsibility for Performance), Director of Strategic Development and Operational Planning, Director of Workforce and OD and Director of Nursing. Additional executive colleagues will be invited to attend if required. The sessions will focus on any concerns that teams wish to escalate, which may originate from the data in the dashboard and progress around KPIs for each team. These sessions have been scheduled to commence on the 30th and 31st January 2023.	TBC	TBC	Red	09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation will be followed up through their review of operational governance. Recommendation turned back from green to red and a revised completion to be requested from the Director Finance.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	High	R4. 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. A new Plan on a Page (POAP) template has been developed which included outcomes and trajectories. The completed POAPs will be reported to the Board Committees in June 2023. This is fundamental to Master Action C and will form part of the revised planning process going forward. 09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation is not complete. Recommendation turned back from green to red and a revised completion to be requested from the Director of Strategic Development and Operational Planning.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	High	R5. 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 - Update to ARAC confirms the recommendation is completed. 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. 09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation is in progress. Recommendation turned back from green to red and a revised completion to be requested from the Director of Strategic Development and Operational Planning.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Finance	TBC	TBC	High	R6. The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	The 2023/24 planning cycle is underway which will, with Board approval, reflect the challenges that have been experienced during 2022/23. Opportunities have been clearly articulated, and the planning cycle will be the vehicle for teams across the Health Board to deliver sustainable plans in the areas highlighted as opportunities, as well as undertaking their delegated financial responsibilities to review and deliver all efficiency and benchmarking opportunities. With the unprecedented demand challenges that have been experienced, the financial overspends have resulted in a significant deterioration to our deficit. The recovery plan will need to be cognisant of the impact which these demand challenges are having across our system.	Mar-24	Mar-24	Amber	01/06/2023 - There is a Planning Objective to deliver a plan in the year, which will be taken to Board in September 2023 and form the basis of the development of the IMTP for March 2024. 09/02/2024: Audit Wales Report of November 2023 has advised that this recommendation is in progress.
Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Nursing	Director of Corporate Governance	Director of Corporate Governance	N/A	R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes, with a clear process to provide feedback to visited services and monitor actions points However, those we interviewed were unclear about what happened after the visit. The Health Board should clarify the Patient Safety Walkabout process with new Independent Members.	A refreshed briefing on the role and content of the Patient Safety Walk Rounds will be drafted for use within induction for all new Independent Members and Executive Directors. Reporting and monitoring arrangements following Patient Safety Walk Rounds will be refreshed and reconfirmed for all participants. Reports are action oriented and prepared by the Quality Assurance Team. All actions are logged on the AMAT system and monitored via the Quality Assurance Team. The refreshed Patient Safety Walk Round handbook will be reviewed and recirculated to all Board members by the Head of Quality Assurance.	Mar-24	Mar-24	Amber	08/02/23: Audit Wales November 2023 report confirms this recommendation will be implemented by March 2024.
Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Nursing	Director of Corporate Governance	Director of Corporate Governance	N/A	R2. Board member patient safety walkabout Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes. However, those we interviewed were unclear what happens to the notes afterwards. The Health Board should: b) report back on walkabout themes, twice a year, for example, through the Quality Assurance Report received by the Quality, Safety and Experience Committee (Medium Priority).	Consideration will be given to providing a Patient Safety Walk Round update to Board members at a future Board Seminar. To be forward work planned through the Director of Corporate Governance/Board Secretary.	Jul-24	Jul-24	Amber	
Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Finance	Director of Corporate Governance	Director of Corporate Governance	N/A	R3. Performance Management Arrangement Assurance Given the Health Board is under Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended.	We will commission an annual review of the effectiveness of the Improving Together Framework from Internal Audit. We will ask for the first review to be undertaken during Q1 2024/25.	Jun-24	Jun-24	Amber	

Nov-23	2023/24	Audit Wales	Structured Assessment 2023- Hywel Dda University Health Board	Open	N/A	Governance	Strategic Development and Operational Planning	Director of Corporate Governance	Director of Corporate Governance	N/A	R4. Aligning planning and strategic objectives The Health Board has taken steps to better articulate its planning objectives in its 2023-24 Annual Plan, by streamlining the planning objectives and setting them against eight strategic planning goals and four domains. However, the domains and strategic planning goals do not explicitly align to the Health Board's six overarching strategic objectives, as detailed in its Board Assurance Framework (BAF) and Integrated Performance Assurance Report (IPAR) dashboards. As part of the next planning cycle, the Health Board should more explicitly set out how each of its planning objectives link to its strategic objectives.	A process and action plan has been detailed as part of the Planning Cycle for the development of the 2024/25 Plan. This process and action plan (as detailed in the annex), sets out the process for reviewing the Strategic Objectives, the Planning Objectives and the removal of the four planning domains to simplify the process. Steps are also included to ensure the appropriate alignment of Planning Objectives to the appropriate Committees of the Board for assurance purposes, and the revision of the BAF.	Mar-24	Mar-24	Amber	

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Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/7/2023- USC lead has spoken to the WG Lead who confirmed that the Discharge requirements is still under review and would be published shortly. Work is ongoing locally to review the discharge policy in readiness. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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~~ N/K	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. 10/07/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 07/07/2023 - The three West Wales local authorities and the Hywel Dda University Health Board have agreed to work together to produce a Quality Assurance Framework, initially for care homes, with the intention of broadening the scope to other areas of service. The Institute of Public Care (IPC) from Oxford Brookes University has been commissioned to work with us on this project. A workshop was arranged where all parties met and put forward suggestions. We are now waiting for the collated response back from IPC. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/7/2023- USC lead confirmed training modules have been developed by the national 6 goals programme and were released in July 2023. This will from part of the mandatory training on ESR and will be rolled out on a phased approach across the HB. The optimal Flow Framework delivery group is meeting on a weekly basis to accelerate the delivery and has representation from all the acute sites. Working with communication colleagues to develop an internal intranet site where all the resources, local learning , FAQs etc can be housed for ease of access. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.

Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/07/2023- USC lead confirmed training modules have been developed by the national 6 goals programme and were released in July 2023. This will from part of the mandatory training on ESR and will be rolled out on a phased approach across the HB. The optimal Flow Framework delivery group is meeting on a weekly basis to accelerate the delivery and has representation from all the acute sites. Working with communication colleagues to develop an internal intranet site where all the resources, local learning , FAQs etc can be housed for ease of access. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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-22~~ ~~Aug-23~~ N/K	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. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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~~ N/K	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. 07/07/2023 - LTC are now involved in the discharge planning/coordination task and finish group which is Health Board wide. 10/07/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	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. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach. 20/12/2023 - The IA Discharge Management follow up report is due to be presented at the February ARAC, which will incorporate the recommendations raised in the report. 16/02/2024 - A full report incorporating all recommendations received in this report will be presented at the April 2024 ARAC.

Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Long Term Care	Mental Health & Learning Disabilities	Jill Paterson	Director of Primary Care, Community and Long Term Care	Low	R1. Progress updates on the development of the referral spreadsheet and web-based referral form should be provided regularly to management.	The Digital Project Support request submitted to the IT team was agreed in October 2023. The implementation of this project will commence once resources have been confirmed and allocated.	Mar-24	Mar-24	Amber	30/11/2023 - Project has now been accepted and work commenced. Digital services have given an interim date of March 2024 to begin training and rollout of the new processes.
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Long Term Care	Mental Health & Learning Disabilities	Jill Paterson	Director of Primary Care, Community and Long Term Care	Medium	R2. An action plan setting out the projected impact of additional resource and training programmes should be developed, including milestones and deadline for delivery. Regular progress updates should be provided to an appropriate group or committee.	Initially measurement of the impact of the additional resources and training programmes will focus on two key measurements: 1. The number of potentially inappropriate DoLS referrals received by theteam, expressed as a percentage of all new referrals received. 2. The total number of DoLS assessments completed by the team. Success would be shown by a decrease in inappropriate referrals and an increase in assessments completed. We will set a 6 month target to reduce inappropriate referrals by 30% and to increase completed DoLS assessments by 10%. Data for both measurements will be collected and reported monthly to the LTCT and quarterly to the Consent and Mental Capacity Group.	Mar-24	Mar-24	Amber	
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Long Term Care	Mental Health & Learning Disabilities	Jill Paterson	Director of Primary Care, Community and Long Term Care	Medium	R3. The DoLS backlog record listed on the risk register should be reviewed and updated to reflect the steps and actions that are being undertaken mitigate the identified risk.	Actions have been added to the risk register with new review dates set.	Jan-24	~~Jan-24~~ N/K	Red	30/11/2023 - All current steps and actions are listed on the risk register and will be updated as and when they change. 23/02/2024 - Risk reviewed, awaiting confirmation from IA to close the recommendation.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	N/A	1.2 Improve networking and collaboration with other sites and health boards	Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid.	Mar-21	~~Mar-21~~ ~~Mar-23~~ N/K	Red	23/03/2022- Covid has been problematic in progressing this recommendation however there are Immensely improved relationships between BGH and scheduled care. Working with team to deliver elective care and repatriate back where appropriate. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - BGH have a large capacity to deliver int erms of Theatre space, with greater engagement received from Powys' Consultant Surgeon for Scheduled Care. Plans for the new hospital will require for this continued engagement to be in place. Request to be made to Lead Execuitve to close this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023.
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties. The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	Mar-24	Red	23/03/2022- GM to liaise with officer on digital strategy of the UHB for current progress on virtual systems. A lot of changes still taking place and Covid still presents challenges for this. Revised date of March 2024 provided 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Attend Anywhere system in use, and BGH are also taking part in the Telemed roll-out. Assurance and Risk team to enquire if BGH's participation is reported anywhere to support closing this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023.
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Medical Director	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility.	Dec-20	~~Dec-20~~ ~~Dec-23~~ Dec-24	Red	23/03/2022- GM will pick up with recommendation owner for current position of this recommendation. 05/05/2022- Requested revised timescale from GM, no response received as of 18/05/2022. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 10/03/2023 - BGH are not able to do the core training for trainees in the current set up. BGH are accredited but cannot recruit. The new SAS contract came into force last year (2022) for specialist grade, which provides mid-grade specialist with acknowledgement of their skills. There is a SAS tutor in place (from Surgery) for support. Leadership and management training is offered to clinical fellows and SAS doctors. All trainees are provided with self-directed learning and teaching time (quality improvement) with a few doctors following into the teaching path now. There is a monthly middle grade meeting where the doctors can discuss training, issues, and areas for improvement. There is also a regular meeting for junior doctors with consultants in attendance where training for juniors is part of the agenda. Due to the improvements made the GM is requesting this recommendation be closed. 20/04/2023 - BGH have developed everything within their gift. BGH are unable to develop anything further from the site. The qualification would need to be formally recognised to encourage core trainees to not leave BGH and go into formal training.. A Medical Education strategy would assist in establishing if this is a priority. Recommendations to be presented to the Director of Operations for approval to close. 07/07/2023 - Solution for PGEC development was proposed, but requires c£3.5m investment. Mandate required from Executive for group to recommence work supported by dedicated PM and Estates input to ensure capacity to deliver. Please note that responsibility for PGEC sits with Medical Director. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023. 16/10/2023 - Discussions are ongoing regarding the introduction of core medical trainees to BGH. Risks associated with training within the medical specialty at BGH have led to targeted visits from HEIW and so we are in the process of trying to improve the experiences currently offered with the aim of reducing the current risks before introducing additional trainees to this specialty and site. We are confident that this will occur and that we can revisit these discussions over coming months. Revised completion date 31st Dec 2023. 22/12/2023 - Discussions have started in terms of looking for opportunities to introduce IMTs/CTs. Site team needs to ensure that there are sufficient opportunities for trainees to meet learning outcomes and put a plan together which takes into consideration the following :- -We need to build on the excellent HEIW visit and 100% unanimous recommendation for education at BGH -Supervision of the trainees – who will fulfil this role, it's different to FP supervision -What clinics are there that the trainee will be able to have access to? -There will need to be a geriatric component in Year 1 – how will this be delivered? -There will need to be an ITU component (usually) in Year 2 as a 3 month block – how will this be delivered? Can it be delivered on site or will we need to look at one of the other hospitals to support? 01/03/2024 - Discussions are ongoing. Royal College Tutor needs to be identified to cover WGH and BGH. The role has been advertised a number of times with no interest and so we will need to undertake further work to attract a suitable candidate and support the introduction of these core trainees.
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R1. The outbreak has not yet concluded and the high level of latent TB infection in the population implies further risk. This risk is heightened because the active disease in this population is predominantly pulmonary and therefore more infectious. Although the level of active TB infection is low in West Wales, delayed presentation in unrecognised cases may lead to further outbreaks and deaths. The level of awareness amongst the public and their health care professionals must be therefore increased and maintained. This also applies to trainee health professionals.	To manage the risk of the outbreak and raise awareness amongst the public and Healthcare Professionals, to reduce the risks of any future outbreaks.	Jun-23	~~Jun-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response recieved from PHW as follows: PHW - The TB elimination strategic action plan has been developed with input from TB clinicians, behavioural science experts and inclusion health teams. In relation to raising awareness of TB it includes the following recommendations: All HBs to ensure that clinical staff have completed the Wales Institute of Clinical Science and technology (ICST) TB training. A multiagency partnership will work with local authorities, communities and third sector organisations to raise awareness and improve health education regarding screening for latent TB infection. HBs in collaboration with PHW will also work to raise awareness and tackle stigma among populations at high risk of TB and who could self-present to health services. As part of monitoring towards TB elimination HBs will be asked to provide an annual update on completion of TB training and collaborative activities undertaken to raise awareness. The All-Wales TB Group (AWTBG) will work with PHW Comms to promote the launch of the TB elimination action plan. It is proposed that this is launched to coincide with World TB Day in March 2024.
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R2. Any future outbreaks should be overseen by PHW from the outset with a TB -specific standard operating procedure for the conduct and recording of outbreak management. The current SOP and OCT policy needs to be updated in this respect. The latter needs to be developed alongside modern data analysis and WGS typing so that outbreaks are identified and contained. Comprehensive contact networks of all cases should be recorded electronically and plotted with social network analyses undertaken to ensure links between cases are uncovered quickly and easily.	To work with PHW to create a Standard Operating Procedure and updated OCT policy. Development of a revised methodology for managing contact networks and analyses to ensure links between cases are uncovered quickly and easily.	Jul-23	~~Jul-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - A specific TB OCT policy is not in place for PHW. However, part of this work falls under the review of the Outbreak Control Plan for Wales. The outbreak control plan for Wales is being revised and the learnings from the external review have been taken on board and will reflect in the next version, which is due towards the end of this calendar year. From a Health Board perspective we have completed contacts with all 470 contacts identified. We are also now in receipt of the Communicable Disease Outbreak Control Plan for Wales.
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R3. Funding should be identifiable ahead of time for outbreaks of infectious diseases so that such outbreaks can be managed in a timely and effective manner without the need for time-wasting discussion.	To develop an agreed service modeland contingency plans for resourcing any future outbreak	Jul-23	~~Jul-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - The outbreak control plan for Wales is being revised and the learnings from the external review have been taken on board and will reflect in the next version, which is due towards the end of this calendar year. In addition to the work being undertaken with the All Wales Communicable Disease Outbreak Plan the All Wales TB Group has recommended to WG that they consider commissioning a cost effective and targeted mobile outreach and intervention (informed by proven models such as 'Find and Treat' in London) including specific services for active case finding for pulmonary TB among inclusion health groups including people supported by justice and probation services, homeless people and those engaged with substance misuse service Such a service may also be utilised to support TB screening exercises and 6/11 7 case finding as part of cluster or incident/outbreak management and control as well as provision of screening for other diseases (e.g blood borne viruses) where appropriate.

Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R5. At a national level, the Cohort Review Programme needs to be supported with adequate funding for each contributing health board.	To agree a plan with WG, other HB's & External Partners to agree an adequate funding model	N/K	N/K	External	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. WG/PHW have not provided a completion date for this recommendation to date. 06/03/2024 - response received from PHW as follows PHW - Cohort review is the systematic review of all notified TB cases in a 3– 4-month period, to ascertain outcomes for these patients and to facilitate learning for the multi-disciplinary team attending the cohort review meetings. The AWTBG has recommended that an All-Wales TB Nurse Consultant post is created whose role would be to oversee and strengthen the Cohort review process. There is a 10-year evaluation of the Cohort Review in progress and outcomes from this evaluation will allow further recommendations to be identified to improve Cohort review. Changes are being made to the process of identification of cases for Cohort review to ensure that cases that need further review are resubmitted. Cohort review will also include additional details on the identification and outcomes of contact tracing. Part of the work of the AWTBG will be to help to develop a TB service specification as recommended in the TB elimination action plan.
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R6. Welsh Government should support both the Cohort Review Programme and the proposal for a National Service Specification that includes the development of a TB pathway to tackle delayed diagnosis (e.g. investigating cough lasting longer than three weeks).	To work with WG and PHW to agree a way forward for the cohort Review Programme and the National Service Specification	N/K	N/K	External	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planne WG/PHW have not provided a completion date for this recommendation to date.d for the end of May 2023 with plans to submit and present this in June 2023. 06/03/2024 - response received from PHW as follows: PHW - Part of the work of the AWTBG will be to help to develop a TB service specification as recommended in the TB elimination action plan. Welsh Government are currently exploring funding for the Getting it Right First Time (GIRFT) programme for TB which would enable evaluation of TB services across Wales and support the development of a comprehensive service specification.
Dec-22	2022/23	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	N/A	R7. Wales does not seem to be properly prepared for the challenges of new migrants, refugees, and the occurrence of future drug resistance. These factors should be included in a future TB plan supported and funded by Welsh Government.	To work with WG and at an All Wales level to agree a TB Plan which addresses the shortfalls highlighted for new migrants, refugees and the occurrence of future drug resistance.	N/K	N/K	External	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023. WG/PHW have not provided a completion date for this recommendation to date. 06/03/2024 - response received from PHW as follows: -PHW have supported WG in the development of a national health pathways for Asylum Seekers and Refugees which incorporates standards for TB screening. PHW have also supported WG to develop guidance for NHS and private healthcare settings on the health clearance requirements for staff in relation to TB with a particular emphasis on those staff from countries of high incidence. PHW have supported the publication of an evidence review of TB screening in Wales among the Ukraine refugee population (the only country to do so) There are additionally a number of recommendations in the TB elimination action plan with regards to screening of those at higher risk of TB including the development of a business case for the resources required to implement screening for 9/11 10 active and latent disease for all new entrants from high prevalence countries as this may require additional funding.
Dec-22	2022/23	Internal Audit	Individual Patient Funding Requests	Open	Reasonable	Medical	Medical	Head of Effective Clinical Practice & QI	Medical Director	High	R1. The IPFR Team, Finance and Pharmacy should collectively agree and establish a suitable mechanism for capturing and monitoring IPFR spend to ensure that approved costs and treatment duration are not exceeded. Noting that the IPFR budget sits outside of the IPFR Team, responsibility and arrangements for monitoring cumulative IPFR spend should be agreed. If this is outside of Finance (as budget holder), sufficient information needs to be provided Clarify ownership and accountability for the IPFR budget, including responsibility for monitoring spend.	To agree a mechanism with Finance (budget holder) and pharmacy to ensure spend is monitored and not exceeding the approved treatment duration. Agree a reporting process for monitoring cumulative IPFR spend against defined budgets and within standing budgetary control requirements.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Nov-23~~ Mar-24	Red	08/08/2023 - Update from NWSSP. Evidence of new reporting was requested from senior finance business partner in April 2023. Pending review of the evidence, this recommendation can be closed. A sample of the work done has been provided, however IA still need to see a bit more around the controls and processes before they are happy to close this rec. A meeting is being scheduled to discuss the new process. 05/10/2023 - Progress has been made in implementing the management actions. The papers are going to a Panel meeting in October 2023. 06/12/2023 - The reports have been presented at Panel for non-drug IPFR cases (Q1 - 22/08/23; Q2 - 14/11/23). The evidence on the non-drug reports has been shared with the Internal Audit team. However the team is still awaiting input from the Pharmacy department in relation to the drug IPFR spend. Once the report is available this will be shared at the IPFR Panel and the evidence can be shared with the Internal Audit team. 23/02/2024 - The IPFR Panel are scheduled to meet on the 27th February 2024 and the report is on the agenda. pharmacy colleagues will be chased for their input in to the report.
Apr-23	2023/24	Health Education and Improvement Wales (HEIW)	Surgical Specialties Glangwili General Hospital	Open	N/A	Medical	Unscheduled Care (GGH)	Head of Medical Education & Professional Standards	Medical Director	N/A	R4. The Health Board should collect and discuss trainee feedback about the handover, particularly the cross-cover and T+O arrangements. In addition, the audit of handover that has been previously mentioned should be completed and appropriate recommendations made and implemented.	To collect trainee feedback with regard to effectiveness of the new handover system.	Jul-23	~~Jul-23~~ ~~Dec-23~~ Mar-24	Red	15/06/2023 - Several meetings have been organised with Service Delivery Managers and Clinical Leads to develop the new handover system. Sessions held at induction and out of sync for new doctors to ensure they are aware of the system and obtain regular feedback. The following new processes have been developed:. •~~N~~ight to Day Handover Night cross cover doctor will hand over to the night T&O doctor any issues with T&O outlying patients @ 7.30am. Night T&O SHO will then disseminate that to the morning Trauma Meeting. •~~D~~ay to Night Handover ENT and Urology to handover to cross cover doctor @ 8pm in the Merlin doctor's office. Day Orthopaedic doctor to handover to night orthopaedics doctor @ 8pm in Orthopaedic handover room. •~~C~~ross cover night doctor and Orthopaedic night doctor meet at 8.30pm to handover Orthopaedic outliers (this could be in person/phone call/teams) •~~H~~ywel Dda Surgical Specialties Teams Channel Teams channel has been set up. Admin rights given to Medical Education staff members, Service Managers and Educational Supervisors 19/06/2023- Management response formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. Following presentation of the report at PODCC, the RAG status of this recommendation was changed back to amber. 10/10/2023 - Draft Standard Operating Procedure had been drafted and shared with relevant stakeholders for comment before being submitted for ratification in November. New starters all had outline of the new induction format as part of induction and trainees asked to sign declaration form to confirm that relevant information has been shared and that they are aware of the arrangements. Audit of the current process will be undertaken and FP2 will start collecting data. No specific feedback with regards the handover has been reported by trainees and we are fairly confident that there are no current issues with the process. Revised date of Dec 2023 once SOP has been formally ratified and audit undertaken. 30/10/2023 - HEIW revisit took place on the 18th October 2023. Acknowledgement made of progress, this action is now only attributable to Trauma & Orthopaedics. Awaiting outcome of re-audit. 22/12/2023 - Re-audit to be carried out in February 2024 when new trainees have had a chance to review the handover.
Apr-23	2023/24	Health Education and Improvement Wales (HEIW)	Surgical Specialties Glangwili General Hospital	Open	N/A	Medical	Unscheduled Care (GGH)	Head of Medical Education & Professional Standards	Medical Director	N/A	R10. That HEIW will increase the risk rating assigned to these concerns and arrange a further visit for 6 months. An interim catch-up meeting will be scheduled for three months in order to assess progress.	No formal management response presented in PODCC June 2023. Date of visit has yet to be confirmed.	N/K	Apr-24	External	19/06/2023- Report was formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. No formal management response presented for this recommendation. Date of HEIW visit has yet to be confirmed. 10/10/2023 - Next visit to take place on Wednesday the 18th October 2023. 30/10/2023 - Re-visit took place on the 18th October. Some progress made with regards ENT, Surgery and Urology and going forward these specialties will not form part of the visit which will be made in 6 months time. 22/12/2023 - Date of visit has yet to be confirmed.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Aug-23~~ ~~Dec-23~~ Apr-24	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 18/08/2023 - Revised job planning toolkit with new process has been included on the agenda for the next LNC meeting which will take place on the 29th August 2023. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 10/10/2023 - Job planning toolkit has been updated to reflect new process and will be taken to the next LNC. Revised completion date Dec 2023. 20/12/2023 - IA update - A follow up review of this audit report to take place in 2024. 22/12/2023 - Regular meetings between Deputy Medical Director and Managers have taken place to support the completion of job plans within the appropriate timescales. Information also included and monitored as part of DITS meetings in addtion to the monthly compliance information sent through to deparments by the medical directorate team. Further audit to be undertaken at the beginning of 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC. 01/03/2024 - A process to mirror that of appraisal non-compliance was insitgated however, it became clear that due to various reasons why job plans weren't updated in a timely way (not always through the fault of the clinician), the process was not effective and so we have had to look at alternative ways of raising compliance. We have added job plan dates as part of revalidation readiness profromas which is helping us to identify job plans which are out of date and we have also drafted communications which asks doctors to include up to date job plans as part of the scope of work sections of their annual apprasial portfolio. We are hoping that this will contribute to a rise in job plan reviews and we will continue to monitor.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 10/10/2023- Revised completion date Dec 2023. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.

May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 10/10/2023 - Revised completion date Dec 2023. 20/12/2023 - IA update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 10/10/2023 - Revised completion date Dec 2023. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 10/10/2023 - Revised completion date Dec 2023. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
May-23	2022/23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	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~~ ~~Dec-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 08/09/2023 - Work is progressing with job plans being checked against pay and then meetings being held with the service and finance to discuss findings/resolve queries. 10/10/2023 - Revised completion date Dec 2023. 20/12/2023 - IA Update - A follow up review of this audit report to take place in 2024. 16/02/2024 - Follow up report to be presented at April 2024 ARAC.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R1. Improve engagement and support for the International Medical Graduates within the Health board. Include information regarding the appraisal requirements on the MARs system, at induction, training sessions and in newsletters	HEIW team - consider allocating an Appraisal Lead to oversee their first appraisals. we only have 2 appraisal leads and the IMGs are numerous, this may overload our Leads. This will be considered following appraiser and appraisal lead recruitment	Dec-23	~~Dec-23~~ Apr-24	Red	22/12/2023 - overwhelming response to Appraiser recruitment drive initiated. We are in the process of carrying out interviews for appraisers with a view to then recruiting further appraiser leads. 01/03/2024 - We have successfully recruited 7 new appraisers with a further interview scheduled to take place over coming weeks. We are keen to ensure that we have recruited sufficient appraisrs before recruiting appraisal leads and so this will be the next stage.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R2, Identify a new Independent Member	Awaiting new IP to be announced.	Sep-23	~~Sep-23~~ ~~Dec-23~~ N/K	Red	10/10/2023 - The team have been informed that we will need to identify an alternative individual to sit as lay member on the ROAG meetings. We will approach the Revalidation Support Unit to find out if one of the QA visit lay representatives could also act as lay representative for the Health Board.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R5. Identify Appraisal Leads for Withybush and Glangwili	MH&LD to be split between the site appraisal leads. Appraisal lead to be identified for Withybush and additional appraisal lead to cover Glangwili to reduce the numbers of appraisers being led by Mr Gadgil (currently covering both Prince Philip and Glangwili).	Apr-24	Apr-24	Amber	22/12/2023 - Once the full appraiser recruitment drive is complete we will ask for expressions of interest in the role of appraisal lead. 01/03/2024 - Closure of this action will be dependent upon the recruitment of further appraisal leads and this will be progressed over coming months now that we have appointed additional appraisers.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R6. Consider holding an internal quality assurance event.	HW & DS to attend a Swansea Bay event due to take place 04/09/2023. Once completed; Hywel Dda event to be planned.	Aug-24	Aug-24	Amber	10/10/2023 - Meeting attended and first local QA event to take place on 25th October 2023. 01/03/2024 - All Wales QA event clashed with the event due to be held locally and so a local event has been scheduled to take place at the beginning of November 2024.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R7. Current appraisal leads to quality assure the first 2-3 summaries for all new appraisers.	Existing appraisal leads quality assure the summaries of those they lead but this is currently not consistent across the Health Board. Examples of good practice to be shared with appraisal leads along with AL to Appraiser Feedback template.	Aug-24	Aug-24	Amber	29/09/2023 - Original report specified the timescale as Ongoing. Date for completion date to be requested from the service. 10/10/2023 - Completion date of August 2024 received from the service. 01/03/2024 - Closure of this action will be dependent upon the recruitment of further appraisal leads and this will be progressed over coming months now that we have appointed additional appraisers.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Jun-15	2015/16	Audit Wales	Medicines Management in Acute Hospitals	Open	N/A	Medicines Management	Digital and Performance	Chris Brown	Director of Primary Care, Community & Long Term Care	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	~~N/K~~ Mar-25	External	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales. 30/12/2022- WG have provided some funding for a small pre-implementation team that is now in place to develop local business case to secure funding for Electronic Prescribing and Medicines Administration (ePMA). Nationally there are currently 3 systems that have been approved on the framework and once funding approved then a mini-procurement process will be undertaken to secure most appropriate system for the UHB. 28/06/2023- ePMA business case to be submitted to WG. 26/09/2023- at MMOG it was confirmed that an outline business case and SBAR to request approval to go to tender to suppliers that sit on the National Framework have been submitted to the Sustainable Resource Committee and awaiting UHB approval. 15/11/2023 - The Agile Digital Business Group are scrutinising the Electronic Prescribing and Medicines Administration (ePMA) full business case prior submission to November 2023 public Board. 28/11/2023 - Continued preparations ongoing for the national programme to be implemented. 17/01/2024 - The business case due to be reported to the Digital Oversight Group in February 2024. This is reflected in risk 1171. 08/02/2024 - EPS has gone live in the first GP practice and community pharmacy in Rhyl in November 2023, with the second site due to go live in March 2024 within Betsi Cadwaladr University Health Board. GP practices within Hywel Dda are not yet compliant with the new EPS system, therefore rollout is unlikely to commence prior to quarter 3 of financial year 2024/25. In addition, following a mini-procurement exercise, some GP practices within Hywel Dda have opted to switch from their existing systems to the Egton Medical Information Systems (EMIS). It is currently not known if these changes will impact on the EPS implementation timescale for Hywel Dda. The existing system supplier have also announced that they are pulling out of Wales and therefore these GP practice will be required to find new system suppliers.
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R38. Understanding and continually improving the quality of pharmaceutical care The Chief Pharmacists' Peer Group should commission a refresh and refocus of the Pharmacy Research Strategy in Wales aligned to the recommendations of the independent review	N/A - for consideration by the Cheif Pharmacists' Peer Group.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R39. Understanding and continually improving the quality of pharmaceutical care The Welsh Government working with health boards, HEIs, and Health and Care Research Wales (HCRW) should develop a network of research mentors for pharmacy professionals	N/A - for consideration by Welsh Government.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R40. Understanding and continually improving the quality of pharmaceutical care Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising research and development commensurate with the stage of individuals' careers	Consultant pharmacists have this identified, wider workforce require job plans.	Apr-29	Apr-29	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R41. Understanding and continually improving the quality of pharmaceutical care The Chief Pharmacists' Peer Group should establish a programme of work with HEIW to establish a continuous rolling programme for formally appraising pharmacy and medicines management workforce needs aligned to new technologies and NHS priorities	N/A - for consideration by the Cheif Pharmacists' Peer Group.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R45. Improving organisational scrutiny of the quality and effectiveness of pharmacy services Health boards and Velindre University NHS Trust should ensure pharmacy services are included within their strategic planning cycle	Pharmacy integration within directorates and specialities to ensure pharmacy is always considered in their strategic planning cycle and IMTPs.	Sep-24	Sep-24	Amber	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs. Need to increase opportunities to collaborate and be routinely included in strategic planning cycle.
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R46. Improving organisational scrutiny of the quality and effectiveness of pharmacy services The Welsh Government will work with the NHS Executive, health boards and Velindre University NHS Trust to develop and implement key performance indicators including those derived from digital systems, which demonstrate the effectiveness of pharmacy services, on improving the quality of care	N/A - for consideration by Welsh Government.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R47. Pharmacy system leadership Each health board's Director of Pharmacy should be responsible for producing a plan for pharmacy and medicines management within the health board setting but how pharmacy teams are responding to relevant Welsh Government and NHS Executive priorities	Directorate structure been created to have an agile way to respond to any relevant WG and NHS Executive priorities	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R48. Pharmacy system leadership Health boards and Velindre University NHS Trust should review pharmacy senior leadership and management arrangements including job titles to ensure they meet the new GPhC regulatory requirements and the needs of increasing clinical roles	New GPhC requirements not yet ratified. Pharmacy leadership structure aligns to Clinical Boards which does create a lack of site-based leadership.	Apr-29	Apr-29	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R49. Talent management and developing future leaders within pharmacy. Working with HEIW and Academi Wales, the Welsh Government will ensure aspiring leaders in pharmacy have access to a range of multidisciplinary and public sector wide opportunities for leadership development such as HEIW's Executive Talent Pool and Academi Wales' Leadership Development Programmes	N/A - for consideration by Welsh Government.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R50. Talent management and developing future leaders within pharmacy. Health boards and Velindre University NHS Trust must implement the actions identified in the HEIW "Senior Leadership Development in Pharmacy" report	See action plan in appendix 4.	Apr-29	Apr-29	Amber	

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R51. Talent management and developing future leaders within pharmacy. HEIW should work with Health boards and Velindre University NHS Trust to promote awareness of the tools in the "Gwella" leadership platform to promote leadership development at all stages of pharmacy professionals' careers and personal development	N/A - for consideration by HEIW.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R52. Talent management and developing future leaders within pharmacy. HEIW will review the outcomes of participation in the Centre for Pharmacy Postgraduate Education's (CPPE's) programme, "The Chief Pharmaceutical Officer's Pharmacy leaders' development", with a view to establishing a rolling programme to develop future NHS Wales Directors of Pharmacy	N/A - for consideration by HEIW.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R53. Clinical leadership HEIW will lead the development of a consultant pharmacist strategy and implementation plan, and health boards and Velindre University NHS Trust should establish a succession plan for advanced practice and consultant pharmacist roles within their respective workforce plans	N/A - for consideration by HEIW.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R54. Clinical leadership The Welsh Government will work with health boards, Velindre University NHS Trust and HEIW to establish clinical governance arrangements for all pharmacist and other non-medical prescribers, which will include the implementation of the agreed NHS Wales Non-Medical Prescribing (NMP) standards, signposting to guidance and facilitating prescribers to expand their scope of practice	N/A - for consideration by Welsh Government.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R55. Clinical leadership The Chief Pharmacists' Peer Group should review the arrangements for sharing and adopting examples of best practice between health boards. There should a specific focus on standardising clinical pharmacy services in urgent and emergency care and pre-admission/pre-habilitation care, within the first 12 months of this plan being published	N/A - for consideration by the Cheif Pharmacists' Peer Group.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R57. Better use of data and technology to prioritise pharmaceutical care Health boards and Velindre University NHS Trust should prioritise the development of digital and technological skills within pharmacy workforce training and establish clinical informatics pharmacy professional roles within their organisations	Digital lead pharmacist in post, - Can helena help fill this in? Undergraduate project underway to establish current workforce digital skills	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R58. Better use of data and technology to prioritise pharmaceutical care Working with the DMTP, the Chief Pharmacists' Peer Group should establish a short life working group to agree how ePMA systems and the development of the Shared Medicines Record can be used to provide optimal support for prioritisation and pharmaceutical care planning including outreach services in enhanced community care (virtual wards)	N/A - for consideration by the Cheif Pharmacists' Peer Group.	Sep-24	Sep-24	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R59. Realising the benefits of wider use of innovation to guide therapeutic decision making. Health boards and Velindre University NHS Trust should have plans in place to support the wider use of pharmacogenomic testing including the role of pharmacy professionals in advance of the development of a Wales-wide pharmacogenomic panel	Need to develop CAV wide strategy for pharmacogenomics.	Apr-29	Apr-29	Amber	Work with Abdulla and Hannah to see what they have learnt on courses and how can be developed in HD
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R60. Realising the benefits of wider use of innovation to guide therapeutic decision making. Health boards and Velindre University NHS Trust should work with HEIW to provide opportunities to develop awareness of innovative technologies (e.g. Artificial Intelligence and pharmacogenomics) which impact on therapeutic decision making amongst pharmacy teams. This should include but not be limited to, encouraging more pharmacy professionals to access the Swansea and Bangor University postgraduate programmes in genomic medicine	University modules offered to staff, being undertaken this year.	Apr-29	Apr-29	Amber	Please work on the AI component of this - R&D to look at genomics
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R61. Realising the benefits of wider use of innovation to guide therapeutic decision making. Health boards and Velindre University NHS Trust should develop advanced practice and consultant pharmacist roles for pharmacogenomics to lead the development and implementation of pharmacogenomics plans across the NHS	All Wales JD developed and banded by CAV and VCC in collaboration with AWMGS. To be hosted in CAV (awaiting credentialing).	Apr-31	Apr-31	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R1. Reducing time spent by pharmacy professionals on non-clinical activities The Welsh Government will commission a review of opportunities to improve the efficiency of hospital medicines supply and logistics arrangements and release pharmacist and pharmacy technician time for clinical care	N/A - for consideration by Welsh Government.	Sep-24	Sep-24	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Gap and demand analysis to be undertaken. Directorate vacancy control process and review panel in place to modernise roles in line with WG actions and directorate 4 strategic aims. Directorate subgroup structure developed around 5 pharmaceutical themes to empower the workforce to co-design and deliver the new models of service delivery.	Sep-24	Sep-24	Amber	Awaiting Gina - and approval to see details
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Staffing establishment review currently being undertaken to identify pharmacy-funded and directorate-funded staff and their roles for the speciality and pharmacy obligations within the speciality.	Sep-24	Sep-24	Amber	Support a day where the speciality pharmacists meet with RPS and CB to discuss advanced and consultant frameworks - looking at support and ideas of pathways

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R3. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Pharmacy and Medicines Optimisation benchmarking work undertaken on a regular basis.	Sep-24	Sep-24	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R4. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards and Velindre University NHS Trust should identify specialities or clinical areas that currently do not receive or only have a limited clinical pharmacy service; determine which if any should be prioritised for pharmacy input; and develop plans to enable more appropriate deployment of pharmacy professionals in those specialities/areas. This could include reprioritisation or disinvestment and redeployment, from lower priority and lower value activities	Currently informal and based on funding. To follow from stocktaking action above.	Apr-25	Apr-25	Amber	Team to meet once stocktake complete
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R5. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists are designated to support clinical divisions/directorates based on the results of the resource mapping exercise	To follow on from stocktake action above	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R6. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Currently informal prioritisation undertaken by pharmacy teams, Pharmacist Leads for Clinical Services and Chief Technicians in the process of formalising this into an SOP.	Sep-24	Sep-24	Amber	Clinical leads to approve clinical prioritisation SOP (required by course)
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R6. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Electronic prioritisation tools already exists in the Renal Pharmacy Service across Hywel Dda. This can be used as a blue print for development. This has had demonstrable productivity, quality and safety gains	Sep-24	Sep-24	Amber	Being led by Dafydd. Share with E&T and Digital
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R6. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	The implementation of EMPA will allow for the development of clinical & business intelligence. The capability for prioritisation may not be available from the commercial offering of the EPMA product. However these can be developed and digital and informatics capabilities will be Prudent investment from the P&MM. Developing these in Hywel Dda could lead to scale and spread opportunities for other Health Boards; the SWW renal model shows how this is possible	Sep-24	Sep-24	Amber	Share with Clinical Integrated services and Digital
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R6. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Pharmacy have engaged with Frontier to support and develop its use for the needs of our clinical pharmacy service	Sep-24	Sep-24	Amber	Kelly has met with QI team and Frontier to discuss how to include pharmacy in its development. Raised at a national level to include pharmacy red to green module. Withybush to pilot?
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R6. Prioritising clinical pharmacy service provision to better meet the needs of the NHS Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Pharmacy technicians from each site are about to start a clinical priortisation course feedback from this can add to the creation of SOP for priortisation for pharmacy technicians.	Sep-24	Sep-24	Amber	This group to pilot priotisation SOP and input into its development and roll out.
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R7. Scope of clinical pharmacy services and the relationship with multidisciplinary teams Where a clinical pharmacy service is provided to a clinical division(s)/directorate(s) or clinical area, health boards and Velindre University NHS Trust should establish: i) a formal agreement defining the nature and extent of the service and the specific role(s) of any advanced practice and consultant pharmacists involved in the provision of the service, as set out in their job plan(s) ii) the agreement should set out clearly the arrangements for managerial, clinical, and professional accountability	Services based on historic levels. SLA to be developed detailing levels of service to be provided to areas and accountability arrangements. Currently no SLAs in place for clinical services.	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R8. Scope of clinical pharmacy services and the relationship with multidisciplinary teams Health boards and Velindre University NHS Trust should determine the demand profile for pharmacy services in all clinical areas and ensure working patterns of pharmacy teams are aligned to patient and service needs. This should include times when pharmacy services may not currently be being provided and should ensure provision wherever it is needed, seven days a week	Following stocktake action, need to develop demand plan, Subsequent resource map needed to understand demand profile and capacity gap.	Apr-29	Apr-29	Amber	Once stock take has happened - team to decide where to send action
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R9. Scope of clinical pharmacy services and the relationship with multidisciplinary teams Health boards and Velindre University NHS Trust should ensure the requirements for clinical and non-clinical pharmacy services are considered in all new service developments and in any clinical service redesign	Clinical pharamcy services are only sustainable if core pharamcy services are robust. In order to liberate time for clinical service development the access to medicines functions need to be modernised for centralised coordination and localised delivery. Creation of a hub within directorate budget can achieve this. This will include development into logistical support to increase the productivity of the clinical pharmacy service to expand their capacity e.g. dedicated IT support, data analytics and communications.	Sep-24	Sep-24	Amber	

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R10. Realising the potential of pharmacist prescribing Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists in clinical roles are or are training to be, prescribers	No consultant or advanced practice pharmacists in post 67% of pharmacists in the HB are independent prescribers	Apr-29	Apr-29	Amber	All hospital pharmacist to be IPs by 2026
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R11. Realising the potential of pharmacist prescribing The Chief Pharmacists' Peer Group should establish a multidisciplinary short life working group to agree how recommendations 12 and 13 of the RPS's review relating to pharmacist prescribing should be implementes	N/A - for consideration by the Cheif Pharmacists' Peer Group.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R12. Improving pharmacy support to meet the NHS stated priorities Health boards should ensure all Urgent and Emergency Care settings receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams within all Emergency Departments and Same Day Emergency Care units as a priority	Clinical pharmacy services currently being provided to Emergency Care settings across Hywel Dda 7 days a week in 3/4 sites.	Sep-24	Sep-24	Amber	Some gaps in recruitment (WGH)
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R12. Improving pharmacy support to meet the NHS stated priorities Health boards should ensure all Urgent and Emergency Care settings receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams within all Emergency Departments and Same Day Emergency Care units as a priority	Pharmacist Prescribing capabilities need to be developed. The directorate will develop clinical mentors to support pharmacist prescribers on their advanced practice journey	Sep-24	Sep-24	Amber	SDEC fully funded by primary care - to discuss with OW
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R13. Improving pharmacy support to meet the NHS stated priorities HEIW will prioritise funding opportunities to develop pharmacists' skills to work in Urgent and Emergency Care settings. Funding will include the development of skills in independent prescribing, clinical examination and clinical health assessment, diagnostics and triage	Pharmacist and pharmacy technician input into ED patients across the health board. SDEC recruitment in progress to reinvigorate service.	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R14. Improving pharmacy support to meet the NHS stated priorities Health boards should review and where necessary amend, the working patterns and contractual hours of pharmacy teams to ensure they are aligned with service demand in Emergency Departments and Same Day Emergency Care units	Pharmacist and pharmacy technician input into ED patients across the health board. SDEC recruitment in progress to reinvigorate service.	Apr-25	Apr-25	Amber	OW to look at SDEC working hours. Clinical integrated team to scope ward staff including medical teams opinions on pharmacy working patterns, building on MPharm 4 project. Shared with workforce
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R15. Improving pharmacy support to meet the NHS stated priorities Health boards should ensure planned care services receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams, prioritising pharmacist prescriber roles in pre-admission and pre-habilitation services	Pharmacists currently available to give advice to pre-admission services. Discussions underway in sites to understand the demand. Should also be highlighted in stocktake action	Apr-25	Apr-25	Amber	Surgical lead from each site to scope what that would mean for preadmission. Review and standardise leaflets - speak to Daf about videos. Mairead, Joanna Rees, Khoi and Mary to send PPH name
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R17. Pharmacy's role in optimising patient flow Health boards and Velindre University NHS Trust should establish and fully implement their patient medicines self-administration policies to enable patients to manage their own medicines whilst they are in hospital	Self administration policy has been used in some sites, lack of suitable patient lockers and size of policy is a barrier. Being reviewed alongside nursing.	Apr-29	Apr-29	Amber	Work with Medication safetys to review and streamline policy.
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R18. Pharmacy's role in optimising patient flow The Welsh Government will commission updated messaging encouraging patients to bring their regular medicines to hospital, supported by national communications activitiea	N/A - for consideration by Welsh Government.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R20. Pharmacy's role in optimising patient flow Pharmacy teams should ensure that all patients requiring post-discharge support with their medicines are referred to the most appropriate community services (e.g. a medicines review by GP or GP practice pharmacist, or a community-based/domiciliary medicines service)	Need improved widespread understanding of differing support available to be able to refer appropriately.	Apr-25	Apr-25	Amber	Liase with primary care and Daf - make a crib sheet/digitial solution for signposting
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R21. Improving pharmacy workforce planning Health boards and Velindre University NHS Trust should ensure their organisational workforce plans take account of the benefits of integration of pharmacy professionals in multi-disciplinary teams	Need to link with directorates and specialities and wider health board to ensure pharmacy is routinely considered in MDT workforce planning and IMTPs	Sep-24	Sep-24	Amber	Pharmacy integration within directorates and specialities to ensure pharmacy is always considered in their workforce planning and IMTP. The Health Board, with P&MM taking the lead, need to establish a model for expectations for pharmacy staff employed outside the P&MM directorate to ensure core service delivery and pharmaceutical care is not overlooked.
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R22. Improving pharmacy workforce planning Health boards and Velindre University NHS Trust chief pharmacists should ensure the organisation has a pharmacy workforce plan to support and expand advanced and consultant pharmacist practice and to identify more clinical roles for pharmacy technicians	Work currently ongoing to develop workforce plan. Beginning planning for development and training of consultant and advanced practice pharmacists. Expand the role of pharmacy technicians using enhanced training courses.	Apr-25	Apr-25	Amber	Share with workforce
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R24. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care HEIW will work with health boards and Velindre University NHS Trust to develop standardised post registration career frameworks aligned to post-registration curricula, for all pharmacists and pharmacy technicians employed by the NHS in Wales	N/A - for consideration by HEIW.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R25. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care As part of the career frameworks, NHS organisations will develop standardised national nomenclature for job titles for NHS employed clinical pharmacists aligned to the RPS curricula for post registration practice	N/A - for consideration by HEIW.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R26. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care Once agreed, health boards and Velindre University NHS Trust should adopt the standardised national nomenclature for pharmacist job titles	N/A - for consideration by HEIW.	Apr-29	Apr-29	External	

Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R27. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care Health boards and Velindre University NHS Trust should ensure the career progression of all NHS employed pharmacists and pharmacy technicians requires individuals to demonstrate they meet the required minimum standard for practising at the level of practise required by the job description (and the standardised nomenclature for job titles) including through credentialling by a professional body where available	Credentialling of pharmacists supported. Pharmacy technician career development pathway underway some enhanced roles (administration) and training (clinical skills diploma).	Apr-29	Apr-29	Amber	Share with workforce
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R28. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care National template job descriptions, updated Agenda for Change job profiles, and national template job plans (encompassing the four pillars of advanced practice) should be developed for all pharmacists	N/A - for consideration by HEIW.	Apr-25	Apr-25	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R29. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care Health boards and Velindre University NHS Trust should ensure all NHS employed pharmacists have a job plan appropriate for each stage of an individual pharmacist's career	Job plans need creating/reviewing	Apr-29	Apr-29	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R30. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care Job plans for advanced practice and consultant pharmacists should include time for providing outreach services and integrated working across sectors to support community-based practitioners and patients in the community	Same as above and no consultant/advanced practice pharmacist posts in health board	Apr-29	Apr-29	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R31. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care HEIW, working with the Association of Pharmacy Technicians UK (APTUK), will develop comprehensive post-registration curricula for pharmacy technicians employed by the NHS in Wales	N/A - for consideration by HEIW.	Apr-29	Apr-29	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R32. Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care Once such curricula have been developed, further work should be undertaken to develop a standardised national nomenclature for job titles for NHS employed pharmacy technicians. The nomenclature for job titles should be aligned to those curricula; and national template job descriptions, updated Agenda for Change job profiles, and national template job plans for pharmacy technicians. Health boards and Velindre University NHS Trust should then adopt the standardised national nomenclature for pharmacy technician job titles; and ensure all NHS employed pharmacy technicians have a job plan which is appropriate for each stage of an individual pharmacy technician's career	N/A - for consideration by HEIW.	Apr-31	Apr-31	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R33. Supporting professional development at all stages in careers HEIW should work with the Schools of Pharmacy at Cardiff and Swansea Universities to describe examples of pharmacy undergraduate placements within hospital multidisciplinary teams which meet their educational requirements. This should include maintaining and publishing a list of entrustable professional activities for pharmacy undergraduates including appropriate clinical pharmacy activities in hospitals	N/A - for consideration by HEIW.	Sep-24	Sep-24	External	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R34. Supporting professional development at all stages in careers Health boards and Velindre University NHS Trust should develop plans to ensure adequate numbers of pharmacy undergraduate, foundation and post-registration foundation placements are available aligned to the planned number of trainees in Wales including placements with pharmacist prescribers and within multidisciplinary teams	Some sites already offering placements to undergraduate students, all sites offering places for foundation and post foundation trainees. To develop a plan on how more can be supported and gain support from other healthcare professionals as part of an MDT approach.	Apr-25	Apr-25	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R35. Supporting professional development at all stages in careers Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising education commensurate with the stage of individuals' careers	Consultant pharmacists have this identified, wider workforce require job plans.	Apr-29	Apr-29	Amber	
Sep-23	2023/24	Welsh Government	Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Open	N/A	Medicines Management	Medicines Management	Chris Brown	Director of Primary Care, Community and Long Term Care	N/A	R36. Supporting professional development at all stages in careers HEIW should undertake a review of the continuing professional development offer for hospital pharmacy teams to ensure it is meeting their development needs and provides a sufficiently flexible approach for participants	N/A - for consideration by HEIW.	Apr-25	Apr-25	External	

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Sep-21	2021/22	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	High	The Health Board 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~~ ~~Jan-23~~ ~~Mar-23~~ ~~May-23~~ ~~Jul-23~~ ~~Dec-23~~ ~~Mar-24~~ Apr-24	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 completed by end of May 2023. 03/07/2023 - QAST chased for update June 23. QAST update 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. 03/10/2023- Estates work has been delayed due to prioritising the WGH RAAC work, revised date of December 2023 provided. QAST update 30/10/23 actions chased, fire works approaching completion, to be confirmed once finalised. 10/01/2024- QAST Update 14/12/23 Door on order, 3 month lead time, underway at this time. Update 29/01/24 from AMAT- "snags list" One door to be installed in St Nons' expected March 24, some locking issues expected Feb 24 and a fire rated transfer grill in the Laundry room down by the Waldorf suite, expected Feb 14. Update 20/02/24 from AMAT - confirmation from major capital team that works will be completed by end of April 2024, further delays were experienced.
Sep-21	2021/22	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC.	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~Jan-23~~ ~~May-23~~ ~~Aug-23~~ ~~Dec-23~~ N/K	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response. 20/12/2022- All IPC issues with furniture have been addressed as all communal dining and lounge furniture has been replaced. Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed. QAST update Feb 23 Advanced for works were delayed and currently underway and due to end in May 2023. As per information above when these works are complete then painting work ban be progressed. 03/07/2023 - QAST chased for update June 23 - this is corrective work after the action above is completed. QAST update 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. 03/10/2023- Estates work has been delayed due to prioritising the WGH RAAC work, revised date of December 2023 provided. QAST update 30/10/23 actions chased, fire works approaching completion, then repaint can take place. To be confirmed once finalised. 10/01/2024- QAST Update 14/12/23 Estates advised that a start date for these works will be provided. Update 20/02/23 from AMAT- painting work will commence when all fire related work will be completed - which has been delayed until April 2024 - date will be provided once all work is completed. Update 04/03/24 from AMAT - advised to reallocate action to estates.
Jan-22	2021/22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Estates	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	High	HIW requires details of how the health board will assess and address all risks to fire safety within the unit. HIW is not assured that all environmental risks within the service are managed appropriately.	There are currently no patients on the unit. Detailed risk assessments have been undertaken, and corresponding action plans are being developed in order to address the concerns raised in the report.	Mar-22	~~Mar-22~~ ~~Jun-22~~ ~~Oct-22~~ N/K	Red	21/12/2021 - Awaiting confirmation from Richard Jupp, Head of LD sent chaser on 21st December. 20/01/2022 - Walk around took place on 19th January, good progress made, some final areas to be addressed once re-decoration is complete. Separate fire assessment completed, with decoration works currently on track 27/01/2022 - Walk arounds have been undertaken in January 2022, and fire assessment completed, with noted actions to be addressed once redecoration has been completed. Decoration works are on track for completion by March 2022. 18/05/2022 - all fire detector heads have been replaced and all call points are clear and accessible. Fire signage has been updated and fitted. In order to provide additional assurances on this, the estates team have procured an external company to assess all fire doors. This survey has identified further improvements necessary. This work is currently being costed and procured accordingly with anticipated timelines for completion after March 2022 (first quarter of 2022/23). End of March fire doors, single tender action completed, 10 fire doors have been ordered, delivery expected to take 10 – 12 weeks. Anticipated mid-June, 5 days' work time has been identified in readiness to fit the doors when they arrive. Hence new completion date 30th June 2022. QAST Update 11/07/22 Fire/anti ligature doors, Doors are on order and are due for supply and install shortly. They have been on a 12 week order, because they have to be specially manufactured to be fit for purpose. Estates are liaising directly with the company and the work to fit them once they are delivered has been identified as a priority. QAST update 07/09/22 There was a further delay on the installation of the doors as Head of Fire Safety explained the service changed the use of certain rooms with good reason. The HB were not made aware initially and so we have had to change the specification of the doors as a consequence. They were delivered w/c 26/08/22 and all doors EXCEPT 3 were installed. The 3 that were not installed had to be sent back due to the change in specification. The manufacturers have reported a 3-4 week turnaround expected completion by 31/10/22. QAST Update 01/11/22 all work completed from fire plan, further improvements identified, currently being costed. 10/01/2024- last update on AMAT states: Update Sept 23, site being considered for use, plans re patient care being reviewed.
Oct-22	2022/23	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	N/A	Appropriate and safe curtains are to be placed in patient bedrooms	Estates to review the environment in bedrooms and identity work plan to replace curtains.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ ~~N/K~~ ~~Sep-23~~ ~~Dec-23~~ ~~Jan-24~~ Mar-24	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. Update Feb 23 Review completed, awaiting suitable alternative. QAST update 09/05/2023 - work underway. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 expected to be resolved by service with budget by end of September 23. 03/10/23- request for works has been submitted to Estates and this is being chased. Update 30/10/23 ward funding replacement of blinds/ curtains. Estates placed order. Update 14/12/23 The order is in with Swanmac the suppliers since October, and approval given for funding the new blinds. No update from estates since his chase email, Head of Adult inpatient to chase. Update 27/12/2023. Suppliers are due to fit Blinds on 03/01/2024 . Update 6/2/2024 via AMAT. There was an issue with the magnet fittings of the blinds despite them being anti lig and MH ward specification. Estates (SE) and ward manager are due to meet supplier to rectify the issue. Revised date end of March 2024
Nov-22	2022/23	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	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	~~Feb-24~~ Mar-24	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for implementation by December 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. 26/10/2023- Lead for Steering group has been established and first meeting held in September 2023 including LA's and third sectors. 30/11/2023- delayed due to the MH Act Legislation committee not meeting until Jan 2024 and the service have yet to receive final agreement form partner agencies. Revised date of February 2024 provided. 25/02/24 – Service Manager confirmed no change to the information given on the 10/01/24, awaiting the appropriate sign off meeting on 26th March 2024.
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements.	Dec-23	Apr-24	Red	31/08/2023 - Medical Staffing Committee audit lead identified, and a meeting scheduled for September 2023 to develop the audit framework and plan and to discuss its implementation. MHLD directorate themed audits have also been identified and have been accepted as part of the Health Board's Clinical Audit Plan. 03/10/2023- Associate Medical Director requesting update by 20/10/2023. 12/10/2023- The Associate Medical Director confirmed that a Medical lead has been assigned to support this work, however they are on leave returning beginning of November 2023. Associate Medical Director to meet with Medical lead on their return to pick up the progress of this work. A multi professional group is to be arranged to oversee this work. 11/01/2024- Senior Speciality Doctors is taking the lead on behalf of the Psychiatry MSC supported by the MHLD Nurse Consultant. Revised date April 2024 provided. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of April 2024.

Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Update reports on progress of the clinical audit programme to be provided to MHLD QSE in order to provide oversight on outcomes.	Mar-24	Mar-24	Amber	31/08/2023 - Medical Staffing Committee audit lead identified, and meeting set up for September 2023 to develop the audit framework and plan, and to discuss its implementation. MHLD directorate themed audits have also been identified which has been accepted as part of the Health Board's Clinical Audit Plan. Once implemented, outcomes of the clinical audit programme will be reported to MHLD QSE, with frequency to be determined. 12/10/2023- linked to the actions above. 10/01/2024- Updated report to be submitted to the next MHLD QSE meeting. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms.	Mar-24	Mar-24	Amber	31/08/2023 - a meeting with colleagues from Workforce scheduled for 16th August 2023 has been deferred to 27th September (due to annual plan and financial savings work). It is noted that discussions were held in June 2023 amongst senior leadership team to address this issue and to confirm the commitment with relevant staffing groups, with plans to be finalised, implemented and embedded throughout the Directorate. It is envisaged that this will be implemented by December 2023. 11/10/2023- Meetings have taken place with Workforce colleagues who will be undertaking engagement sessions with staff. 10/01/2024- on track for March 2024 date. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Continue to promote on a regular basis a regular approach to leadership visibility and engagement visits across clinical areas as early as possible	Jun-23	Jun-24	Red	10/07/2023- Director of Mental Health and Learning Disabilities confirmed a Triumvirate away day on 21/06/2023 established the work going forward to enable progressing this recommendation. A time out day took place as a Triumvirate along with other key colleagues in June 2023 where we began looking at this with a further meeting now in the calendar with our relationship manager. The follow up plan is being worked up with an aim for completion by December 2023. 03/10/2023- a detailed list is being written for where service are located, with service visits to be scheduled to take place by end of December 2023. 11/10/2023- linked to the action above. 11/01/2024-to be implemented by March 2024 – the Director MHLD has begun to undertake service visits for this financial year and a rolling programme will be created for 2024/25 onwards. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of June 2024.
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Engagement and culture change to be included while developing the Directorate Staff Engagement and Organisational and Development Plan	Mar-24	Mar-24	Amber	31/08/2023 - a meeting with colleagues from Workforce scheduled for 16th August 2023 has been deferred to 27th September (due to annual plan and financial savings work). It is noted that discussions were held in June 2023 amongst senior leadership team to address this issue and to confirm the commitment with relevant staffing groups, with plans to be finalised, implemented and embedded throughout the Directorate. It is envisaged that this will be implemented by December 2023. 03/10/23- meeting took place on 27/09/23, with a plan to hold an initial two workshops in order to identify key areas to develop the Workforce and People plan. 11/10/2023- linked to the action above. 10/01/2024- on track for March 2024 date. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed on schedule for March 2024.
Feb-23	2022/23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	N/A	R6. There are significant vacancies within the Directorate which are affecting the ability of the service to meet demand in a timely fashion. Although the Directorate has developed an embryonic workforce management group, there needs to be a more formal approach. The Directorate should develop a formal and targeted approach to address recruitment hotspots and ensure sustainability.	Work has been undertaken by each service within the Directorate to identify significant vacancies. These findings are to inform the development of an overarching Directorate Recruitment and Retention Plan, which will be aligned to wider Health Board strategic objectives and wider national priorities. The development of the Recruitment and Retention Plan will be completed and overseen by the MHLD Workforce Group, which is attended by Heads of Service and Professional Leads monthly.	Dec-23	Jul-24	Red	31/08/2023 - work is currently being undertaken by the service as part of wider Health Board ask in terms of vacancies, and has allowed the opportunity to better understand the vacancy position, with an ongoing reconciliation process in place, overseen by the Directorate Workforce Group. The Directorate has also engaged with the Health Board's retention team, with focus on staff feedback in terms of new starters and leavers, providing rich information which will inform the development of the Directorate Recruitment and Retention Plan. Conversations have also commenced regarding overseas recruitment, and linking with the future workforce team. Noted that there are several service-level risks on the MHLD risk register int terms of concerns on recruitment and retention, with a view to drafting a Directorate-wide risk. However it is noted that there may be constraints given the current financial climate of the Health Board. 11/10/2023- Meeting is up and running to progress this, including engagement with Corporate teams on recruitment (e.g. NQPE directorate on nursing retention and workforce colleagues on targeted recruitment. 10/01/2024 – The Directorate have met with Work force and Organisational Development colleagues along with finance and there will be service level evaluations take place in relation to resolution of the vacancy position within the service. Revised date of July 2024 date provided considering the number of services that are involved. Director of Mental Health and Learning Disabilities believes December 2023 was in an incorrect date provided on the original action plan and a later date should have been originally provided. 22/02/2024- Management Response Update SBAR provided to ARAC 20/02/2024 confirmed revised date of July 2024.
Feb-23	2022/23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Produce a report for QS&EG with any required pathway improvement/equality recommendations.	Aug-23	~~Jan-24~~ ~~Feb-24~~ Mar-24	Red	16/03/2023- To be submitted for QS&EG Meeting 21/08/23 at the latest. 11/07/2023- Head of Service (Older Adult MH) confirmed on track for end of August. 28/09/2023- Head of Service (Older Adult MH) confirmed the review has been completed (a review of 23 case-studies - inclusive of recent near-miss and serious incidents - for people experiencing functional mental ill health [including some people with mild-cognitive impairment but capacitated and able bodied] using Older Adult Mental Health Services). Additionally, the OAMH Clinical Risk Lead held case and practice discussions CR[H]T Team Leads and a range of CR[H]T clinicians within this assessment process. The report is drafted nearing completion and there needs to be more time to consult within stakeholders before the report can be finalised and submitted to BPPAG. The reason for the delay in implementing the recommendation is in part due to underestimating the scope of the work involved combined with competing high clinical risk priorities consuming the reviewers time to complete the consultation and report. Revised date of December 2023 agreed. 05/12/2023- Head of service has meeting on 08/12/2023 with the author and will provide update following this meeting. 28/12/2023-Head of service confirmed meetings have taken place and the information is in final draft, which is being checked against the crisis teams service specification that was very recently published via global. This should be ready to be tabled at to table at the next BPPAG January 25th 2024. 02/01/2024- Assurance and risk officer responded for clarity if the management response of 'Produce a report for QS&EG with any required pathway improvement/equality recommendations' has been completed or if a revised date is required. 05/02/2024- Recommendation owner confirmed this will be reported to MHLD QSEG in February 2024, after which the recommendation can be closed. 26/02/2024- recommendation owner confirmed it has been concluded by the Director of Mental Health and Learning Disabilities that the report is more suitable for being tabled at BPPAG, the next meeting of which is taking place on 28/03/2024.
Feb-23	2022/23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R4. The Health Board should review accommodation within the Emergency Department to provide an environment where a mental health assessment can be provided to ensure privacy, low stimuli and safety for patients and staff.	Review undertaken. Appropriate areas in place Bronglais, Withybush and Prince Phillip. Layout change in Glangwili ED has led to identified area no longer available for mental health assessment. On-going discussions needed with ED management across HDUHB to resolve and ensure the provisions of appropriate assessment areas.	Mar-24	Mar-24	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. 05/12/2023- this is being progressed, however slowly during winter pressures. 05/02/2024- Recommendation owner confirmed this may be delayed.
Mar-23	2022/23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	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	Mar-24	Red	28/04/2023 - AH to lead on this, initial work done to gather internal pathways. SM to support. 23/06/2023- On track for December 2023 deadline. 14/12/2023- Following Partnership Board the Health Board Part 1 Scheme needs to be submitted for final approval to the MH Act Legislation committee as it is a requirement under the MH (Wales) Measure - the next meeting is taking place Jan 2024 following which this recommendation can be turned green. 10/01/2024- Assistant Director clarified the next MH Legislation meeting is in March 2024 therefore final approval will be provided then, however the document has been taken to the MH Partnership Group meeting and was accepted also. 23/02/2024- service manager confirmed update remains as above.

Mar-23	2022/23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	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	~~Jan-24~~ Mar-24	Red	23/06/2023- Work ongoing, recent Wellbeing posts ongoing which will change and reshape the service slightly. Rebrand of service name and amalgamation of service spec. 09/08/2023-Integration on track and likely to be achieved before December 2023. Rebrand of service name and amalgamation of service spec ongoing. SUI has provoked consideration around some changes – client leaflet, assessment process etc ongoing. 10/01/2024- Assistant Director confirmed integration is complete and the Service specification is complete but can't be ratified until the 29th January 2024 when the next WCDG group convenes. An OCP was undertaken in 2022 which also integrated the service to have integrated pathways and structures where appropriate (Service spec, structure etc). 27/02/2024-Service Manager confirmed the last element was based around a potential change of name for the team (which was not part of the original proposal), however following further exploration this is not feasible due to potential confusion of compliance RTT under part 1 of measure. The service specification has been through the Written Control Document (WCD) group and has undergone a 2 week review across the HB. This has been completed and with the agreed changes will go back to the next WCD for final agreement on 19/03/2024.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Further Actions a)Development of standards for physical health screening to be incorporated into Service Specifications. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ N/K	Red	10/10/24- Multi disciplinary Task and Finish group established. Physical health assessment requirements formulated based on national guidance. Baseline audit planned to confirm current practices against requirements in order to inform implementation plan. Revised timescale for completion 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 19/12/23- AMAT update- Physical health checklist was discussed at the PMSC 19/12/23.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Further Actions b)Further development of Care Partner to capture physical health screening in line with above standards through electronic forms. Please see overarching Clinical Audit Action (Recommendation 34)	Nov-23	Apr-24	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- AMAT update- Physical Health checklist developed for inpatient pathway and awaiting approval. Plan for implementation onpaper from Jan 24 whilst work to embed onto Care Partner is undertaken by system provider. Revised timescale 01/04/24.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R4. The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Further Action d)All teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Dec-23~~ N/K	Red	10/10/2023- All teams across MH/LD directorate are now engaged with Investors in Carers. A full position statement is to be presented to MH/LD QSEG in December through an Investors in Carers Agenda Item agenda item. Timescale for completion revised to 31/12/23. QAST update 30/10/23 no update received from service on action. 11/12/2023- AMAT update- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R6. The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Further Action e)Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ N/K	Red	10/10/2023- Multi disciplinary Task and Finish group established. Previous published work by Hywel Dda on service user perceptions and AIMS standards to be used as a reference point. Timescale revised to 31/01/24 to enable full engagement of service users and carers. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Further Actions: f)Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53). Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Jan-24~~ N/K	Red	10/10/2023-Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity however now impacted by long term absence in team. Revised timescale 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Further Actions: g)Amend the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023- Review of Health Board Policy #370 Discharge and Transfer of Care underway however detailed input from mental health services incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore delayed. Revised timescale for completion 28/02/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R8. The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	Further Action: h)Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Oct-23	Apr-24	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Development of a training resource is incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore progress delayed. Revised timescale 01/04/24.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R9. The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	There are a range of current practices in place in relation to the documentation of inpatient MDT meetings which are supported by admin roles. Further Actions as per recommendation 6.	Sep-23	~~Jan-24~~ N/K	Red	10/10/2023-revised date of January 2024, to coincide with recommendation 6. QAST update 30/10/23 no update received from service on action. 10/10/2023- (update taken from recommendation 6) Multi disciplinary Task and Finish group established. Previous published work by Hywel Dda on service user perceptions and AIMS standards to be used as a reference point. Timescale revised to 31/01/24 to enable full engagement of service users and carers.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R10. The health board must ensure that adequate administrative support is available within inpatient mental health units.	Further Action: i)Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	~~Jan-24~~ N/K	Red	10/10/2023- Ward clerk cover in place for all wards (1 WTE admin available to all units as a minimum through a variety of roles) meeting the MH Principles for safe staffing. Band Ward PA Job Description revised on feedback from ward managers, now job matched, engagement in place with staff side in order to launch an organisational change process. Revised target date of 31/01/24 to have people in all Ward PA roles. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R11. The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Further Actions as per Recommendation 7.	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R12. The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	Further Actions as per recommendation 7.	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R13. The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	Further work to strengthen assurances around consistency and effectiveness of this process will be undertaken through the below actions. Please see overarching Clinical Audit Action (Recommendation 34) Further Actions as per Recommendation 7.	Sep-23	N/K	Red	10/10/2023-revised date of December 2023, to coincide with recommendation 34. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R14. The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Further Action as per Recommendation 6 and 7.	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R15. The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	Further Action j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R16. The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.	Please see response to recommendation 15.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R17. The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	Further Action as per Recommendation 15.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	Further Actions i) Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Sep-23	~~Jan-24~~ Apr-24	Red	10/10/2023- Full transition to paper free clinical records incumbent on national direction. Focus of action therefore revised to: Scope digital priorities and smarter working practices to support shift to digital across MH/LD Directorate (e.g. use of digital dictation) through a digital workshop led by Innovation and Digital Transformation Team. Revised timescale 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 23/11/23 Discussion held at BPPAG with input from the HB Digital Director. Date for directorate wide workshop revised to 30/04/24.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R19. The health board must provide assurances on the electronic patient clinical records systems in place, within its mental health services, to allow for essential information to be shared electronically between inpatient and community services.	Further Action m) Development of process to enable timely access of clinical records for temporary staff eg temporary staff log ins that are issued locally.	Nov-23	N/K	Red	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- no update yet provided on AMAT.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R20. The health board must implement actions to mitigate against risks associated with staff from different teams being able to accessing patient information in a timely manner.	Access to Care Partner is overseen by the MH/LD Directorate. Access to information is immediate to all teams in all locations when it has been added to Care Partner. Further Action as per Recommendation 19.	Nov-23	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet. Linked to action against recommendation 19.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R21. The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010.	Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R22. The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R23. The health board must ensure that discharge summaries are completed and sent out to a patient's GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R24. The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 The health boards policy, Calculating, Maintaining and Reporting Nurse Staffing Levels Policy Framework has been reviewed and is inclusive and reflective of processes across the MH/LD directorate. Action complete. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Sep-23	~~Dec-23~~ N/K	Red	10/10/2023- Mental Health Safe Staffing Principles and Welsh Levels of Care (version 3) remain in draft and unpublished. A review of establishment for inpatient assessment and treatment services is underway. The above draft documents are being used to inform the review. The timescale for completion has been affected by limited capacity within the finance and nurse staffing team. 31/12/23 is a current target date for completion of the review. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Nov-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Further Actions q) Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 22/11/23 MHLD Workforce Management Group established. Support to gain regular breakdown of workforce metrics for MHLD services to enable baseline measures and tracking approach established. Discovery focus groups underway across MHLD areas to gather feedback from staff to inform MHLD retention plan.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R26. The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	Further Action s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Sep-23	~~Dec-23~~ N/K	Red	10/10/2023- Work is being led by the Assistant Director for Mental Health and Learning Disabilities. Timescale for completion revised to 31/12/23. QAST update 30/10/23 Interim MH safe staffing principles and version 3 Welsh Levels of Care reviewed and not applicable to community teams. Action completed. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- on review of AMAT this recommendation is still showing as overdue (not completed as previously stated above) therefore recommendation turned back from green to red. Last update on AMAT states- 10/10/23 Work is being led by the Assistant Director for Mental Health and Learning Disabilities. Timescale for completion revised to 31/12/23.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R27. The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	Further Action t) Resolve CRHT access to space within all emergency departments.	Jul-23	Mar-24	Red	10/10/2023- ED departments currently under significant pressures and are unable to ring-fence identified rooms for mental health assessment only. This challenge has been flagged through Operational Planning and Delivery Programme (04/10/23). Solutions continue to be sought through local discussions. Overdue due to the volume of work involved in completing, alongside capacity pressures across the directorate. March 2024 set as a revised timescale for implementation. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R28. The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Please see responses to recommendation 6 and 7. Further Actions as per Recommendation 6 and 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	~~Feb-24~~ N/K	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R29. The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Further Action (q) as per Recommendation 25	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R31. The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Further Action (q) as per Recommendation 25	Dec-23	N/K	Red	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R32. The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Further Action u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Nov-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- AMAT Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R33. The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	Further Action v) Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	Mar-24	Mar-24	Amber	11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Joint actions agreed by the Directorate leadership team and Culture and OD team to inform and support development of a Directorate Staff Engagement and Organisational Development plan: 1. Review of MHLD data as part of an OD and culture diagnostic to analyse and identify any trends. 2. Undertake a leadership training needs analysis to support further development and succession planning. 3. Workshops to agree the future ODRM support plan for the Directorate on a service/area basis, with a focus on sharing the culture-change vision and what it entails. 4. OD and culture team to attend bi-monthly leadership meetings to feedback and update. 5. To continue to engage and contain the 'hot' areas as they arise. 6. Explore opportunities and education for flexible/agile working and any pilots as part of retention.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of compliance with 72 hour follow up	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- Update taken from AMAT- Medical Staffing Committee audit lead identified, and a meeting scheduled for September 2023 to develop the audit framework and plan and to discuss its implementation. MHLD directorate themed audits have also been identified and have been accepted as part of the Health Board's Clinical Audit Plan.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning	Assistant Director of	Director of Nursing, Quality	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	Further Actions x) Develop a plan to engage frontline staff on the delivery and	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions y) Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Demonstration of AMaT system and its use for tracking and monitoring NICE benchmarking activity and improvement actions delivered to MH/LD directorate service and professional lead roles through training sessions on 1st and 11th August 2023. Further review of action required once clinical audit programme agreed in order to review if additional training is needed.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Further Actions z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Mar-24	Mar-24	Amber	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R36. The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	Further Actions bb) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	Amber	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- update from AMAT- Work to develop an engagement and organisational development plan underway as per update for action MD33/1. A process for reviewing and updating mental health policies and procedures is in place through the Written Control Document Group and a full database of documents is now held which enables forward planning to avoid documents falling out of date. All documents are published and can be accessed by staff through the Health Boards sharepoint system. A plan for sharing updated documents will be agreed through the Written Control Document Group.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R38. The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Further Action dd) Review options for enabling Social Workers who provide a service on behalf of the health board to have direct access to DATIX, establish a process to implement this which includes routine access to DATIX for all new Social Workers joining mental health teams and processes to amend access when moving or leaving the team. Identity existing Social Workers to set up system access and training to enable full use of DATIX and feedback mechanisms within the system.	Jul-23	N/K	Red	QAST update 07/09/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. A written protocol is to be developed to capture and share the process for consistent implementation. No new target date provided by service. 10/10/2023-Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. Overdue due to the volume of work involved in completing, alongside capacity pressures across the directorate. Revised timescale for completion 31/11/23. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. Update 22/11/23 Details of existing Social Workers have been gathered and Datix accounts have been requested.

May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R40. The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	Further Action ffEngagement 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	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker. 08/02/2024- Update from AMAT-Work to develop an engagement and organisational development plan underway as per update for action MD33/1. Attention to how this supports safety culture to be factored into the overarching plan as it develops. In addition to this work a Serious Incident Learning Forum has been established within the directorate to facilitate a coordinated approach to embedding lessons and the schedule for complex case review panel is being structured moving forwards to include sessions that facilitate clinical discussion around learning from incidents.
Jun-23	2023/24	HIW	Clinical Review into the Death of a Service User in HMP Parc	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Ms Caitriona Quinlan	Director of Operations	N/A	R1. Report Recommendation 6.6 verbatim from the report– 'Local guidance should be developed for the section 47 process, for example in the form of a flow chart, to illustrate who is responsible for what and when within each team/organisation involved in the process.'	Initiate and undertake discussion with Prison Inreach contacts at HMP Parc and CTUHB to scope the development of written guidance in partnership with relevant stakeholders that articulates a process for Part 3 (Mental Health Act) patients and their transfer from prison to health boards.	Sep-23	N/K	Red	14/02/2024- update taken from AMAT- This will be the scoping discussion rather than developing the guidance itself as Clinical Audit Facilitator not sure this is for the Health Board to lead on and will need to involve a number of organisations/agencies. Update 04/03/24 on AMAT- The prison pathway chart is done the outstanding action has been agreement with Inreach team and disseminating it to prisons such as Cardiff, Parc, Eastwood Parc. Engagement attempts continue to speak to Inreach contacts
Jun-23	2023/24	HIW	Clinical Review into the Death of a Service User in HMP Parc	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Ms Caitriona Quinlan	Director of Operations	N/A	R1. Report Recommendation 6.6 verbatim from the report– 'Local guidance should be developed for the section 47 process, for example in the form of a flow chart, to illustrate who is responsible for what and when within each team/organisation involved in the process.'	HDUHB currently holds fortnightly Secure Services meetings, involving external colleagues from forensic pathways which supports a systematic approach to information sharing and positive working relationships. Individual team members across pathways have good connections and are in regular contact. Further work is needed to formalise processes for external contacts into HDUHB services out of hours and in urgent situations to strengthen and add resilience to communication across pathways.	Sep-23	N/K	Red	06/03/2024- no update via AMAT system
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R1. While temporary measures have been put in place since June 2021 there remains significant gaps in the delivery of specialist epilepsy reviews for all individuals who were part of the service provided by Professor Kerr and potential new referrals. This does lead to some urgency to install the short-term plan as below to work towards achieving the "Bronze" level standard (5) in the first instance. (Immediate concern). The pathway which was in existence pre June 2021 needs to be reviewed and as feasible adopted. It would be helpful to review if the pathway that was in existence could be reimplemented while broader changes/modifications are considered for local need. The previously existent pathway is apparently similar to those in place and currently in use in Powys and Swansea Bay Health boards and thus could be implemented swiftly. Consideration needs to be given as to why there were challenges for its continued delivery in HDUHB.	To seek short term employment of a "like for like" medical expert in this field and demonstrate that all reasonable attempts have been made by the commissioners including considering re-engaging the previous medic's services in a suitable capacity or attempting to engage suitable locum medical consultant with experience of working with PWID and epilepsy.	Mar-24	Mar-24	Amber	11/01/2024- There was a meeting in December 2022 with the Associate Service Group Director for MH and LD and Head of Nursing for LD in Swansea Bay University Health Board to explore the potential of an arrangement with them but this did not yield a solution. A meeting with Deputy Director for Operations and Planning and the Director and Assistant Director of Mental Health and Learning Disability has been arranged to progress this. Meeting 09.11.23 with Head of Strategic Commissioning, copy of SUHB Epilepsy Care Pathway emailed. Head of Strategic Commissioning to explore the commissioning of a medical expert in this field.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R2. The expectation would be for the new service to oversee the complex clinical pathway required for the current patient population. The expectation is that the service clinicians would have clear clinical roles and job descriptions put together to help support complex individuals currently without a dedicated service. The clinicians need to take forward the service towards a sustainable and safe working model to satisfy in the first instance a three-star service over the coming year with reference to Step Together. This would require identifying medical leadership role from psychiatry and /or neurology to help redesign service needs and to also provide confidence to existing PwID and their families given their recent emotional trauma. This medical leadership role is envisaged to have a stronger engagement with senior management such as Mr Carruthers and Ms Carroll.	To update the pathway ensuring that it to reflects the current practice and following consultation to submit to Written Control Documentation Group for approval and subsequently implement across all CTLDs	Feb-24	N/K	Red	11/01/2024- Pathway needs to provide clarity on how gaps are mitigated and that it is the medical staff in CTLDs who are responsible for determining and making the onward referrals to neurology or return to primary care. Update 24/01/24 AMAT- Responsible person updated, who has attending Written Control Group and leading a working group to progress.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R4. Risk screening matrix for emergencies would be developed by the team in keeping with the NICE 2022 guidance, Step Together and NHS England Right Care Toolkit. The immediate focus would be on safety to ensure people in the service and those coming into the service are safe. Suggested actions include contacting SUDEP Action and asking for the permission for use of the SUDEP and seizure safety checklist for all people in the service. This would also act as a surrogate measure for risk change. (Short term plan (6 months))	To contact Public Health Wales to establish the position of all LHB's across Wales	Dec-23	N/K	Red	11/01/2024- Contact has been made with Public Health Wales and a request has been made for information from across Wales. No revised date provided on AMAT. Update Jan 2024 AMAT- Feedback awaited from PHW.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R4. Risk screening matrix for emergencies would be developed by the team in keeping with the NICE 2022 guidance, Step Together and NHS England Right Care Toolkit. The immediate focus would be on safety to ensure people in the service and those coming into the service are safe. Suggested actions include contacting SUDEP Action and asking for the permission for use of the SUDEP and seizure safety checklist for all people in the service. This would also act as a surrogate measure for risk change. (Short term plan (6 months))	To consider the responses from across Wales and develop a risk screening matrix for implementation in HDUHB.	Jun-24	Jun-24	Amber	Update 24/01/24 AMAT- PHW contacted and feedback awaited.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R6. The current epilepsy nurse job description needs to be reviewed by Ms Paula Hopes or a suitable specialist epilepsy nurse recommended by Epilepsy Specialist Nurse Association (ESNA). The expectation would be to provide a brief report outlining the strengths and weaknesses of the current position holders, competencies as matched to the job description and workload. For any identified areas of the position holder's development, mentoring from an experience specialist epilepsy nurse could be procured from ESNA. This could be part of the professional development of the individual. (Short term plan (6 months))	To review the current epilepsy nurse role description.	Mar-24	Mar-24	Amber	11/01/2024- The epilepsy nursing service is managed by the Strategic Head Community and Chronic Conditions and therefore the review will need engagement with this team. 26/10/2023 Email sent to progress 16/11/2023 AMAT update- staff away from work, forwarded to epilepsy nurse who is not in a position to assist. To seek advice on the cover arrangements for Strategic Head Community and Chronic Conditions.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R7. To put in place emergency guidelines and protocols for all those eligible for rescue guidance such as Midazolam. There also needs to be a protocol in place for rapid review and oversight of those who are admitted to an emergency department. Gaining the expertise of an epilepsy specialist nurse via ESNA on this matter could be helpful. The current situation appears to have arisen due to difference in learning disability staff viewpoints and existing organisational culture. Being mindful of this, applied solutions need to ensure that staff stakeholders are included, confident, involved and supportive of these changes. This might require training, education and outlining of resources such as time in current job roles. Best practice guidelines such as Step Together and NHS England Right Care toolkit could help. This would provide resilience and sustainability for delivery of a high quality epilepsy care pathway. (Short term plan (6 months))	To seek guidance from Epilepsy Wales and ESNA on emergency guidelines and protocols including rescue medication guidance	Jan-24	~~Jan-24~~ N/K	Red	11/01/2024 AMAT update- Service lead emailed Epilepsy Wales for guidance on emergency guidelines and protocols on 26.10.23.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R8. As part of understanding of the challenges within the service, a multistakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To liaise with research and development colleagues to establish the stakeholder's current understanding and expectations of the service.	Mar-24	Mar-24	Amber	

Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R8. As part of understanding of the challenges within the service, a multistakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To take forward agreed actions following meeting with carers of patients which were under the specialist service at the time of closure: 1. To review the care provided to 2 patients represented at the meeting 2. To review the complaints received at the time service was closed. 3. To send an easy read memo updating on the next steps following the receipt of the report.	Mar-24	Mar-24	Amber	Update 24/01/24 AMAT- review of 2 patients has been completed and 2 carers have been approached with an offer to share review. A review of the complaints received at the time has been requested from complaints team in order to update holding letter. Easy Read memo has been written, establishing the completeness of final aspect.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. Consider a suitable model of care for delivering the epilepsy and ID clinical care. Ideally recruiting a specialist ID consultant with competency in epilepsy is desirable. However, there is significant challenges of such specialists being available. In such a situation: a. Consider the existing work force and supporting those psychiatrists working in the current ID service interested in physical health care in developing epilepsy skills and competencies. This should naturally be done as part of service re-design and include suitable job planning (based on work activity) and resource for any potential interested person. There needs to be good peer group and Continued Professional Development arrangements made. b. Offer similar opportunities to neurologists or GPs interested in this clinical area as in point a. above. (Medium term plan (6 months to a year))	To consider options for cover by a specialist LD consultant with interest in epilespy.	Mar-24	Mar-24	Amber	Update 04/03/24 on AMAT- All options explored and there have been no applicants for the NHS Locum and Substantive LD Consultant posts. The meeting with an interested party did not result in a formal job application. This action is unable to complete because we are unable to identify / secure a LD Consultant into one of our vacant posts with a special interest in Epilepsy care
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. Consider a suitable model of care for delivering the epilepsy and ID clinical care. Ideally recruiting a specialist ID consultant with competency in epilepsy is desirable. However, there is significant challenges of such specialists being available. In such a situation: a. Consider the existing work force and supporting those psychiatrists working in the current ID service interested in physical health care in developing epilepsy skills and competencies. This should naturally be done as part of service re-design and include suitable job planning (based on work activity) and resource for any potential interested person. There needs to be good peer group and Continued Professional Development arrangements made. b. Offer similar opportunities to neurologists or GPs interested in this clinical area as in point a. above. (Medium term plan (6 months to a year))	To review and develop a local epilepsy LD care pathway using QI methodology	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Delivery Unit	Review of Memory Assessment Services	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R5. The Health Board should consider how it can reduce the number of did not attends for Memory Assessment Services to support the best use of clinical resources.	The MAS offers scheduled clinic appointments along with home visits if required. Due to the patient group, our administrators will often call to remind individuals/family members of their appointments but there are still a number of appointments that are not attended. These are hard to capture as we are waiting to be aligned to WPAS so that our data capture is more accurate. All of the MAS teams are about to pilot a text messaging service starting in August 2023 to remind people of their appointments, this will allow increased monitoring of cancelled/rearranged/ not attend appointments. As part of this initiative, the service will scope the number of DNA's to set a base-line measure to review and estimate any difference made. MAS will also take this opportunity to review their position in relation to the 'Not Brought' Policy and how this is applied as part of the review.	Mar-24	Mar-24	Amber	11/08/2023- On trajectory for end of Q4 completion. 31/10/2023- Memory Assessment Service's (MAS) situation in regards to the high number of DNA to clinic appointments has been considered to make best use of clinical resources. Three out of the four Memory Assessment Service have subsequently commenced a text messaging service to remind people/carers of their appointments. Over 90 text messages have been sent with all people attending for their appointments with only 4 that have either: • Not attended • Cancelled the appointment • Confirmed that they are unable to attend • Declined All 4 contacts received follow up correspondence from the teams involved ensuring that the 'Monitoring Vulnerable People Who Were Not Brought or Did Not Attend Appointment and No Access Visits Procedure' (HDUHB Policy) is being adhered to. NB the fourth team will follow shortly, the delay is due to inadequate administration support which is being addressed. MAS has still not been migrated to WPAS, this has been ongoing since December 2022, there is no date available from the Informatics team in relation to the migration, Directorate Administration Managers are aware of this and update us regularly. When MAS is migrated to WPAS this will allow further data collection regarding missed/changed appointments that we are unable to gather at present with accuracy. 06/02/2024- on track for March 2024.
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R1. The HB should review access pathways and processes to ensure they are equitable for ASD and ADHD.	Review existing diagnostic/ management, transition and treatment pathways	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R2. The HB should review processes to facilitate the delivery of dual ADHD and ASD assessments.	Explore opportunities for integrated joint working to deliver dual ADHD and ASD assessments.	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should review how children accessing ASD assessment can receive physical health screening as part of the assessment process.	To review existing ASD diagnostic pathways and explore opportunities with Child Health colleagues for integrated working	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The ADHD service would benefit from continuing to progress their plan to review service pathways and embed capacity and demand management processes to improve equity, consistency, and efficiency.	ADHD service will continue to progress and provide action plan.	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The ADHD service would benefit from continuing to progress their plan to review service pathways and embed capacity and demand management processes to improve equity, consistency, and efficiency.	Undertake demand and capacity training provided by the NHS Executive	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. Given the potential impact of delays in ADHD medication initiation on a CYP's social development and educational attainment, the HB should review processes and capacity to support timely initiation of treatment for ADHD.	1.Undertaken an immediate review of waiting times in ADHD medication	Jan-24	~~Jan-24~~ N/K	Red	22/02/2024- request for progress update made to Service Delivery Manager for Community Paediatrics, with response requested by 06/03/2024 for reporting to April 2024 ARAC.
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Review current transition arrangements for older YP people waiting diagnostic assessments of ASD and ADHD	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Develop an all age Transition policy/pathway for Neurodivergent Children & Young People.	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should ensure that patient administration systems are able to collect data to meet national reporting requirements. Services would also benefit from a review of their data needs to support and effective referral management and capacity and demand planning.	Services will meet with HB Informatics to undertake a review of service patient admin systems to explore automated processes for reporting to meet national reporting requirements across both services and will review data needs to support effective referral management and equitable demand and capacity planning	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R8. The HB may wish to consider ways to expand use of information technology to support timeliness and efficiency of information gathering and signposting at referral and along the patient pathway.	The ADHD/ASD Service will explore ways to expand the use of information technology to support timeliness & efficiency of information gathering and appropriate sharing	Jun-24	Jun-24	Amber	

Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R8. The HB may wish to consider ways to expand use of information technology to support timeliness and efficiency of information gathering and signposting at referral and along the patient pathway.	To explore the use of information technology to support the management of referrals and patient pathways.	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure the availability of accessible and appropriate accommodation for diagnostic assessment of CYP with sensory sensitivities and physical impairments.	Explore necessary adaptations that may be required for diagnostic assessments for CYP with sensory sensitivities and physical impairments.	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure the availability of accessible and appropriate accommodation for diagnostic assessment of CYP with sensory sensitivities and physical impairments.	Explore and contribute to new project opportunities for new accommodation, eg, Hwb	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure the availability of accessible and appropriate accommodation for diagnostic assessment of CYP with sensory sensitivities and physical impairments.	Undertake a service review of current estates of both services and develop an option proposal/SBAR	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	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.	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.	Mar-24	Mar-24	Amber	25/02/24 – Service Manager confirmed no change to the information given on the 10/01/24, awaiting the appropriate sign off meeting on 26th March 2024.
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	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.	S-CAMHS will contribute to the update ensuring all the new service developments are aligned to the Measure, including the new SiR Service.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.	Paediatric Psychology will review/update Service Specification	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.	Review/update S-CAMHS Service Specification	Jun-24	Jun-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Task & Finish Group to be established with clear Terms of Reference.	Jan-24	~~Jan-24~~ N/K	Red	22/02/2024- requested confirmation recommendation is complete by 06/03/2024. 27/02/2024-Service Delivery Manager for Community Paediatrics is discussing this action with the Service Delivery Manager (S-CAMHS).
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Benchmark Paediatric Psychology in line with other Health Boards in Wales	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Identify gaps in availability of psychological interventions in HDUHB in line with Matrics Plant	Oct-24	Oct-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Undertake and prepare an options appraisal paper based on the above actions (1,2,3)	Dec-24	Dec-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.	Identify current pathways to S-CAMHS from Paediatric Psychology and initiate improvements where possible.	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Explore within Task & Finishing Group established for R3 .	Jan-24	~~Jan-24~~ N/K	Red	22/02/2024- requested confirmation recommendation is complete by 06/03/2024. 27/02/2024-Service Delivery Manager for Community Paediatrics is discussing this action with the Service Delivery Manager (S-CAMHS).
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify and implement opportunities for improved psychological interventions & patient outcomes across Paediatrics and S-CAMHS	Jul-24	Jul-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify further resource required to further enhance interventions and outcomes to inform option appraisal from Action 4 of R3	Jul-24	Jul-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Benchmark Paediatric Psychology with that in other Health Boards in Wales	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Internal review within paediatrics to identify appropriate development of psychological provision within paediatrics, leadership structures and pathways in line with governance arrangements of the wider health board	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	PTMG to be re-established	Mar-24	Mar-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Paediatric Service to co-produce an annual training plan to include advice and direction from Professional lead and shared training opportunities with SCHAMS	May-24	May-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Identifying gaps in funding and provision for development in paediatric psychology	Jul-24	Jul-24	Amber	

Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.	Exploring and contribute to new projects opportunities for new accommodation, eg, Hwb (Debenhams)	Mar-24	Mar-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.	Review of Agile Working arrangements to increase efficiency of current accommodation – SCAMHS	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.	Undertake a service review of current estates of both services and develop an option proposal/SBAR	Nov-24	Nov-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	Review CoP to identify any areas for improvement of compliance and report into CTP monitoring group	Jul-24	Jul-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	Complete remaining CTP training sessions for S-CAMHS workforce	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	Initiate a rolling quality review process for CTPs	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.	CTP monitoring group to continue - bimonthly basis to ensure continued compliance & quality	Apr-24	Apr-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R8. The HB should embed demand and capacity principles into the management of all services. The HB may wish to access further demand and capacity training from the NHS Wales Executive or other training providers.	Both services will undertake demand and capacity training provided by the NHS Executive	Mar-24	Mar-24	Amber	
Sep-23	2023/24	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Open	N/A	Mental Health & Learning Disabilities	Women and Children's Services	Angela Lodwick	Director of Operations	N/A	R9. The HB should ensure that patient feedback, involvement and outcome measures are used across all directorates in service evaluation and planning.	Paediatric Link with VBHC team to develop both a PREM/PROM informed by national outcome measures in order to utilise patient feedback and outcomes to inform future development of the services. .	Jun-24	Jun-24	Amber	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R1. The health board must ensure that staff have alarms and engage with staff to come up with solutions to make staff feel safer whilst working in a remote area.	To liaise with Health and Safety and action by estates to be undertaken to resolve alarm 'blind spot' on St Caradog Ward.	Jan-24	~~Jan-24~~ N/K	Red	13/02/2024- update on AMAT (but unclear when added to the system)- alarm company have now been contacted and a solution is being discussed with the MH site leads - this action can now be transferred from estates to the local MH service leads.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R1. The health board must ensure that staff have alarms and engage with staff to come up with solutions to make staff feel safer whilst working in a remote area.	Risk to be added to Service Risk Register to reflect alarm 'blind spot' in specific area of St Caradog Ward to detail mitigations and actions to track resolution of risk	Dec-23	N/K	Red	Update 12/02/2024 from AMAT- quote has been received to rectify "blind spot" issue and approved. Awaiting action from Alarm company to attend ward and undertake work required.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R2. The health board must ensure that work is undertaken to improve the appearance and safety of the outdoor areas for patients to use	Estates have attended site and have addressed a number of these concerns. There is a new grounds and gardens contract in place (commencing in early 24) with regular site visits planned to keep the level of grounds maintenance to an acceptable standard.	Feb-24	N/K	Red	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R7. During a review of one patient record it was unclear if the current bed was meeting the needs of the patient. The health board must review this patient and ensure consideration is given to a new bed being provided for this patient	To ensure the Occupational Therapy Assessment is undertaken and documented within clinical record on 16th October 2023. A review to revisit needs to be undertaken.	Dec-23	N/K	Red	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R8. The health board must review the notice boards on the ward and ensure that information is up to date and relevant. The health board must make sure that particular attention is paid to what information is displayed. Information displayed must be relevant to patients and visitors	To undertake a review of arrangements for Healthy Ward Checks to include services user / carer representation on Healthy Ward check teams to strengthen routine review of the quality, relevance and accessibility of patient and visitor information through Healthy Ward Checks.	Feb-24	N/K	Red	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R9. The health board must ensure that anti-ligature equipment is provided and that risk assessments are completed relating to high profile beds for patients on the wards	St Caradog and St Non's are subject to Point of Ligature assessments as per the Health Boards Policy/Procedure 1069. A Health and Safety Officer and the Ward Manager have completed assessments and action plans. Works and equipment required have been identified on both wards and a project feasibility is being prepared due to the extent of work required. Further action to fully implement the identified schemes of work to reduce points of ligature on St Caradog and St Nons Ward is required.	Sep-24	Sep-24	Amber	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates to undertake a review of the area and take further action to address the ventilation defects to prevent further mould	Jan-24	~~Jan-24~~ N/K	Red	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Request to be made to estates to review and improve storage within the occupational therapy room	Dec-23	N/K	Red	AMAT Update 15/01/24 The team have made a prompt declutter of the OT room - senior nurse in conversation with ward manager about getting better storage facilities in the OT room also as currently the storage is too small to store for a wide range of group activities to meet patient needs.

Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates improvements and decoration is currently underway on St Caradog Ward. Temporary signage to be put in place	Dec-23	N/K	Red	14/02/2024- update from AMAT-Estates teams have been made aware of the situation and are arranging for signage to be fitted.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed using anti ligature handrail products to be undertaken	Jan-24	~~Jan. 24~~ N/K	Red	14/02/2024- update from AMAT- A suggested anti-ligature handrail product was submitted by clinicians to estates. Estates advised that these handrails are not suitable for the bathrooms/toilets and they will try to source alternative anti-ligature handrails. Awaiting feedback from Estates who visited the ward 29/01/24. Update 04.03.24 on AMAT- ACTION PART 1.: NB as far as I understand the HIW request, the description above is not accurate. The handrails for the bathrooms were primarily in connection to falls risk not anti-ligature risk. About 10 years ago the rails were removed due to ligature risks. Secondarily, any replacement handrail needs to be proportionately anti ligature risk. This has been followed up with estates multiple times. The clinical team agree the retractable handrails estates looked at/initially suggested are unsuitable for this space. Recommended the Ward Team speak to estates to a) dismiss the need for a retractable handrail and b) assess the feasibility to fit a fixed handrail akin to those on Enlli Ward to the three Communal Bathroom/Toilet areas. This action [Part 1.] therefore remains pending. ACTION PART 2. of this part of the action equates to reviewing the other handrails throughout the ward. A Ligature Ancho Point audit and an Action Plan [new format] has been completed therefore the requirement to review the remaining areas of the ward has been met. Additionally, a Project Feasibility Form has been completed and submitted to the Capital Team for costings (occurring 06.03.24) so that a Discretionary Capital Bid can be drafted for MH&LD Directorate approval before attempting to secure discretionary capital to go to tender to address the respective handrails. The latter part of this process can take years to complete and is not entirely suitable for an AMAT action.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Estates will review thermostat covers and ensure suitable covers are replaced in patient rooms on St Non ward	Jan-24	~~Jan. 24~~ N/K	Red	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R11. The health board must ensure that over the counter medications are stored correctly and in line with health board policy.	Ward medication storage to be reviewed and action taken to identify, purchase and install storage/equipment to fully accommodate ward requirements.	Apr-24	Apr-24	Amber	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R13. The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mar-24	Mar-24	Amber	
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R16. The health board must ensure that records detail consent and capacity to consent are assessed during first 3 months of treatment in accordance with para 25.18 of the Welsh Codes of Practice	Task and finish group to be established to include MCA and MHA leads to review feedback and practice issues raised in relation to capacity and capacity to consent to determine an improvement plan.	Feb-24	N/K	Red	11/01/2024- Membership identified for the task and finish group and dates for initial meeting are being scoped. 29/02/2024- Update from AMAT system 09/02/24- Task and finish group met 08.02.24 with contributions from MCA team, MHA team, Resus Officer, Professional Leads, QAPD, Nursing and Medical colleagues. Feedback from the HIW report was examined and considered alongside relevant sections of the MHA and MCA Codes of Practice for Wales. Outcome was that attempts should be made to seek further clarification from HIW inspectorate team regarding the specific practice issues raised as based on review of feedback by internal experts, no breaches in practice against All Wales guidance (including DNA CPR) or codes of practice for Wales could be identified. Request made to Patient Safety and Assurance Manager to reach out to HIW for further clarification. Update 04.03.24 from AMAT- Awaiting feedback and clarification from HIW to determine if further action needed.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R17. The health board must ensure that where appropriate specific decisions about patient care and treatment are undertaken, as set out in the framework for the Mental Capacity Act in accordance with para 13.7 of the Codes of Practice for Wales, these are recorded in patients notes	Task and finish group to be established to include MCA and MHA leads to review feedback and practice issues raised in relation to capacity and capacity to consent to determine an improvement plan.	Feb-24	N/K	Red	Update 04.03.24 from AMAT- Awaiting feedback and clarification from HIW to determine if further action needed.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R18. The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the CTO might be more suitable option in accordance with paragraph 27.8 -27.9. This must be recorded in patients notes.	A review of the content and layout of the section 17 leave form to be undertaken as part of planned 3 yearly policy review to incorporate prompts for Responsible Clinicians about considering CTO when leave is being granted for more than 7 days.	Oct-24	Oct-24	Amber	The health board should review and discuss these implications with staff from all areas and try and establish a service level agreement between the Accident and Emergency department and St Non's and St Caradog to try and minimise the staffing issues and distress caused to patients who experience significant delays.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R19. The health board should review and discuss these implications with staff from all areas and try and establish a service level agreement between the Accident and Emergency department and St Non's and St Caradog to try and minimise the staffing issues and distress caused to patients who experience significant delays.	The Interim Senior Nurse for Liaison has already started working with Head of Nursing at Withybush Hospital to develop pathways for Mental Health Inpatients accessing the Accident and Emergency Department. This includes protocols where MHLD inpatient medics have prior contact with the DGH to discuss the patient's presentation and accident and emergency contacting the ward to escort the patient to the department when a practitioner is available to see them, this avoids long waiting times in waiting rooms. A Substantive Senior Nurse for Liaison has been recruited and is due to commence in post in January 2024. They will lead on formally developing and agreeing protocols and procedures with DGHs.	Apr-24	Apr-24	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	R1. In order to address the matter arising, further work should be undertaken to ensure the identified key controls within 1032 are fully established and operating as reported to the health board.	ASD services will ensure pre and post diagnostic support is available for children and young people as outlined in the Code of Practice on the Delivery of Autism Services (Welsh Government; 2021) and ensure clients are kept informed on waiting times via regular correspondence and explore the development of websites/ as an additional source of support.Trajectory is addressed in 5(2)	Mar-24	Mar-24	Amber	06/12/2023- emailed service requesting update by 10/01/2024. 10/01/2024 - Service Delivery Manager to provide narrative and provide evidence. Review undertaken by Head of Quality and Governance on 26/02/2024 - reassurance provided that action has been taken. Evidence required to demonstrate assurance and progress to complete.
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	R6. A trajectory for the ASD performance measure should be established.	The ASD service will work with the HB Performance / Operational Team to establish a realistic trajectory considering the demand and capacity impact already highlighted to Board and Welsh Government – a maximum of 1 % will be monitored.	Mar-24	Mar-24	Amber	06/12/2023- emailed service requesting update by 10/01/2024. 10/01/2024 - Trajectory to meet 1% target to be developed.

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Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	~~Apr-23~~ ~~Jun-23~~ ~~Aug-23~~ Mar-24	Red	18/05/23 - Actions considered by the TUEC programme Director, further discussion taking place to determine timescales for implementation and congruence with priorities as determined by NHS Executive and delivery of Ministerial Objectives (Urgent Primary Care, SDEC, Discharge Planning Coordination, D2RA and DPOC). Update to be provided in June 2023 07/07/2023 - Falls strategy work in progress - meeting of the next falls strategy group to be held in July/August 2023 to review strategy progress to date. Draft strategy circulated to members of the work group. 13/09/2023- falls strategy meeting held 05/09/2023cand strategy reviewed to date. Task and Finish/working group established to fine tune the details of the strategy - next meeting due to be held in October. It is anticipated that this group will need to meet on a number of occasions to add more detail to the strategy. UHB anticipate a realistic timescale of March 2024 for a completed strategy. 12/10/2023-the strategy group met in September and reviewed the draft strategy. As a result a working group has now been established to fine tune the detail, before returning back to the main strategy group with actions. The first meeting of the working group is scheduled for 19/10/2023. 28/12/2023- meeting in the diary for January 2024 with a few key stakeholders from the strategy group. PHW making current amendments to the strategy. Once amendments have been finalised, a strategy group meeting will be held to review. 07/03/2024 - Falls Strategy Work is currently on hold following discussions with the new Director of Therapies and Director of Nursing. It is anticipated that the strategy may form part of a frailty strategy. Work remains ongoing.
Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	~~Apr-23~~ ~~Jun-23~~ N/K	External	
Nov-22	2022/23	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	GGH is working with Gwili railway to provide an additional 140 spaces for staff to release space in the hospital site.	Jun-23	~~Jun-23~~ ~~Aug-23~~ ~~Oct-23~~ ~~Jan-24~~ Feb-24	Red	28/11/2022 - Parking on all hospital sites remains a challenge. Alternative ways to support patients access is being continually considered by Director of estates and Facilities 31/05/2023- Business & Governance Manager (central ops) confirmed the Gwili Railway scheme is nearing completion. Confirmation still required from Carms Countil that they will support a change in planning permission prior to finalisation of the remaining enablement works. There will be a 6 week lead time from confirmation of planning consent to commencement of this scheme due to the need to finalise enablement works. Unfortunately no indication has been provided on how long this consent may take. We now estimate that the earliest date for commencement of this scheme will be August 2023. An additional 40 parking spaces are due for completion on the GGH site at the end of June 2023 associated with the W&C phase 2 development 11/09/2023- development have been delayed due to the development and signing of the legal agreements taking longer than anticipated. We expect the development to be completed within three weeks of the legal agreements being approved by both parties. 25/10/2023-Signing of the legal agreements are expecting very soon once some final details have been addressed. Once the date of signature is known the UHB will be confident in reporting a revised timeline. If all goes to plan construction is expected to commence from 06/11/2023 with the car park opening on 01/12/2023. However, this is entirely dependent on the agreement timescales. 02/11/2023- The GRC have completed all the lighting on site and are currently working on the car park barriers. They are still planning to commence their ground works on the 6th Nov 2023 for 2/3 weeks to complete the access ramp. Based on this timeframe and leave commitments etc, a revised date of 05/01/2024 has been provided. 28/12/2023- All aspects of the legal requirements have been completed by our lawyers and similarly by the lawyers representing the GRC. The GRC have financial backing for the numerous changes to the facility via their lenders and they require their approval before completing the legal process. The lenders have approved the partnership with HDUHB verbally but this has yet to be confirmed formally in writing. This has been delayed due to the festive period and is expected to be received early in the new year. Once received the GRC can complete the final enablement works which include, sewerage connection, lighting, walkway construction, fencing to the hospital site etc. Enablement works to be completed on the hospital site to meet H&S recommendations with widening of pavements, road marking, groundworks etc to be undertaken. These have all the relevant capital expenditure finances in place and have been through the contractor tender process. Again, once the legal formalities are complete these should be completed within a matter of weeks. Revised date of February 2024 provided.
Nov-22	2022/23	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	N/A	R7. The Health Board to have better communication by keeping patients regularly informed of waiting times.	Funding agreed via WG for digital communication screens in waiting area, once purchased will have information on waiting times.	Mar-23	~~Mar-23~~ ~~Dec-23~~ Apr-24	Red	28/11/2022 - Funding agreed awaiting screens. 11/07/2023- to be checked with Heads of Nursing if this has been implemented. 15/09/2023- Deputy HON (PPH) confirmed there are no communication screen in MIU in PPH. 06/10/2023- emailed Digital Director (cc'd Director of NQPE) for progress on digital screens and revised date of implementation. 09/10/2023- Digital Director confirmed •The networking for GGH and PPH has been completed and over the next 2 weeks we will the testing the CCTV and Digital Signage before handing over to the service. • The networking team will be starting onsite in WGH and BGH in the next 2 weeks, with an anticipated completion of 6 weeks before a further 2 weeks of resting before handing over to the service. 06/02/2024 - Interim Assistant Director of Nursing has confirmed that all screens are in place but are still not connected due to ongoing difficulties with security/compatibility between screens and resource issues.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R1. HDUHB should ensure that all relevant documentation related to a record is uploaded to the Datix Cymru system and a standard naming convention is used to allow for ease of reference for all staff.	Clarity re access to privileged information and audit trail to be discussed at network.	Mar-24	Mar-24	Amber	Update Dec 2023 - To discuss and clarify the access to privileged information and the audit trail that is available at the network meeting. 06/03/2024 - No new update from AMAT.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R4. HDUHB Should consider documenting the process to ensure early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	Redress and Complaints Staff to attend national training.	Dec-24	Dec-24	Red	18/01/2023 AMAT update- Availability of national training to be confirmed. AMAT system confirms original timescale for action is December 2024, not Dececmber 2023 as originally noted on the tracker. Tracker corrected and RAG status changed back from red to amber. 06/03/2024 - AMAT update - National training for staff is due to be held on how to assess level of potential damages.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R5. HDUHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice.	SOP is being drafted and will be reviewed by the Listening and Learning Sub-Committee in December.	Dec-23	~~Dec-23~~ Mar-24	Red	18/01/2023- No update currently on AMAT. 04/03/2024 - A SOP has been drafted and submitted with the papers for the Listening & Learning Sub Committee on 6th March.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R6. HDUHB should consider the introduction of naming convention for files related to claims management. This will ease record identification issues.	This will be developed and in place by the end of March 2023.	Mar-24	Mar-24	Amber	18/01/2023- No update currently on AMAT. 06/03/2024 - No new update from AMAT.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R6. HDUHB should consider the introduction of naming convention for files related to claims management. This will ease record identification issues.	Consideration of document/ correspondence management system for legal case files.	Mar-24	Mar-24	Amber	18/01/2023- No update currently on AMAT. 06/03/2024 - No new update from AMAT.
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R7. HDUHB to review the process for the managing PTR responses to ensure the requirements of the Regulation are adhered to and that complaint responses include the necessary information.	A revised process will be produced outlining management of concerns, where a patient requests a verbal response only (local resolution and PTR). This will be incorporated into the toolkit.	Dec-23	~~Dec-23~~ N/K	Red	18/01/2023- No update currently on AMAT. 06/03/2024 - No update currently on AMAT.

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Mar-19	2019/20	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments. 28/02/2023- there is no further update on the above. 27/06/2023- confirmed at Primary Care QSE meeting that there is no further progress on this. 04/12/2023 - No further update received from Welsh Government. 28/02/2024 - No further update received from Welsh Government.
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Ensure engagement with key stakeholders as to how services set out in the strategy will be provided	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Ensure that the strategy encompasses a detailed workforce plan and is fully costed	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Use the 2023-24 budgetary information as a baseline position of the cost of primary and community care to enable the shift of resources to be reported on an annual basis	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R1. Through the planned development of its Integrated Primary and Community Services Strategy, the Health Board should: Once the strategy is approved, ensure periodic update reports are provided to the relevant committee demonstrating progress on delivery of the strategy.	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R2. The Health Board should improve oversight at Board and committee level of performance within primary care by: Increasing the coverage of primary care performance within its Integrated Performance Assurance Report	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	
Nov-23	2023/24	Audit Wales	Primary Care Follow-up Review – Hywel Dda University Health Board	Open	N/A	Primary Care	Primary Care	Director of Primary Care, Community and Long Term Care	Director of Primary Care, Community and Long Term Care	N/A	R2. he Health Board should improve oversight at Board and committee level of performance within primary care by: Increasing the focus on outcomes and experience.	Management responses and completion dates are currently being developed by the Assistant Director of Assurance and Risk and the Director of Primary Care, Community and Long Term Care.	N/K	N/K	Red	

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Feb-23	2022/23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	High	R17b. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Sep-23	~~Sep-23~~ N/K	Red	QAST update 09/05/2023 chased, awaiting progress. 03/07/2023 - QAST chased for update June 23 no update received. QAST update 30/10/23 actions chased, no update received from service. 10/01/2024 - Update from QAST = "Update 23/11/23 added to risk register". No revised date provided. 08/03/2024 - Requirement escalated in exception report to OQSEC 09/01/2024
Dec-23	2023/24	Public Service Ombudsman (Wales)	202208381	Open	N/A	Radiology	Radiology	Gail Roberts-Davies	Director of Operations	N/A	R1. a) Within 1 month of the date of this report the Health Board apologises to Mrs A for the failings identified in this report.	Reflect on the Ombudsman's Final Report and draft an appropriate apology letter. Copy of Apology Letter	Feb-24	~~Feb-24~~ N/K	Red	01/03/2024: Evidence of compliance sent to PSOW 12/02/24, await further contact from PSOW
Dec-23	2023/24	Public Service Ombudsman (Wales)	202208381	Open	N/A	Radiology	Radiology	Gail Roberts-Davies	Director of Operations	N/A	R2. b) Within 6 months of the date of this report the reporting radiologist should include a reflection on this event in their Line Manager and Clinical Lead review meeting and the imaging should be reviewed at the local Radiology Events and Learning meeting for shared discussion and learning.	Reporting radiologist to present this case to the Radiology Clinical Audit meeting within the REALM section. Case to be discussed at Reporting Radiologists Line Manager and Clinical Lead Review meeting. Minutes of Radiology Clinical Audit meeting Evidence of discussion at Line Manager and Clinical Lead Review meeting	Jul-24	Jul-24	Amber	Due 23/07/24

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Jan-16	2016/17	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	N/K	~~Apr-22~~ ~~Oct-22~~ ~~Nov-23~~ Dec-24	Red	13/10/2022 - Update from Primary Care: Optometric Advisor as the Diagnostic Treatment Centre (ODTC) contracts have been awarded to two Providers, one in Haverfordwest and the other in Llanelli. The internal process is being finalised between PC and secondary care colleagues and it is anticipated that clinics will start in November 2022. 10/01/2023 - Update from Primary Care: The internal processes have been agreed. ODTCs to use Consultant Connect to save and be able to share the findings with colleagues in HES. Prior to setting this up, the HB Information Governance (IG) team must agree/sign off a Data Processor Data Protection Impact Assessment (DPIA). HES submitted the DPIA to IG in October and despite them requesting an update on multiple occasions, they still do not have a timescale from IG. Unable to provide revised timescale. 16/01/2023 - Update from Rachel Absalom: We are awaiting confirmation from IG that we can progress and, despite repeated emails, have not received this as yet. Revised timescale is therefore unknown. Will continue to chase/raise as an issue. 22/02/2023 - Update from Rachel Absalom: Informed by IG that they would be meeting to discuss on 06/02/2023 but no response received to their requested for an update. Until IG respond, no timescale can be given. 21/03/2023 - Update from Rachel Absalom: No further progress. Still awaiting sign off of/support with a DPIA, which will allow the use of Consultant Connect in the Glaucoma pathway. Without this, we cannot share patient information and therefore, the pathway cannot commence – despite having contractors ready to go. This sign off/support needs to come from our Information Governance Team. We still have not had any correspondence from colleagues in IG, despite multiple emails from various members of the PC and Ophthalmology teams requesting it. 18/04/2023 - SBAR presented at ARAC: No expressions of interest received from providers in Ceredigion – Primary Care Optometry Team liaising with practices in this area. 16/05/2023 - Assurance and Risk Officer contacted Head of IG to ascertain progress and confirm level of input on this recommendation. No response received to date. 08/06/2023 - The DPIA was signed off in March 2023 and the contract went live from 1st June 2023. DITS Response pack June 2023: *ODTC Pathway for Glaucoma patients has last week begun to invite patients to attend an appointment with an optometric practice within primary care .* 23/06/2023 - Awaiting clarification from Head of Optometric Services on the remaining steps to progress this recommendation towards closure. 27/09/2023 - National Optometric implementation is commencing in October 2023. This will take some time to implement fully. Contracts expected to be in place December 2024. Risk to be added to Optometry risk register (Primary Care) around the risk to patient safety. 12/12/2023 - (From ARAC Paper Dec 2023): MAIN CHALLENGES = no expressions of interest received from providers in Ceredigion. Limited interest from other providers in the Carmarthenshire and Pembrokeshire areas. PROGRESS TO DATE: 1) Optometric Diagnostic and Treatment Centres (ODTC) continue in Carmarthenshire and Pembrokeshire on a limited basis allowing HB patients to be monitored in the community and referred to secondary care only if further support is needed. 2) The national Optometrist Contract reform is on a phased implementation with phase 1 rolled out in October 2023 ensuring Optometrists can support secondary care with emergency eye care in the community. The ODTC pathway is identified in phase 2 which is expected in spring 2024 to further support secondary care with its Glaucoma B patients. 3) Additional virtual sessions have been introduced with Glaucoma consultants from SBUHB to review the Glaucoma B patients processed through the ODTC pathway. NEXT STEPS: 1) Scope Glaucoma B patients to attend Friday afternoon screening sessions with technicians to be reviewed virtually in secondary care to deliver an interim process whilst awaiting the ODTC pathway to be further developed. 2) 3 virtual sessions built into SAS doctor's job plans to increase delivery to the Glaucoma pathway by 40 patients per week. 01/02/2024 - Met with OOTCs on 09/01/2024 with SBUHB Glaucoma consultant to review OOTC pathway and associated documentation in preparation for the contract reform for further OOTC development.
Jan-16	2016/17	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	~~Mar-23~~ ~~Apr-23~~ ~~Jul-23~~ ~~Mar-24~~ Aug-26	Red	13/05/2022- SDM provided revised date of March 2024. This will be depending on the regionalisation with Swansea Bay (ARCH), in principle this should cover the whole of UHB. Ceredigion discussions on Mid Wales Collaborative with Powys and Betsi- discussions taking place on Mid Wales lead for Ophthalmology to be advertised, difficulties in recruiting in Ceredigion area. 07/07/2022- Risk stratification of Glaucoma patients now complete. Work continues on outpatient templates to ensure capacity to review patient backlog. Current difficulties with staff capacity March 2023, as per Ministerial measures for addressing backlog. Meeting to take place with WG which will hopefully provide clarity on targets. 30/09/2022- Revised completion date to be kept as March 2023. A discussion has taken place with WG, they want eye care measures and MD to be implemented; the service are micro-managing capacity and booking to ensure both targets are prioritised. 9/1/2023- Meeting with team planned this month (capacity, model for delivery etc). 02/03/2023 - Planned expansion of the glaucoma service is expected to improve review response times throughout 2023. Clinical job plans to be completed by April 2023 to maximise clinic capacity. 18/04/2023 - SBAR presented to ARAC: Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. Planned expansion of the Glaucoma service is expected to improve review response times through 2023. 27/09/2023 - Investment in Glaucoma as we are now linked with SBUHB. There is continued capacity challenges between R1, routine patients and access to IVT. Revised date based on GIRFT programme. 12/12/2023 - (From ARAC Paper Dec 2023): MAIN CHALLENGES = Demand currently outweighs capacity. PROGRESS TO DATE = 1) A Risk stratification process has been implemented and patients have been risk stratified on the waiting list into category Glaucoma A, B C & D (with A being the least risk and D being the most risk). 2) 1 WTE Glaucoma consultants commenced in regional post 20th November 2023 gaining 2 additional clinic session per week for delivery to the Glaucoma D patient cohort. 3) 150 Glaucoma A patients sent to Optometrists for data capture to support virtual review clinics in secondary care and reduce the length of wait for this cohort of patients. NEXT STEPS: 1) Further risk stratification process agreed with new Glaucoma consultants to clinically validate any patient on the waiting lists with no code assigned to their record. 2) 100% delayed FU patients to be focus booked in line with priority. 3) 42 Stage 4 Glaucoma patients being clinically validated by consultant and will be prioritised for theatre following validation in line with urgency 01/02/2024 - 200 patients have been removed from 100% delayed cohort through virtual Glaucoma pathway. Validation of stage 4 GLaucoma patients is now complete.
Jan-16	2016/17	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	N/K	~~Mar-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Dec-23~~ Aug-26	Red	9/1/2023 - Prioritisation still happening (e.g. longest waits). Still don't have capacity to deliver (outweighed by demand). 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. 02/03/2023 - Improvements in follow-up waiting times will be based mainly around extended roles for optometrists which will be possible through contract reform (no date agreed as yet). Planned extension of the glaucoma service is expected to improve response times throughout 2023. 18/04/2023 - Risk stratification of glaucoma patients complete, including those on a follow-up pathway. See on Symptom and Patient Initiated Follow-up is not considered a suitable pathway for Ophthalmology patients; therefore, improvements will be based around extended roles for optometrists which will be possible through contract reform. Planned expansion of the Glaucoma service is expected to improve review response times through 2023. This is reflected in the risk action plan for 1664 in terms of reviewing the Glaucoma plan by July 2023 06/06/2023 - (Taken from DITS Response Pack June 2023) The service remains fragile and links to the request to formally merge with SB to form a regional service to strengthen the workforce and provision of patient care. 27/09/2023 - This is superseded by the R1 Eye Care Measures that were introduced (in 2019). WG have encouraged SOS of PIFU use in follow-ups and collaborating with Primary Care/Optometrists to create further new capacity. Focus on 100% delays. The HB are undertaking a full review of the workforce required internally to deliver the required capacity (multidisciplinary training). The Directorate plan to review all current Audit and Inspection tracked reports as there are concerns that a large proportion are out of date and have been superseded by Eye Care Measures and the recent GIRFT review. We accept that IVT is not formerly included in these new reports and would welcome a discussion how improvements can be captured. The Directorate have added a comprehensive Corporate level risk to Datix that encompasses all sub-specialities within Ophthalmology. 12/12/2023 - (From ARAC minutes Dec 2023) - Director of Secondary Care: The HIW recommendations pose a challenge to the Health Board; whilst the position has been improved, they have not yet been fulfilled. It will only be possible to close these HIW recommendations when patient access to the Glaucoma pathway is occurring on a consistent basis, without delays. This has strategic ramifications as well as operational and will be difficult to resolve. (From ARAC Paper Dec 2023): CHALLENGE = Demand currently outweighs capacity. PROGRESS TO DATE = 1) Additional Glaucoma clinics have been introduced with start of new consultants increasing capacity for FU patients. 2) Additional Intravitreal injection (IVT) sessions have been delivered through WLI to reduce the length of wait for this cohort of patients. 3) RACE clinic capacity has been increased to reduce the length of wait for emergency patients. 4) Phase 1 of contract reform went live in October 2023 for community optometrists trained as Independent prescribers (IP) to support Rapid Access Casualty for eyes (RACE). NEXT STEPS = 1) To commence 3 additional Glaucoma virtual clinics with SAS doctors to increase capacity for the FU cohort of patients. 2) To introduce treat and extend to IVT service to assist recovery and reduce the length of wait for patients. 3) To undertake a review of the infrastructure within the HB for IVT delivery across the HB to ensure efficient delivery of service. 4) To review RACE follow up capacity with introduction of SOS/PIFU for suitable patients to further reduce pressure on the RACE clinic 01/02/2024 - Secured 2 additional virtual clinics for Glaucoma. Treat and Extend has been completed 15.01.2024. Review of infrastructure is currently ongoing.
Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red	30/09/2022- No official response from IMTP. The UHB has a funded Glaucoma plan and diabetic retinopathy plan, which are both in place. The overarching plan for the whole service is outlined in the IMTP. To clarify with Director of Operations if this recommendation to be closed. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm that this recommendation can now be closed. 9/1/2023 - Dependent on outcome of IMTP - no response yet. 02/03/2023 - Outcome of regional clinical workshop (being held early 2023) will influence long-term model. 18/04/2023 - SBAR presented at ARAC: Further review of Glaucoma plan is scheduled due to lower than anticipated contractual interest from community-based optometrists. Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - The GIRFT requires us to form an Executive-led implementation board that is expected due to the volume of actions for GIRFT, the majority of this will be included (IVT and diabetic retinopathy are not included but are covered in the Corporate risk). There needs to be consideration of the regional model including the mid-Wales collaborative model ad this needs to be assessed for not only clinical impact, but financial surety. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Delivery of Glaucoma plan restricted by contractual interest from community based optometrists. Delivery of cataract plan restricted by availability of AVH theatre. Challenges around Regional delivery of cataract plan. PROGRESS TO DATE = 1) The Integrated Medium Term Plan (IMTP) was agreed and resourced with medium term plan for Glaucoma and Cataract delivery. 2) A Getting it Right First Time (GIRFT) review undertaken for Glaucoma and Cataract delivery with recommendations made for service improvement. 3) Cataract lists in Amman Valley Hospital (AVH) increased to 7 patients per list to provide more capacity for cataract patients. 4) Complex cataract list in GGH introduced weekly to provide more capacity for complex cases. 5) Additional cataract list introduced on a Friday p.m. bi-weekly to provide more capacity for cataract patients. NEXT STEPS = 1) To continue the delivery of the GIRFT recommendations to assist delivery and increase capacity within the HB. 2) To introduce a treat and extend pathway to the IVT service which will give further capacity to reduce the length of wait. 3) To review current delivery in AVH theatre to potentially release capacity for further cataract operations. 4) To review RACE follow up capacity and introduce SOS/PIFU for suitable patients to further reduce pressure on emergency eye services. 5) To produce a detailed delivery plan for other sub-specialities within the service to ensure all sub-specialities within Ophthalmology have a focus for improvement. 01/02/2024 - Paper on GIRFT progress submitted to SDODC Feb 2024. 12 recommendations are now completed with 18 recs progressing. Treat and extend pathway has now been launched 15.01.2024. AVH review to be undertaken when IVT service transferred to Manchester Square. Demand and Capacity review undertaken 25.01.2024 with further work needed to review sub-speciality data.
Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	~~Jul-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red	30/09/2022- No official response from IMTP. Sustainable monies have been invested into Glaucoma plan and cataracts, however there are still other areas of the service (such as AMD, plastics, paeds, VR, etc.) that require investment. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm current position of this recommendation and revised date. 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 18/04/2023 - Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There is currently a financial gap, in particular to deliver the required activity for IVT and there is a concern which could be addressed by regional working as to the reliance on high-cost locum support in the HB, therefore a further regional meeting is to be held to look primarily on-call and also on joint working. 12/12/2023 - (From ARAC Paper Dec 2023): CHALLENGES = To work within agreed financial budgets. PROGRESS TO DATE = 1) Sustainable monies have been invested in the Glaucoma, Diabetic retinopathy (DR) and cataract sub-specialties which has improved the DR delivery and has ensured the Glaucoma pathway has made steps towards improvement. 2) Funding has been agreed for the changes to infrastructure needed to accommodate the IVT service back to Pembrokeshire to improve travel for patients and staff and potentially free up AVH theatre for further cataract surgery. 3) Short term funding has been agreed for the delivery of additional IVT lists whilst the sustainable capacity is developed. 4) Short term funding has been agreed for outsourcing to reduce waiting times, whilst a sustainable solution is worked through NEXT STEPS: 1) To secure permanent positions for clerical staff (sustainable funding has been identified within budget) to continue the delivery of the DR and Glaucoma pathways, where significant clerical input is required. 2) To secure further Glaucoma practitioners (sustainable funding has been identified within budget) to expand the Glaucoma service and 'grow your own' specialist practitioners for future service delivery. 3) To introduce the new biologic pathway across the HB and introduce treat and extend, which will reduce costs. A proportion of these savings could be used to secure longer term funding for IVT service development. 4) To agree outsource providers for the delivery of additional cataract operations. 01/02/2024 - IVT: new Biologic pathway introduced on 15.01.2024 and outsourcing for cataract operations due to commence Feb 2024.

Sep-19	2019/20	Delivery Unit	All Wales Review of progress towards delivery of Eye Care Measures	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Mar-23~~ ~~Sep-23~~ ~~Dec-23~~ Aug-24	Red	13/05/2022- Honorary contract in plan, and substantive Consultant Ophthalmologist to start in March 2023 (from New Zealand) . No further progression on the collaboration with Shrewsbury & Telford . Mid Wales clinical lead to be readvertised. 30/09/2022- We have successfully recruited 2 speciality doctors and 2 locum consultants. A second honorary annual contract with Swansea Bay glaucoma consultants is in progress via ARCH. The midwales (Powys and Betsi) clinical lead was readvertised with no applicants. SDM to meet with the County Director Ceredigion for next course of action. 02/03/2023 - Regional clinical view is that without central prioritised investment, it would be difficult to attract appropriately qualified skilled individuals who are able to be recruited into centres of excellent elsewhere across the UK. 18/04/2023 - Update from SBAR presented at ARAC: Between September – November 2022 the service has successfully recruited two locum consultants and four speciality doctors. A second consultant with an interest in glaucoma has been awarded an honorary contract to continue to support this service. Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There has been further successful recruitment at consultant level, however further recruitment needs to be considered at joint regional posts. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Recruitment of substantive consultants with currently 4 substantive consultants within the HB. Recruitment of nursing staff with Ophthalmic experience. Recruitment of Nurse injectors for IVT service. Recruitment of Optometrists with experience for delivery of ODTC pathway. PROGRESS TO DATE = 1) Ophthalmology has successfully recruited a fourth substantive consultant with an interest in plastic surgery strengthening the substantive team. 2) The substantive consultant team is supported currently by 1 WTE locum Glaucoma Consultants from SBUHB, 4 locum consultants across the HB and 1 agency consultant which supports the current substantive posts with service delivery. 3) Tysul ward in GGH have recently successfully recruited another 3 WTE nurses which will ensure a more robust nursing model in Ophthalmology. NEXT STEPS = 1) To review current consultant job description and release to advert. 2) To continue development of ophthalmic training programme for nursing staff to make ophthalmology nursing jobs more appealing. 3) To develop the IVT nurses skills and identify a career progression for this cohort of nurses to make the job role more attractive. 4) To scope the introduction of a training pathway for outpatient nurses supporting ophthalmology clinics. 01/02/2024 - Consultant job description is under review.
Jan-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ ~~Apr-22~~ ~~Jun-23~~ Aug-26	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update when HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found. 14/10/2022 - Update from Joao Martin: LHBs have not yet received the OpenEyes UAT for testing. Believed to be pending on CRNs duplicates issues and last Monday's test was unsuccessful. Unknown when this will be resolved nationally. We do meet with the National Team every Monday and I expect clarification on some of the issues next week. Further guidance may be provided at the National Programme Board at the end of month. 18/05/2023 - Update from Head of Digital Programmes: At national level the governance of the EyeCare project is transitioning from Cardiff and Vale to DHCW, this raises some uncertainty around the national plan during the transition, discussions are ongoing to clarify. At local level some concerns have been identified with the DPIA for version 6 of OpenEyes, but work continues with Information Governance, the national project team and Ophthalmology to address the concerns in readiness for when the transition at national level is complete, which is expected in Q3 this year 06/06/2023 - (Taken from DITS Response Pack June 2023) - This continues to be delayed and we are awaiting a "Go Live" date. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = The implementation of the National Electronic patient record (EPR) was awarded to Cardiff and Vale. This project was not delivered due to concerns around governance. Digital Health and Care Wales (DHCW) have now commenced a review of how the EPR can be delivered across Wales. PROGRESS TO DATE = 1) The DHCW have undertaken a review of the delivery and time lines for the 'Open Eyes' project with a view to re-start in April 2024. 2) Funding has been awarded from the DHCW for the recruitment of a Band 7 project manager to support the 'Open Eyes' project. 3) An applications support manager is in post for the 'Open Eyes' project. 4) A regional approach to roll for the 'Open eyes' project with Swansea Bay has been agreed and a plan of delivery has been finalised. NEXT STEPS = 1) Confirm how DHCW are going to deliver this project. 01/02/2024 - Update from DHCW. National Eyecare Digitilisation Programme transition Board meeting held on 22/01/24 with proposed options analysis: 1 - Cardiff & Vale retain the contract with Delivery partner, 2 - A new procurement, 3 - In-house development of digital eyecare solution for Wales , 4 - Commission NHS Education Scotland to develop solution for Wales, 5 - Hybrid procurement to cloud host plus in-house development team. Timescale revised to reflect minimum 18 month turnaround, depending on option chosen.
Mar-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Aug-22~~ ~~Mar-23~~ ~~Jun-23~~ ~~Mar-24~~ Aug-24	Red	08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Positive progress being achieved in the delivery of Ministerial measures for the 52/104 week waiters. Further work underway to deliver additional weekend clinics to reduce the backlog of people awaiting appointments. This will continue until approximately June 2023 at present. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Template and job plan redesign has been completed to ensure outpatient activity is protected whilst allowing emergency eye services to continue. Positive progress being achieved in delivery of Ministerial Measures requirements for the 52/104-week pathway measures. Balancing the Ministerial Measures with the Eye Care Measures due to the backlog continues to be a challenge, however, through close micro-management of all available clinics and capacity we anticipate further improvement into 2023. 12/09/2023 - Current focus on 2 high risk areas: Intravitreal Therapy service - additional lists undertaken and whole pathway being reviewed (15 week breach has been reduced to 6 week breach) and an SBAR for this service is currently in draft. Glaucoma - Recent ARCH meeting with Swansea Bay UHB identified areas for improvement. Alongside GIRFT review, several additional actions identified. Several actions identified - Eye Care steering group due to meet November 2023. 2) To employ the Band 7 project manager. 3) To continue to develop the platforms for Glaucoma delivery to align with Swansea Bay HB. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Balancing the Ministerial Measures with the Eye Care Measures continues to be challenging. PROGRESS TO DATE = 1) The Glaucoma service is developing further capacity with the introduction of 1.0 WTE Glaucoma consultants, additional virtual review clinics for SAS doctors and 13 optometrist providers supporting virtual clinics to increase capacity. 2) Additional IVT lists have been introduced to reduce waiting times within this sub-specialty. 3) The Diabetic Retinopathy (DR) pathway has successfully reduced the pressure on secondary care services by sending patients to Optometrists in primary care for their yearly review. NEXT STEPS = 1) Secondary care technician clinics to be introduced to provide data capture for virtual review in secondary care as an interim support to the current ODTC pathway. 2) Glaucoma C patient pathway to be developed for general clinics to increase capacity for this cohort of patients. 3) A review of infrastructure for the IVT service to be undertaken to potentially identify further capacity for delivery. 4) Introduction of treat and extend protocol for IVT to be rolled out HB wide to assist with the development of further capacity. 5) To further develop delivery of DR pathways in Ceredigion ensuring delivery of care close to home for all HB patients 01/02/2024 - 2 additional virtual Glaucoma clinics identified for potential start date April 2024. IVT service: displaced by RAAC is being transferred to Manchester Square, Milford Haven on 19.02.24 which will provide an IVT service back in Pembrokeshire and gain 20 further injections per week. New Biologic pathway launched on 15.01.24 alongside a treat and extend pathway to gain future capacity. Ongoing review of service to increase capacity.
Mar-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ ~~Jun-23~~ ~~Mar-24~~ Sep-24	Red	08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Investment into Amman Valley has supported the repurpose of OPD for wAMD to allow the DSU to undertake high volume Cataract lists. Sustainable monies have been invested in the Glaucoma and Cataract Plans, however, there still remains other areas of the service (AMD, Paediatrics, VR, plastics) that require investment. On Demand Training Centre (ODTC) Contracts have been awarded to two providers Carmarthenshire and Pembrokeshire. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. Pan-Wales clinical view that central investment in estate, infrastructure and workforce is required to develop a sustainable long- term Ophthalmology Service model. 12/09/2023 - wAMD workshop identified several areas of improvement. Ophthalmology team has reviewed demand and capacity for this service. We have also reviewed the biologic and biosimilar pathways with a view to the introduction of a virtual process to reduce pressure on this service. Regional discusssions around a workforce development plan which will inform the 3-year service development plan. Further ODTCs to be scoped once contracts/funding have been confirmed. 12/12/2023 - (From ARAC Dec 2023 Ophthalmology Deep Dive Paper): CHALLENGES = The current Ophthalmology service is delivered out of 9 sites which presents a challenge when staffing all 9 sites across 3 counties. PROGRESS TO DATE = 1) The delivery of data capture from 13 optometrist's providers ensures all Glaucoma A patients can access services closer to home. 2) The Diabetic Retinopathy (DR) pathway has successfully been introduced ensuring patients can access care closer to home as this is delivered in primary care with a small secondary care element. 3) Phase 1 of the National Optometrist contract reform commenced in October 2023 which ensures that patients with red eyes no longer need to attend RACE and can access care with specialist trained optometrists locally. NEXT STEPS = 1) With further roll out of the National Optometrist contract reform, the ODTC pathway will potentially be delivered in primary care ensure all Glaucoma B patients can access services closer to home. 2) The introduction of DR pathway to Ceredigion will ensure delivery of care closer to home for this cohort of patients. 3) A review of infrastructure for IVT service to ensure delivery of this service in all three counties, currently scoping delivery in Pembrokeshire after the service was moved due to the RAAC issues in WGH. 01/02/2024 - Met with ODTCs on 09/01/2024 with SBUHB Glaucoma consultant to review ODTC pathway and associated documentation in preparation for the contract reform for further ODTC development. Displaced IVT service to move back to Pembrokeshire 19.02.2024.
May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12h. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	June 2022 -Recommendation was accepted by HDUHB - Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	Jun-22	~~Oct-23~~ ~~Dec-23~~ ~~Mar-24~~ Apr-24	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. 09/06/2023 - The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7). The Orthoapedic Portfolio Management team and CL are fully supportive of such expansions. 25/09/2023 - Orthopaedics has a clear understanding about the demand within the service currently and data reports have been developed in conjunction with Informatics and Performance teams to assist with the management of patient referral to Treatment pathways and improve efficiencies across the stages. The service monitors and reports on RTT data, KPI's and governance in order to reduce duplication and avoid pathway variation, with the aim of improving standardisation of care. Work to increase activity across the Health Board continues with scrutiny around addressing inefficiencies and maximising the use of resources. Weekly Health Board wide theatre scheduling meetings have been established and are used to review and challenge utilisation of lists. A focussed Trauma & Orthopaedic specific theatre utilisation meeting is also held to discuss and review the ability to increase sessions across sites on an ongoing basis. BGH currently has an allocation of 5 main theatre sessions per week which is in line with pre-covid capacity. WGH currently has an allocation of 7 main theatre and 3 day case theatre sessions per week which is 4 main theatre sessions below the pre-covid allocation. PPH currently has an allocation of 12 main theatre sessions per week which is 8 sessions below the pre-covid allocation. However we also have 7 day case sessions available to us through the Demountable Day Unit which we did not have pre-covid. Delivery is directly impacted by the Health Board's current financial position and the lack of recovery money that has been made available. Andrew Carruthers, Director of Operations, is the lead for the Health Board on the South West Wales Regional Orthopaedics work between HDUHB and SBUHB. Some progress has been achieved in recruitment of theatre staffing and Consultant Anaesthetists but levels have not increased enough to allow an increase in elective theatre sessions. Scheduled Care Risk 1657 highlights the risk around non-delivery of ministerial priority expectations of planned care recovery ambitions due to uncertain resource, availability of workforce and UEC pressures which continue to impact on available capacity. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. 15/01/2024 - Further additional in patient capacity has been created from the 18th January 2024 at PPH main theatres at which there will be 16 theatre sessions per week allocated to Orthopaedics. This additional capacity has arisen following relocation of some theatre staff from WGH and from DSU PPH. The pre-Covid funded theatre allocation was 20 session per week. The further lift and shift of theatre and anaesthetic staff from DSU PPH is planned with staff requiring enhanced training which is ongoing. 26/02/2024 - During March 2024, the Orthopaedic service will be undertaking a "perfect month" supported by the NHS Executive (though this has now reduced to 3 weeks due to planned industrial action during the final week of March) during which time it will return to 20 theatre sessions per week. This has been achieved with the above actions (lift and shift etc) and some specialties have been relocated to other sites during this time. During the "perfect month" theatre/patient throughput efficiencies will be monitored against national targets and GIRFT recommendations with a view to enhance overall efficiency within the service. It has been confirmed that from 1st April, there will be 18 theatre sessions per week at PPH. BGH remains at 5 sessions per week, its original pre-Covid theatre template and WGH will remain as a Day-Case facility during March. It is anticipated that during April a dedicated Scheduled Care overnight stay facility on which Orthopaedics will have beds, will increase the patient case mix that can be treated on this site. However theatre sessions per week will remain at 11. Expansion towards 3 day sessions and 6 day working is dependent on additional funding and, thereafter, workforce recruitment. Regional working with SBUHB has resulted in theatre capacity being offered to HDDUHB at Neath Port Talbot Hospital, however, due to the complexity of patients on the HDDUHB waiting list currently waiting more than 156 weeks, it has been difficult to identify appropriate patients to utilise this facility.

May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12i. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	June 2022 -Recommendation was accepted by HDUHB - Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	N/K	~~Oct-23~~ ~~Dec-23~~ ~~Feb-24~~ Apr-24	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7) 09/06/2023 - Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services. 25/09/2023 - A number of actions are replicated within recommentation 12. An EQUIP (Enabling Quality Improvement in Practice) project is currently being run by Pre-assessment and focusses on streamlining processes Health Board wide due to a lack of consistency. There continues to be discharge delays for medically fit patients due to delays in social services assessments. Work is being undertaken through NHFD groups around early mobilisation and is captured through NHFD reported KPI's. This work also advises on the reasons for being unable to mobilise patients. Updates to be obtained from NHFD groups and Pre-assessment EQUIP project. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. A Task and Finish Group has been established to standardise the Pre-assessment process across the Health Board - increasing efficiency and the flow of patients across the HB to where theatre and surgical staff capacity exist, thereby utilising resources more effectively. An all Wales group is also being established to assist facilitation of Regional work 26/03/2024 - Data around multiple pre-assessments prior to surgery and pre-assessment timeliness is being collected as part of the "perfect month" in March 2023 to further support improvements within the pre-assessment service.
May-22	2022/23	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R12j. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	June 2022 -Recommendation was accepted by HDUHB -Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	Jun-22	~~Dec-23~~ ~~Feb-24~~ Apr-24	Red	30/06/2022 - Pre-operative assessment pathways subject to current review in line with NHS Wales IP&C guidance 09/06/2023 - Pre-operative assessment pathways are subject to current review in line with NHS Wales IP&C guidance and is being undertaken through an EQuIP project. This is not a rate limiter for Orthopaedics. 25/09/2023 - EQIP project in pilot phase, with the aim of standardising all documention across the Health Board. The pilot commenced at BGH on 11/9/2023 and rollout will continue at PPH & GGH week beginning 9/10/2023, then finally at WGH the week beginning 16/10/2023. 3 month pilot. Feedback will be expected through the Scheduled Care QSESC directorate meetings. 15/01/2024 - As part of the regional Orthopaedic work with SBUHB there is a group looking at pre-assessment across the region.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	N/A	R2. HDUHB to establish a robust mechanism for capturing procedure level data of impatient day case and outpatient procedures.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ ~~Jan-24~~ Mar-24	Red	01/06/2023 - Communication underway with Clinical Coding Team and Gareth Beynon 06/09/2023 - Data received, to be analysed and discussed in the joint business meeting on 05/10/2023 20/11/2023 - Meeting has had to be rescheduled due to availability (date to be confirmed). 20/01/2024 - Clinical lead is analysing data to simplify coding methods in our specialties, follow up meeting to take place in February to agree on final list of clinical codes. Clinical Coding team have access to a weekly catch up with service management and the clinical lead, for any issues that arise in relation to coding.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	N/A	R3. HDUHB to develop a relationship between clinical coders and consultants to improve data collation.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ ~~Jan-24~~ Mar-24	Red	01/06/2023 - Communication underway with Clinical Coding Team and Gareth Beynon 06/09/2023 - Data received, to be analysed and discussed in the joint business meeting on 05/10/2023 20/11/2023 - Meeting has had to be rescheduled due to availability (date to be confirmed). 20/01/2024 - Clinical lead is analysing data to simplify coding methods in our specialties, follow up meeting to take place in February to agree on final list of clinical codes. Clinical Coding team have access to a weekly catch up with service management and the clinical lead, for any issues that arise in relation to coding.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R5. WGH to review emergency appendicectomy minimal access rates and develop an improvement strategy.	Awaiting management response.	Jun-23	~~Jun-23~~ ~~Jan-24~~ Mar-24	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, SCP to lead on the Audit at WGH and has started. Andrew Burns and Dawn Davies are collecting the data. 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint buisness meeting on 25/01/2024. Audits are to be ongoing.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R6. GGH to review emergency readmission within 30 days following emergency appendicectomy and develop an improvement strategy.	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ Mar-24	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, ANP's to lead on the Audit at GGH and have started collecting the data. 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint buisness meeting on 25/01/2024
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R7. BGH to review their Emergency laparotomy pathway in order to improve length of stay rates.	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ Mar-24	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, Mr Soare to lead on the Audit at BGH 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - This has been delayed. Audit data is being collected by the team but it has been rejected by the clinical audit team. This has been escalated to the clinical director for scheduled care.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R8. HB to review the care of patients having emergency laparotomy at WGH at this site is an outlier on the NELA data with an extremely high 30-day mortality rate	Awaiting management response.	Jul-23	~~Jun-23~~ ~~Jan-24~~ Mar-24	Red	01/06/2023 - Meeting being arranged with the Glangwili General Hospital site triumverate, Scheduled Care triumverate team and the General Surgery Clinical Lead/Management team 20/11/2023 - Ongoing audits being presented in quarterly joint business meeting. Data presented at first meeting. Recommendations from next meeting in January to be reviewed. 20/01/2024 - Next set presentation is to be presented at the next joint business meeting on 25/01/2024. Audit will be ongoing.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R9. HB should develop plans to implement and staff dedicated surgical SDEC on acute sites	Awaiting management response.	Aug-23	~~Aug-23~~ Mar-24	Red	06/09/2023 - Meeting being arranged with the Glangwili General Hospital site triumverate, scheduled care triumverate team and the General Surgery Clinical Lead/Management team. Due to conflicting pressures, this meeting has been difficult to arrange and we will pursue this for September. It is high on our agenda as an action. Meeting was planned for September but has been delayed, due to the WGH position. 20/11/2023 - Delayed due to RAAC/bed issues in WGH. 20/01/2024- Meetings have commenced between clinical leads, scheduled care management and unscheduled care management at GGH. Two meeting have taken place in December 2023. Unscheduled care pressures and industrial action have delayed further meetings. Further meeting to be arranged for February 2024.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R12. HB should develop both the pelvic floor service and concentrate elective IBD surgery in the hands of fewer surgeons to develop and maintain expertise.	Awaiting management response.	Aug-23	~~Aug-23~~ ~~Oct-23~~ Mar-24	Red	01/06/2023 - Conversations are underway - meeting with SBUHB to look at regional pathway 06/09/2023 - Hywel Dda has a health board IBD and functional LGI lead. Meeting with SBUHB to look at regional pathway in September, after summer holidays 20/11/2023- Initial meeting with Bladder and Bowel Service held. The meeting has shown this to be a complex pathway that requires a longer timescale for completion.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R14. HB to review their internal criteria for day surgery and benchmark them against this outlined in the National Day Surgery Delivery Pack.	Awaiting management response.	Jun-23	~~Jun-23~~ ~~Nov-23~~ Mar-24	Red	01/06/2023 - Meeting being arranged with relevant Portfolio teams to discuss Day Surgery criteria / Pre-Assessment 06/09/2023 - First meeting has taken place with relevant Portfolio teams to discuss Day Surgery criteria / Pre-Assessment. A follow up meeting needs to be arranged once we have had the discussion in our joint business meeting on 05/10/2023. 20/11/2023 - Ongoing work which is quite complex due to multiple factors (e.g. number of people involved across multiple disciplines)
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R18. HB should conduct a review of the preoperative assessment system and take action to implement the Guidance from CPOC of Pre-Operative assessment and optimization.	Awaiting management response.	May-23	~~May-23~~ ~~Nov-23~~ Mar-24	Red	01/06/2023 - Picked up alongside reccomendations 14,15 & 16 20/11/2023 - Recs 15 and 16 now completed. See update for Rec 14.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R19. HB to review pathway for patients with diabetes and to consider developing a preoperative diabetes team led by nurse specialists.	Awaiting management response.	May-23	~~May-23~~ ~~Nov-23~~ Mar-24	Red	01/06/2023 - Picked up alongside reccomendations 14,15 & 16 20/11/2023 - Recs 15 and 16 now completed. See update for Rec 14.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R20. Action Plan to increase operating capacity to above pre-Covid levels in order to deal with the backlog of patients waiting for surgery.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ Mar-24	Red	01/06/2023 - Strategic Group underway to discuss additional capacity on the Glangwili Hospital site for the complex upper GI patients 06/09/2023 - Strategic Group underway to discuss additional theatre and bed capacity on the Glangwili Hospital site for the complex upper GI patients. This is dependent on unscheduled care patient flow pressures. 20/11/2023 - Delayed due to RAAC plank/bed issues.
May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	N/A	R22. HB to review the current processes for obtaining and documenting patients consent for Surgery.	Awaiting management response.	Aug-23	~~Aug-23~~ ~~Dec-23~~ N/K	External	01/06/2023 - Conversations underway within the Health Board and Welsh Government in relation to E-Consent 06/09/2023 - There is a national programme underway in relation to E-Consent 18/01/2024 - Recommendation is currently outside the gift of the Health Board as it is reliant on the rollout of a national E-consent programme.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack /Marta Barreiro Martins	Director of Operations	N/A	R3. Review the line management structure and explore whether a MDT cataract or whole ophthalmology surgical team across all areas (OP, day case, theatres, preop, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care	1) Workforce review to be undertaken by head of nursing and Senioer Nurse Manager 2) Workforce development plan to be written and implemetnted.	Apr-24	Nov-24	Amber	16/11/2023 - New Ophthalmology management structure inclusive of Nursing representation will work closely with Clinical teams to review theatre delivery. Workforce development plan to be developed with Swansea Bay HB.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R4. Appoint a formal clinical lead who has enough time in their job plan, and appropriate stable, senior service manager support to deliver.	1) Clinical lead JD to be reviewed and updated 2) Clinical lead role to be advertised for recruitment	Apr-24	Apr-24	Amber	16/11/2023 - JD for Clinical lead to be circulated to all elegible staff within the service as an expression of interest for this role.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R5. Review the reasons with local optometrists as to why conversion rates lower than should be and take action to improve. Use a formal shared decision making tool, such as the NHS England one, in primary care	1) Review data for conversion rates 2) develop decision making tool for use in primary care	Jan-24	~~Jan-24~~ ~~Feb-24~~ Mar-24	Red	27/09/23 Preliminary meeting held with Optometrists. 02/01/2024 - Updated decision making tool currently being reviewed and agreed.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R6. Hospital optometrists and nurses to undertake phone calls to screen out patients who don't need surgery and to counsel and prepopulate pre-op assessment documents at same time for those who do go ahead; consider using a health questionnaire.	1) Telephone assessment document to be developed. 2) Telephone assessment of patients on backlog to be undertaken. 2) Pre-operative documentation to be developed.	Apr-24	Apr-24	Amber	27/09/23 Pre-operative assessment documentation currently being reviewed. 02/01/2024 - EQIP programme to look at delivery of pre-opreative assessment (starting 7th Novembet 2023).
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R7. Do all cataract pre-ops as a one stop, even GAs and complex cases, especially for patients living far away – aim for no more than 3 months before the date of surgery. For those done a long time ago or second eyes, do phone assessments and get "obs" from local GP or pharmacist.	1) One stop cataract pathway to be developed. 2) One stop cataract pathway to be introduced.	Apr-24	Apr-24	Amber	Clinic area identified for potential one stop cataract clinics with access to the required equipment for assessment. Staffing and processes to be scoped. Enabling Quality Improvement in Practice (EQIP) programme successful bid starts in November
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R8. Expand the staffing of pre-op assessments and the remit of the MDT, with techs and HCSWs doing more of the routine work up and biometry, and practitioners including nurses, orthoptists and optometrists able to undertake the fundal checks and consent; obtain IOLMaster 700s in all relevant sites to support the wider range of those who can undertake biometry. Consultants need to be present in the preops to give short input to all patients.	1) Workforce review to be undertakenby head of Nursing and Senior Nurse Manager 2) Workforce development plan to be written.	Apr-24	Nov-24	Amber	27/09/23 - HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R9.Consent patients for both eyes at the first eye preop visit. Consent by phone for second eye or very long waiters already assessed and on list and post consent form out to read +/- sign at home.	1) Review of current consent process for bilateral cataracts 2) Review of current consent forms to align with above process.	Apr-24	Apr-24	Amber	27/09/23 Review of consent process currently being explored with HB consent lead.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R11.Offer ISBCS to all suitable patients..	1) Review current process for Bilateral cataract delivery. 2) Develop pathway for Bilateral cataract delivery. 3) Implement delivery of Bilateral cataract operations.	Apr-24	Nov-24	Amber	Documentation being developed and to be discussed at upcoming QSE meeting. All documentation will need to go through Scheduled Care Working Controlled Documentation group (WCDG).
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R12. Introduce standardised risk (in line with College guidance) and priority ratings for cataract surgery and change waiting list forms to support this	1) Review current waiting list forms and agree clear priority ratings. 2) Develop protocol to align with waiting list forms with clear priority ratings. 3) Implement new waiting list forms.	Apr-24	Apr-24	Amber	16/11/2023 - Any change to documentation will need to go through WCDG

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R14. Create a protocol on managing co-morbidities based on GIRFT/RCOphth guidance, simplify relevant pre-op and on the day of surgery documentation in line with this and train staff to implement.	1) Identify patients with co-morbidities (e.g.via telephone screening) 2) Agree a pathway for patient with co-morbidities prior to theatre attendance (GGH and BGH theatre)	Apr-24	Apr-24	Amber	27/09/23 Pre-assessment process and documentation currently being reviewed.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R15. Introduce high flow principles and processes to cataract lists and patients of ANY complexity to drive higher numbers of cases in all lists. Send for patient early enough to ensure they are ready in the anaesthetic room to enter theatre once the last case finished.	1) Review BGH and GGH suitability for high flow lists 2) If environment is not deemed suitable review process for current delivery of complex patients. 3) Review patient pathway and reduce delays with patient arriving in theatre.	Apr-24	~~Apr-24~~ May-24	Amber	Work undertaken to increase to high volume lists in AVH. Patient lists have been increased from 5 to 6 and now from 6 to 7 patients per list. Review of processes would need to be undertaken to introduce high volume lists on other sites as recommended.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R16. Do cataracts on cataract only lists and do GAs on GA only or primarily GA lists.	1) Review list of procedures delivered on theatre lists 2) Ensure dedicated cataract only lists are formulated on all three sites.	Apr-24	Apr-24	Amber	We currently have mixed lists mainly GA however LA patients added to fill the lists rather than lists go under utilised. 02/01/2024 - To meet with main pre-assessment lead to discuss streamlining process for GA patients.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R17. Non-medical MDT staff admitting the cataract patients should be trained and empowered to mark the eye, check or take consent etc – consider whether to involve the clinical nurse and optometrist practitioners and/or train the day surgery staff. Do not do routine obs on the day.	1) Review staff training to mark the eye with Senior Nurse Manager. 2) Review process for baseline obs	Apr-24	Apr-24	Amber	27/09/23 Workforce development plan commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R18. Eliminate the surgeon preop ward rounds. Trust each others' assessments OR put the patients on the same consultants list as assessed them at one stop. Consultants then only check notes (ideally before list begins or before the day of surgery) and greet and reassure the patient, ideally in the anaesthetic room. If really necessary to check the eye, provide a hand held slit lamp.	1) Consent patient in pre-assessment prior to procedure 2) Develop protocol for pre-checks prior to surgeon review on the day of operation.	Apr-24	~~Apr-24~~ May-24	Amber	27/02/23 Pre-operative processes currently being reviewed.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R19. Stagger greeting of patients by surgeons, so that there is no delay to the start of surgery on the list. Ensure there is a "golden patient" listed first. Do not make patients wear gowns and hats.	1) Stop use of hats and gowns for patients where possible. 2) Consent patients in pre-assessment.. 3) Staggered arrival times can be introduced when patient consented in pre-assessment.	Apr-24	~~Apr-24~~ Nov-24	Amber	27/09/23 SNN to review theatre processes with theatre team. Theatre review days are booked.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R21. Do not have patients climbing on and off a trolley in the operating room - position patients in the anaesthetic room and wheel the patient in and out on trolley or couch.	1) Check if theatre trolleys are fixed in theatres or if surgical trolleys can be wheeled in AVH- BGH- GGH-	Dec-23	~~Dec-23~~ ~~Jan-24~~ ~~Feb-24~~ Apr-24	Red	SNM to review theatre processes with theatre team.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R22. Organise some HVLC lists pilot and prove the principle, then roll out the learning. Use those consultants particularly who have done this elsewhere and consider using senior trainees from other health boards where available. Consider a "cataractathon" or "cataract month" to start – ABUHB have done this.	1) Scope outsourcing options. 2) Scope costs and possibility of cataractathon within own HB.	Apr-24	Apr-24	Amber	Experienced Consultant who has undertaken Cataractathon now employed in a substantive post to support and advise.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R23. Agree more cases per list and do not finish early or start late routinely or take a leisurely approach. Patients are waiting a long time for sight restoring surgery and this must drive everyone to operate efficiently and optimise surgical time. If high volume surgery with high numbers are achieved, early finish should be acceptable as a bonus to teams who achieve this.	1) Review start and finish times of theatre lists. 2) Feedback start and finish times to Consultants at QSE meeting. 3) Reduce delays to theatre lists following audit detail and discussion. 4) re-audit start and finish times.	Apr-24	Apr-24	Amber	16/11/2023 - SNM to review theatre processes with theatre team. Theatre start and finish times. Theatre attendance at QSE.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R24. Rationalise cataract surgery to only units that are, or can be changed to be, suitable for high flow. Move other work out of the most suitable units to accommodate this.	1) Move IVT out of AVH OPD back to Pembrokeshire. 2) Move IVT service out of day theatre into AVH OPD. 3) Increase cataract delivery through AVH theatre.	Apr-24	Apr-24	Amber	Review of IVT service in AVH to clinic rooms to create further capacity being scoped.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R25. Urgently explore greater regionalisation and ability to offer cataract surgery for the region at Swansea as a surgical hub.	1) Explore outsourcing options with Swansea Bay.	Apr-24	~~Apr-24~~ May-24	Amber	27/09/23 - Regional post secured for Glaucoma patients. Exploring further regional options with Swansea Bay. 01/02/2024 - Exploring further regional options with Swansea Bay.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R26. Non-medical MDT staff should be trained and empowered to routinely prep the skin with iodine, apply the drape, insert speculum, position microscope for surgeon, draft the operation note, print the op note/letter/discharge medication.	1) Train staff to prep the patient for surgery to reduce delays -Iodine -Drape -Speculum -Position microscope	Apr-24	Nov-24	Amber	27/09/23 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R27. The unit should undertake a whole MDT workforce review, pushing everyone to the top of their licence and assessing numbers and training requirements for cataract and HVLC.	1) Scope current workforce. 2) Scope current workforce competencies. 3) Develop a training pathway and competency assessment framework.	Apr-24	Nov-24	Amber	27/09/23 - HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R28. RNOH/GIRFT recommends use of the Modelling software available RCOphth cataract workforce calculator.	1) Establish demand and capacity tool for cataract service. 2) Increase capacity through HVCL and inreased delivery of cataract lists. 2) Develop trajectory for recovery.	Apr-24	Apr-24	Amber	27/09/23 - Workforce planning in line with the RCOphth will be undertaken alongside the workforce development plan discussed with Swansea Bay.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R29. Use both efficiency/finance aspects and patient safety issue to agree to source and start using pre-loaded lenses .	1) Establish which lenses the clinicians want to trial. 2) Scope with procurement. 3) Undertake trial and feedback to procurement. 4) Procure preferred lenses across site.	Mar-24	~~Mar-24~~ Apr-24	Amber	27/09/23 - Three companies identified for trial and 4 doctors who are going to participate. 02/01/2024 - Trial of pre-loaded lenses currently being undertaken with one trial completed and second trial to commence January 2024.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R31. Do not duplicate recording the same data on both paper and IT records	1) Review current process on paper and electronically. 2) Remove any steps that are duplicating information.	Jan-24	~~Feb-24~~ Mar-24	Red	27/09/23 Senior Nurse Manager for Ophthalmology shadowing all theatre processes to discuss changes required with theatre Sisters.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R33.Recommndation 33: Ensure regular internal cataract audits are done looking at PCR AND visual loss for the whole unit and individual surgeons	1) Review current audit data and identify gaps. 2) Establish audit timetable. 3) Feedback audits at QSE.	Apr-24	~~Apr-24~~ Jun-24	Amber	02/01/2024 - Discussed at QSE meeting and audit timetable to be agreed.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R34. Undertake regular observational audits to measure and monitor the flow in cataract lists - Consultants and managers to go and observe the timings and flow of other consultant lists.	1) Review theatre lists and udertake initial audit. 2) Present report at QSE. 3) Repeat audit 6 monthly and report back to QSE.	Apr-24	Apr-24	Amber	27/09/23 Senior Nurse Manager for Ophthalmology has observational dates booked to review all theatre processes.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R35. Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Apr-24	Nov-24	Amber	27/09/23 - Preliminary discussion held with ward Sister.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R36. Undertake a pilot of patient self dilating and, if successful, roll out to all suitable patients.	1) Discuss self dilation with ophthamology team around logistics. 2) Meet with Pharmacy to explore possibility and risks of self dilation.	Apr-24	Apr-24	Amber	27/09/23 - Preliminary discussion held with ward Sister, next steps, to be explored with pharmacy.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R37. Consent must be taken before the day of surgery. Consider supporting the primary care optometrists to do more and share the consent form. Consider posting the consent form out to patients in advice, nurses and optometrists in clinic to be trained to consent and all consents done within the one stop clinic.	1) Explore consenting patient at pre-assessment. 2) Review consent form format and update as necessary. 3) Explore nurse led consent.	Apr-24	Apr-24	Amber	27/09/23 - Review of consent process started with Head of Consent for the HB.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R39. Review methodology for ophthalmology/glaucoma activity and waiting times data collection, validation and sense checking and ensure all of the relevant team have sight of this and can discuss any actions required.	1) Review of Demand and Capacity. 2) Review of outpatient delivery. 3) Increase primary care delivery to Glaucoma A and B patients.	Feb-24	~~Feb-24~~ Mar-24	Red	16/11/2023 - Work has commenced on coding and data analysis.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R41. Ensure tests are done by techs and HCSWs were possible, ideally in layouts which support high flow, freeing up MDT clinicians in primary, community and secondary care to be clinical decision makers.	1) Review tech support in secondary care to increase virtual capacity 2) Continue to increase patient flow through Optometrists for Glaucoma A&B.	Feb-24	~~Feb-24~~ Mar-24	Red	Currently 8 Optometrists hold a higher certificate with another 15 Optomotrists currently being developed in the HB.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R42. Ensure accurate data is regularly reported on the performance of referral filtering as well as ODTC's to drive improvements – as well as the % of first hospital glaucoma attendance discharge, what % of patients are kept out of new hospital visits by the repeat measures and ODTC refinement separately?	1) Discuss referral refinement delivery and delivery with primary care colleagues. 2) Undertake agreed audit of referral pathway. 3) Feedback data at QSE.	Apr-24	Apr-24	Amber	27/09/23 - Review of data collection and referral management has commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R43. Ensure consistent risk stratification is used for all patients at every glaucoma visit. This needs to be done at all sites and at all types of visit, including, as the pathway develops, in community optometry. Use this data to create a view of the whole glaucoma patient population who are at high, medium & low risk - this is critical to ensure they are managed appropriately and that resources can be deployed appropriately. This needs to be delivered as a matter of urgency.	1) Review of current waiting list and risk startification. 2) Optometrists to support with completing risk startification. 3) Glaucoma Consultants to assist with completing risk staratification process.	Apr-24	Apr-24	Amber	Risk stratification has been applied with E and F category almost eliminated from the New pathway. Plan to validate whole FU waiting list with plans to eliminate uncoded patients and the E and F catgories in the the FU cohort.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R44. Rationalise where ophthalmic outpatients are delivered to fewer better sites with dedicated ophthalmic spaces.	1) Undertake review of current delivery for Glaucoma clinics. 2) Plan increase in delivery of Glaucoma clinics including review of infrastructure. 3) Commence delivery of increased Glaucoma clinics	Apr-24	~~Apr-24~~ May-24	Amber	27/09/23 - Review of Ophthalmic delivery and infrastructure has commenced.

Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R45. Re-explore the use of remote consultations after diagnostic data collection, to reduce the burden on outpatient space. Virtual reviews have to be carried out on a hospital site, but ensure they and remote consultations are not being done in clinical consulting rooms, as long as the clinicians can see the diagnostics data and records.	1) Introduce further virtual Glaucoma sessions for Consultants. 2) Scope delivery of virtual Glaucoma sessions for SAS doctors.	Apr-24	~~Apr-24~~ May-24	Amber	27/09/23 - Delivery of further virtual sessions has been job planned for new Glaucoma consultants and tech support for these sessions is currently being scoped.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R46. Review the footprint and usage of all the outpatient areas and create ophthalmology and subspecialist areas with teams and all equipment in one or two area/sites for glaucoma.	1) Review current structure and delivery. 2) Plan new structure and delivery. 3) Commence new structure and delivery. This action may be restricted by cost to implement.	Apr-24	Apr-24	Amber	Review of all sites delivering care and maximise footprint where possible. Also scoping space in Pentre Awel and in the primary care hub in Carmarthen to expand infrastructure.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R47. Work with the health board and the regional team to find a better outpatient solution, fit for modern ophthalmic care and the longer-term rising population demand which can support training the MDT. Consider all options for the regional collaboration with other relevant health boards.	1) Review where SAS doctors currently support Consultant clinics to identify training opportunities. 2) Develop SAS doctors and non medical staff in line with training needs and liaise with SBUHB for support with development.	Apr-24	~~Apr-24~~ May-24	Amber	27/09/23 Review of Ophthalmic delivery and infrastructure commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R48. HDUHB working within the regional context needs also to ascertain the required community ODTC footprint to support the long-term outpatient capacity, taking into account population demand over time and the likely implementation of the new WGOS contract. Plans need to describe how this is to be established on a sustainable basis, ensuring all sites can support high flow efficient, technician/HCSW led assessments.	1) Review of Glaucoma categories and suitable pathways for management. Glaucoma A - optom Glaucoma B - ODTC Glaucoma C - general clinics Glaucoma D - Specialist clinics 2) Implement management plan for all categories.	Apr-24	~~Apr-24~~ May-24	Amber	Discussion with Swansea Bay to develop a regional workforce development plan have been commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R49. Consider mobile vans and units - "the glaucoma bus".	1) Scope the need for a Glaucoma bus and what this would deliver. This action may be restricted by cost to implement.	Apr-24	Apr-24	Amber	27/09/23 The use of a mobile centre will be scoped as part of the infrastructure review.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R52. Urgently link up regionally to use resources to their best availability including medical and MDT manpower for cataract, glaucoma and other areas.	1) Continue to develop open eyes project as a regional development. 2) Scope possibility of cataract delivery through SBUHB.	Jan-24	Nov-24	Red	27/09/23 - Regional Glaucoma Consultants secured. Regional EPR system being scoped and workforce development plan to include regional support from Swansea Bay. 02/01/2024 - Funding secured for 1.0 WTE Band 7 digital project manager and 0.5 Band 5 application support manager.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R53. Fund more ophthalmic (optometrist, orthoptic and nurse) practitioners and develop them. Fund more technicians and health care support workers and train them to deliver a wider scope of practice.	1) Scope the recruitment of 1.9 WTE Glaucoma practitioner. 2) Plan development of Glaucoma practitioners. This action may be restricted by costs to implement.	Apr-24	Nov-24	Amber	27/09/23 - Funding available for further Glaucoma Practitioners. Regional workforce development plan will need to be implemented to support the development of these nurses.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R54. Consider adapting UKOA Guidelines across all 3 professions including training SLT practitioners using UKOA guidance. Utilise the OPT framework for training MDT staff.	1) Develop a rolling programme of staff to go through OCT training. 2) Identify a training lead for the HB.	Apr-24	Apr-24	Amber	27/09/23 - The OPT competency framework is being utilised in the development of the nurse practitioners and one of the middle grade doctors is atteding the OCT training to support as training lead.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R55. Undertake a comprehensive review of the roles, job plans, numbers and professional development of the MDT, in glaucoma services in hospital and the ODTCs. Utilise the capabilities of non-medical staff to maximum so that the consultants can concentrate on the complex cases, training and service improvement.	1) Undertake review of current roles in delivery of Glaucoma pathway by Head of Nursing and Senior Nurse manager. 2) Map development of workforce within pathway to align with service plan.	Apr-24	Nov-24	Amber	27/09/23 - Review of workforce commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R58. Undertake proper demand and capacity work and explore realistic options for change, and how much and how quickly they will deliver. Accelerate business cases to imrpove capacity and implement.	1) Utilise demand and capacity work recently undertaken to build a robust model of service delivery. 2) map recovery plan in line with the above.	Feb-24	~~Feb-24~~ Mar-24	Red	27/09/23 - In-depth Demand and Capacity planning undertaken, recovery plan to be developed in line with proposed increase in capacity as workforce and infrastructure developed.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R59. The very long waiters need to be assessed now (e.g. by virtual assessments) regardless of the original risk rating to avoid cases of serious harm.	1) Scope potential Increase in virtual capacity in the HB to virtually review high risk cohort of longest wait patients.	Apr-24	Apr-24	Amber	02/01/2024 - 100% delayed patients in high risk categories being reviewed with plans to increase virtual sessions to review lower risk patients to free F2F appointments for the Glaucoma C&D categories.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R40. Develop two stop/virtual diagnostics sessions in the ODTC's, hospital sites and optometry practices even when the decision maker is not the hospital consultant, to optimise new patient throughput. Separate interactions to differentiate between diagnostics (tests) from the virtual clinical review.	1) Meet with Optometrists to discuss further development of ODTC pathway. 2) Increase delivery through ODTC for Glaucoma B patients.	Feb-24	~~Feb-24~~ Mar-24	Red	Further work being scoped to increase patient utilising ODTC style clinics both in primary and secondary care supported via virtual platforms. 02/01/2024 - Contract reform will give further opportunities to develop this pathway.
Nov-23	2023/24	Public Service Ombudsman (Wales)	202103161	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	N/A	R2. Provides evidence that it has shared this report with the Trauma and Orthopaedic Surgeons who carry out shoulder surgery to provide an opportunity for learning from these events.		Apr-24	Apr-24	Amber	01/03/2024: PSOW confirmed - Due 26/04/24
Feb-24	2023/24	Internal Audit	Follow-up: Theatre Loan Trays & Consumables Final Internal Audit Report	Open	Reasonable	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	Medium	R1. Management to decide whether: • Patient details are required to be provided by the private hospital (subject to information governance implications) and manually recorded on the Health Edge system; or • Given the infrequency of such requests, the risk associated with the lack of patient traceability is deemed tolerable / acceptable. 3.1 Previous Matter Arising 3: Patient Traceability (Design)	Risk assessment to be considered via the Directorate Q&S Group in March 2024. Adoption of an alternative patient traceability solution will require confirmed sign off from the Directorate Management Team (Clinical Director, General Manager and Head of Nursing).	Jun-23	Mar-24	Red	01/03/2024 - Awaiting response from service
Feb-24	2023/24	Internal Audit	Follow-up: Theatre Loan Trays & Consumables Final Internal Audit Report	Open	Reasonable	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	High	R2. Previous recommendation reiterated: High value consumables such as implants and prostheses should be treated as controlled stock with appropriately restricted access and a record of stock balances, purchases and issues maintained. This should include both Health Board-owned and consignment stock 7.1a Previous Matter Arising 7: Consumables – Stock Control (Design)	There is limited access to Theatre spaces and inventory. All sites have either swipe or code access to Theatres. No stock is in plain view and is stored in dedicated storage areas. The implementation of Scan for Safety (S4S) and related Inventory Management System (IMS) into Bronglais is progressing with support of NWSSP All Wales Implementation Lead, NWSSP Hywel Dda project partner, and HDUHB Theatre Commodities lead. (Endoscopy and Critical Care have recently launched). The inventory build for Bronglais theatres is due to commence mid-February with some 3500+ itemdetails to be loaded. Theatre teams are working on PAR levels, restock trigger levels, minimum stock numbers, and items to be directly scanned to patients which will ultimately be placed on against the inventory database. Proposed launch date for Bronglais Theatres: 22 April 2024. Proposed order of launch – dates to be determined based upon ease or challenge of BGH Theatre launch: • PPH Endoscopy, PPH Critical Care, PPH Theatres • GGH Endoscopy, GGH Critical Care, GGH Theatres • WGH Endoscopy, WGH Critical Care, WGH Theatres Introductory visits to PPH have taken place; outlining intentions of S4S and IMS, steering staff interest to related website and what the next steps will be.	Dec-24	Mar-25	Amber	01/03/2024 - Awaiting response from service

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Jun-21	2021/22	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	High	R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked.	As part of Targeted Intervention, the Health Board is undertaking an assessment of its planning maturity, incorporating the alignment of plans. In addition, an Independent Review is being conducted by Sally Attwood on behalf of Welsh Government. Once complete the Health Board will develop action plans to respond to both of these pieces of work. The capacity and role of the planning function will be important considerations within this, see below for an update on capacity.	Sep-21	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - Update to ARAC -The review has now been complete. However, only a draft version has been sent to date with the recommendations omitted. The Health Board has responded to the factual accuracy and overall content relating to the body of the report. Unfortunately, at this stage (31 May 2023), the final report is yet to be received. 11/01/2024-Deputy Director of Operational Planning and Commissioning confirmed recommendation is completed, with report provided to the Targeted Intervention meeting January 2024. 09/02/2024: Audit Wales Report of November 2023 has documented that this recommendation is in progress.
Jun-21	2021/22	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	The Health Board has recently (January 2023) transferred the commissioning function in to the Planning Directorate. The alignment and amalgamation of the Planning and Commissioning team has provided additional resilience within the Directorate. However, it is worth noting the commissioning team only consisted of 2.0 WTEs (with 1.0 WTE split between Planning and Commissioning) and are responsible for a budget of circa £170m. As part of Targeted Intervention, there is an Independent Review being conducted by Sally Attwood on behalf of Welsh Government. It is anticipated this will consider the capacity and capabilities within the team, which the Health Board will then consider how best to respond.	Mar-22	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - Update to ARAC -The current position remains extant to the summary update provided as at the 9 February 2023. However, there has been changes to the planning cycle and overall process. Equally, a greater understanding of the roles and responsibilities the planning function may undertake has increased through the planning cycles aligned to the Annual Plan (submitted to WG on the 31 March 2023) and the Annual Plan supplementary (submitted to WG on the 31 May 2023) document. Therefore, subject to the final report being received from Welsh Government, a planning directorate structure inclusive of the proposed roles and responsibilities will be produced. 11/01/2024-Deputy Director of Operational Planning and Commissioning confirmed whilst the original intention was for to expand the Corporate Planning and Commissioning team; this has been superseded due to the financial position. Moreover, the Transformation Programme Office now sits under the Deputy Director of Operational Planning and Commissioning and as such, the resources within the TPO are supporting both the Annual Plan and the Medium Term direction through the Clinical Service Plan. Therefore, this improves both the capacity and capabilities in the interim. To be clarified with the Director of Strategy and Planning if this recommendation can be closed. 09/02/2024: Audit Wales report of November 2023 has documented that this recommendation remains in progress.
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R2. Consideration should be given to establishing the Programme Group as a formal Committee of the Board.	To be considered as part of the overall governance requirements of the programme.	Jan-24	~~Jan24~~ Mar-24	External	24/02/2023- Under suggested timescale the Internal Audit report states 'To be considered in advance of the Outline Business Case stage'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 20/06/2023 & 19/07/2023- Capital Planning Project Manager confirmed there is Executive Team discussion around future governance of the programme, awaiting outcome. 05/09/2023- Further work on this will be undertaken following the Gateway Review of the Strategic outline case (SOC) in October 2023. 08/01/2024 - This work will be completed following SOC completion and submission to Welsh Government. RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R4. When linkage is required to the Executive Team/ Executive Steering Group, the accountability arrangements should be clearly defined.	Agreed.	Jan-24	~~Jan24~~ Mar-24	External	24/02/2023- Under suggested timescale the Internal Audit report states 'As required'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 08/01/2024 - This work will be completed following SOC completion and submission to WG. RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R5. Linkage to the Major Infrastructure PBC will be defined.	To be considered as part of the overall governance requirements of the programme.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R9. The master programme should be activity/ task based.	Agreed.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 -RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R13. An activity-based resource schedule will be produced for the Outline Business Case stage.	A resource plan has been agreed for the current stage, however a full exercise is required for the next stage.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R14. Existing Health Board staff (including the SRO and Executive Team) will be advised of the expected level of commitment anticipated for the production of the Outline Business Case.	Agreed.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R15. Adequate representation will be secured from all key functions e.g. workforce, clinical, finance, IT, hotel services etc.	Agreed.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Feb-23	2022/23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	N/A	R16. Having identified the resource requirement to prepare each aspect of the Outline Business Case, the Health Board should seek to build its own internal resource/ expertise.	Agreed.	Sep-23	Mar-24	External	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG. Revised completion date of March 2024 provided. 08/01/2024 - RAG status changed to 'External' until WG have made a decision (as agreed with Internal Audit).
Mar-23	2022/23	Peer Review	Planning Arrangements in Hywel Dda University Health Board	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Shaun Ayres	Director of Strategic Development and Operational Planning	N/A	R1. Establish its operating model for managing and delivering change - paragraph 81 provides a blueprint.	Management responses to be presented at August 2023 SDODC. 08/12/2023: The Health Board has integrated learning from the annual recovery work phases one and two into ongoing planning activities. This integration is a core part of the operational planning framework, ensuring a seamless transition of insights and strategies into future plans. The operational framework is underpinned by the integrated planning process, which serves as the cornerstone of the approach to managing and implementing change. This process is more than a strategic document; it is a live operational tool that brings together all aspects of the organisation. It enables us to align our efforts with the Board's overall objectives, ensuring that operational initiatives are in sync with our risk appetite and strategic goals. The savings process, integral to the operational planning, ensures continuity and sustainability. It is a cyclical ongoing process where lessons learned and efficiencies identified in one cycle will feed in to the planning of the next, allowing us to maintain a dynamic and responsive operational planning approach. This cycle not only addresses financial efficiencies but also reinforces our commitment to quality care and service improvement.	Dec-23	Mar-24	Red	Management responses to be presented at August 2023 SDODC. 12/09/2023- Paper to August 2023 SDODC confirms a thematic approach that consolidates the UHB response to the Maturity Matrix; Peer Review and the internal planning Master Actions emanating from the original Targeted Intervention expectations. December 2023 timescale provided by Deputy Director of Operational Planning and Commissioning. 11/01/2024-Deputy Director of Operational Planning and Commissioning update- the UHB has integrated learning from our annual recovery work phases one and two into our ongoing planning activities. This integration is a core part of our operational planning framework, ensuring a seamless transition of insights and strategies into future plans. Our operational framework is underpinned by the integrated planning process, which serves as the cornerstone of our approach to managing and implementing change. The savings process, integral to our operational planning, ensures continuity and sustainability. It's a cyclical on-going process where lessons learned and efficiencies identified in one cycle will feed into the planning of the next, allowing us to maintain a dynamic and responsive operational planning approaches. Revised timescale of Macrh 2024 provided to coincide with the plan being submitted to WG.

Mar-23	2022/23	Peer Review	Planning Arrangements in Hywel Dda University Health Board	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Shaun Ayres	Director of Strategic Development and Operational Planning	N/A	R2. Develop effective means for strengthening and supporting planning by operational teams, ensuring that there are clear pathways for turning strategy into implementation plans. A clear route map for delivering the strategy is needed to support this.	Management responses to be presented at August 2023 SDODC. 08/12/2023: The Health Board has focused on enhancing the Integrated Planning Process as the key driver for transforming strategic and planning objectives into actionable implementation plans. This process is at the heart of our operational planning, effectively bringing together diverse strands such as financial management, service delivery, workforce planning, and recovery requirement to the heart of the planning process. Through the Integrated Planning Process, we will ensure there is a clear coherent approach for operational teams to develop and execute plans. This process is informed by insights from our Annual Recovery Plans, which provide valuable lessons and strategies for service improvement and risk management. Additionally, it incorporates elements from our Clinical Services Plan, ensuring that our planning objectives are aligned with patient care priorities and broader Health Board wide service fragility issues and concerns. The savings process, integral to our planning, follows a structured approach from enquiry to delivery, ensuring that every potential efficiency is explored and implemented within the broader operational context. This systematic approach aids in strengthening our planning capabilities, supporting teams to identify, design, and implement effective changes. The inclusion of detailed reports, such as the 'Planning Objective 6a Highlight Report' and the '6a Planning Objective Deep Dive Report,' further illustrates the depth and comprehensiveness of our planning process. These reports demonstrate our commitment to continuous improvement, governance, and documentation clarity, ensuring that every step from strategy to implementation is well-defined and effectively executed. In summary, our Integrated Planning Process is the cornerstone of our response to this recommendation, providing a robust, adaptable, and comprehensive approach for operational teams to turn planning objectives into both deliverable and implementable operational plans.	Dec-23	Mar-24	Red	Management responses to be presented at August 2023 SDODC. 12/09/2023- Paper to August 2023 SDODC confirms a thematic approach that consolidates the UHB response to the Maturity Matrix; Peer Review and the internal planning Master Actions emanating from the original Targeted Intervention expectations. December 2023 timescale provided by Deputy Director of Operational Planning and Commissioning. 11/01/2024-Deputy Director of Operational Planning and Commissioning update- the UHB has focused on enhancing our Integrated Planning Process as the key driver for transforming strategic and planning objectives into actionable implementation plans. Through the Integrated Planning Process, we will ensure there is a clear coherent approach for operational teams to develop and execute plans. This process is informed by insights from our Annual Recovery Plans, which provide valuable lessons and strategies for service improvement and risk management. In summary, our Integrated Planning Process is the cornerstone of our response to this recommendation, providing a robust, adaptable, and comprehensive approach for operational teams to turn planning objectives into both deliverable and implementable operational plans. Revised timescale of Macrh 2024 provided to coincide with the plan being submitted to WG.
Feb-24	2023/24	Internal Audit	Decarbonisation , issued February 2024	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategic Development and Operational Planning	High	R1. Matter Arising 1: Action Plan and Funding Strategies (Design) Management should ensure: - A fully costed plan should be developed to meet the 2030 target and re-evaluated to update the baseline projections; - A review of staff resources dedicated to decarbonisation should be undertaken and actions identified to mitigate any staff resource risk; and -A long-term financial model for the funding required to support the decarbonisation programme to provide assurance to the Board regarding achievement of WG targets should be developed. A clear timeline should be determined for undertaking this exercise, with progress monitored at a relevant forum. Management should review the current service level risk entry for decarbonisation (Risk No. 1544) with a view to escalating to the corporate risk register where the above cannot be progressed and impacts the Health Board's ability to meet national targets.	The Health Board's Decarbonisation Delivery plan provided indicative costs for the first phase of the programme, where those costs could be quantified. Given the scale and duration of the Decarbonisation programme it isn't possible to fully cost all elements, ahead of knowing the options and implications of plans. Feasibility studies for example will be required to create the costing outputs and there is currently little/no funding available to conduct these. In addition work continues nationally to define the measurements for carbon reporting and therefore the baseline against which the plan needs to deliver is yet to be determined. In response to the action the Decarbonisation Task Force will formally consider: - The potential to provide updated cost estimates for the delivery plan, recognising the limitations on this as noted above; - A review of staff resources and potential mitigations; - The actions we anticipate will be funded through the HB (either revenue or capital) and the actions which will require Welsh Government funding, this will then be shared with the national programme and recommended for discussion at the National Programme Board; and - The directorate risk for decarbonisation and requirement for escalation to corporate risk register.	Mar-24	Mar-24	Amber	
Feb-24	2023/24	Internal Audit	Decarbonisation , issued February 2024	Open	Limited	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Lee Davies	Director of Strategic Development and Operational Planning	Medium	R2. Matter Arising 2: Training and Awareness (Design) The sustainability video should be reviewed (following the addressing of any potential issues) and uploaded back on the Sustainability Resource hub to support individual and service improvements.	Note that staff training is currently a responsibility of HEIW as it's a NHS wide requirement and the action has been assigned to them nationally. Furthermore, there are a number of other internal and external training/learning resources on ESR (e.g. Net Zero) and on the HDd Sustainability SharePoint page as well as signposting/raising awareness to reputable external resource/learning from HEIW and the Centre for Sustainable Healthcare that enables staff to keep informed and up to date with the relevant knowledge, training and awareness.In respect of the specific recommendation the appropriate actions are already in progress and the issue will be addressed.	Apr-24	Apr-24	Amber	

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

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Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	Medium	R1. Previous Matter Arising 2: Governance Arrangements 1.1 Quality and safety orientated supporting groups and meetings should report into the Quality Forum ensuring key issues and risks are brought to the attention of hospital management.	Band 3 "committee support" post has been advertised with interviews scheduled for late February. This post will support the formalisation of the various meetings that need to feed into the Quality Forum, ensuring risks are flagged up to management.	Dec-23	Apr-24	Red	09/02/2024- this recommendation supersedes the previous recommendation on the original report (HDUHB-2324-03)- 2.1. Previous Matter Arising 2: Governance Arrangements
Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	Medium	R2. Previous Matter Arising 2: Risk Register 2.1 Outstanding overdue risks recorded on the directorate register should be promptly addressed.	Risks are being reviewed on an ongoing basis. Actions being taken are sometimes open-ended (such as recruitment campaigns) and a review of how much this, along with other mitigations, reduces the presenting risk level is underway.	Oct-23	Apr-24	Red	09/02/2024- this recommendation supersedes the previous recommendation on the original report (HDUHB-2324-03)- 4.1 . Previous Matter Arising 2: Risk Register
Feb-24	2023/24	Internal Audit	Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Open	Reasonable	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	High	R3. Previous Matter Arising 5: Incidents Management A review of the remaining open incidents are promptly investigated and correctly assigned for clearing.	New incidents are reviewed and assigned quickly; the Head of Nursing for Quality and Safety is working with service areas to fully investigate and close incidents. The priority incidents will be those where harm has been identified. This process has begun.	Nov-23	Aug-24	Red	09/02/2024- this recommendation supersedes the previous recommendation on the original report (HDUHB-2324-03) - 5.1. Previous Matter Arising 5: Incidents Management

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Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	To ensure work alongside estates to review refurbishing staff changing rooms, shower facilities and toilets	Sep-23	~~Sep-23~~ Mar-24	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update received. QAST update 30/10/23 Awaiting quotation from Estates for refurbishment of staff facilities and seeking Charitable Funds support to fund the refurbishment. Update 20/12/23 partial refub taken place, awaiting painting of room and chartable funds for lockers. 25/01/2024- this action will be implemented by March 2024, as discussed at the GGH Quality, Safety and Assurance meeting in January 2024. Update 23/2/24 The repair of the wall has been undertaken in the staff toilet awaiting all other planned maintenance to be done Linked with estates today and will meet in the department next week to confirm date to complete all works needed. Colour scheme and paint have already been decided. We are also in the process of ordering new lockers for staff through charitable funds. To instigate a refurbishment of staff facilities is complete though understanding the works may take up to 3 months to complete

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Jun-16	2016/17	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	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 of lung cancer. Cancer Services continue to work alongside the service management team monitoring cancer waiting times in their weekly lung cancer MDT tracker meetings. 16/03/2023- Funding sources have been obtained from establishment across Carmarthenshire and sites to provide lung cancer services across the UHB footprint, the barrier now facing the service is the difficulty in recruiting the middle grade doctor. At present the Hospital Director is lone working as the only consultant for the lung cancer service. A succession plan is in place but recruitment remains difficult. This has been reflected in risk 1655 (Fragility of Lung Cancer Service). To be raised with Director of Operations if he is happy for this recommendation to now be closed, as this is reflected in risk 1655. 27/10/2023- The strategic review has taken place and we have recruited a locum consultant to support the previous lone working consultant. Recommendation to be discussed with Director of Operations for closure.
Jan-20	2019/20	Peer Review	Hywel Dda UHB Lung Report, issued January 2020	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	TBC	N/A	R1. Absence of Pathologist in some MDTs. There is often no pathology input to the MDT meeting due to time constraints on the pathologist.	This a whole health board problem affecting all cancer sub-specialities. There needs to be innovative ways of working to find a solution. This isn't within the gift of the Lung cancer MDT lead.	N/K	N/K	Red	16/05/2023- Due to staff recruitment challenges there isn't availability for a consistent presence of Pathologists at all MDT meetings, however they are offering a case by case service outside of these forums, as required. This has been reflected in the risk 1655 (Fragility of Lung Cancer Service). To be raised with Director of Operations if he is happy for this recommendation to now be closed, as this is reflected in risk 1655. 01/12/2023- email sent to Head of Pathology Service if this recommendation can be closed requesting any further update by 15/12/2023 following which a request will be made to the Director of Operations to close the report. 12/02/2024: email sent to SDM Respiratory to request that discussions be held with Pathology to determine if this recommendation can be transferred to the Pathology Service. Awaited.
Jun-23	2023/24	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R4. We identified ligature risks in the mental health assessment room was not free from ligature risks. Whilst we were assured that the MIU does not leave patients with mental health needs unattended in the mental health assessment room, we could not be assured that this was always maintained by other staff / teams.	Standard operating procedure for the management of patients experience mental health crisis to be reviewed and circulated to all. This review will require input from the MH &LD Directorate	Aug-23	~~Dec-23~~ ~~Jan-24~~ N/K	Red	20/09/23- confirmation from MH&LD the staff (from crisis pathway) who will be assisting with this piece of work. Provided names to MIU Senior Nurse. Aiming for completion by 01/12/23 Update 20/12/23 meeting / strategic work underway re scope of MIU service, to inc MH service and delivery. Expected to go to Committee January 2024. 23/02/2024 - Advised by Head of Nursing (USC GGH) that a meeting is scheduled for 29/02/2024 with Mental Health colleagues as the actions for this are within their 'scope'.
Jun-23	2023/24	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R19. The health board must review this staff feedback in the context of these findings. It must continue to provide a platform to listen to staff and must take robust and sustained actions where appropriate to do so.	Liaising with Mental Health colleagues to review management of MH patients presenting to MIU	Nov-23	~~Nov-23~~ ~~Jan-24~~ N/K	Red	Update 20/12/23 meeting / strategic work underway re scope of MIU service, to inc MH service and delivery. Expected to go to Committee January 2024. 01/02/2024: AMaT updated on 17/01/2024 - meeting/strategic work underway re scope of MIU service, to inc MH service and delivery. Going to CDG on 24th January 2024. 23/02/2024: Head of Nursing (GGH USC) advised that a meeting is scheduled for 29/02/2024 with Mental Health colleagues as the actions for this are within their 'scope'.
Jun-23	2023/24	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R20. The health board must consider its approach to community engagement and communication at a corporate level regarding the 'front door' services available at Prince Philip Hospital and accessing the right service according to need.	Review of current MIU scope and criteria documents and development of redirection protocols underway.	Dec-23	~~Dec-23~~ ~~Jan-24~~ N/K	Red	Update 20/12/23 meeting / strategic work underway re scope of MIU service, to inc MH service and delivery. Expected to go to Committee January 2024. 01/02/2024: AMaT updated on 17/01/2024 - meetings and strategic work remains in progress - being presented to CDG on 24th January 2024.

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R1. Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	The Stroke Steering Group (SSG) will review the need to engage with GP practices and localities GP engagement and for the stroke medical team to develop relationships.	Dec-24	Dec-24	Amber	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- The Clinical Lead for Stroke has contacted the Deputy Medical Director for Primary Care and a response is awaited.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R2. Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Hywel Dda University Health Board will work collaboratively with Public Health Wales to support the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign.	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R3. Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Hywel Dda University Health Boards to work collaboratively with Public Health Wales and with black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R4. Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R9. Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	The Health Board has commissioned a partner to review any opportunities there may be relating to predictive methodology for demand. This development work is scheduled to continue through Q3 & Q4 2023/24.	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R10. Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	The all Wales Escalation policy and associated processes are currently being reviewed, all health boards are working with Welsh Government colleagues to review the current policy with the aim to have this complete before the end of the calendar year. This will inform on any local processes required and our local HdUHB Escalation Policy will be amended once this is complete.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- await All Wales National stroke escalation policy. Once received this can then be reviewed. Actions that require all Wales work raised with WG Oct 2023.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R11. Welsh Government should consider strengthening its promotion of the Help Us to Help You campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R12. Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	The HDdUHB is undertaking a major review of clinical services. A major stakeholder in the re design off health service in the health board is the stroke service and supporting team. As part of the Clinical Service Programme review, commissioned by the Board in March 2023, a patient engagement exercise is planned with stroke patients and families. This will help inform future service design and our understanding of patient perceptions of barriers to their health in regards to stroke. This exercise is being assisted by the Stroke association.	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R12. Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	The issues paper will be ready by March 2024. There will be further work and planning required in relation to the stroke service whereby the information gathered from the patient survey will be pivotal in the re design of Stroke care in HDdUHB	Apr-24	Apr-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R12. Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Part of the clinical service programme the Health Board are surveying the population during October 2023 via the CIVICA system. This is part of a patient survey as part of the early engagement assisted by the Stroke association. The national stroke board is also supporting an All Wales patient Survey.	Apr-24	Apr-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R13. WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R14. Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R15. WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R16. Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	The Health Board stroke CNS to develop a training package for the receptionist team. This will be available on line.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- one to one training has been delivered to receptionist team on all sites, the training package awaits development.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R21. Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	A summary report of finding and recommendations will be shared with operational site teams in March 2024	Apr-24	Apr-24	Amber	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R22. Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	The Health Board will review any recommendations arising from the NHS Executive review the stoke pathway through the self-presenting patient's perspective. The report is yet to be released.	Nov-23	~~Nov-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. Update 05/03/24 on AMAT- The NHS Executive review of stroke pathway has yet to be released. Actions that require all Wales work raised with WG Oct 2023.

Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R24. Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.	ED Senior sisters to keep an up to date training record and to inform the Stroke team of any new staff starting in their departments	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R30. Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R32. Recommendation 32 WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R35. Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.	Early Supported Discharge (ESD) operational in WGH, with planned phased expansion and implementation of ESD across remaining 3 acute sites by March 2024	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R36. Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Therapy Staffing reviewed as part of Stroke Services Redesign Program, Regional CRSC Programme, Clinical Services Plan (CSP) and factual assessment of staffing profile. CSP issues paper to be reviewed by Board March 24	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R37. Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	1) Neuropsychologist post out to recruit for second time. Reviewing potential of regional service model with SBUHB cover if recruitment remains problematic 2) Neuropsychology Assistant Practitioner posts currently being recruited to with aim of delivering a stepped care model to support the Stroke pathway by end March 2024	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R38. Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Therapy 7 day staffing, including ESD reviewed as part of Stroke Services Redesign Program, Regional CRSC Programme, Clinical Services Plan (CSP) and factual assessment of staffing profile. CSP issues paper to be reviewed by Board March 24	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R39. Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Majority of stroke rehabilitation environments across the Health Board are appropriate and adequate to meet the patients' needs. There are currently significant short to medium term operational challenges in : 1) WGH site due to impact of RAAC - local mitigation in place to provide acute in-pt rehab WGH and in SPH. ESD to support split pathway	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Therapies	Senior Nurse Manager	Director of Operations	N/A	R39. Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Majority of stroke rehabilitation environments across the Health Board are appropriate and adequate to meet the patients' needs. There are currently significant short to medium term operational challenges in : 2) Stroke rehab on the BGH site is considered as part of BGH strategy. Interim arrangements include ward& bed based rehab, with longer term inpatient rehabilitation provision being scoped as part of CDU / Leri Day business case, due to be developed by December 2024.	Dec-24	Dec-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R44. Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.	N/A	N/A	N/A	External	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R48. Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	A scoping review of all current discharge lounge services across the acute sites will commence in November 2023, including mapping current service provision, criteria, opening times, staffing etc	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R48. Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Findings and recommendations identified from the scoping review will be shared with acute operational teams in March 2024.	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R49. Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	All four acute sites have established operational discharge lounge services; however, these vary across acute sites. A review of the current services and effectiveness of the services will be managed in the actions for recommendation 48.	Apr-24	Apr-24	Amber	10/01/2024 - update via the AMaT system - At present there is no discharge lounge facilities at BGH . Having scoped the footprint there are no suitable clinical spaces to allocate one. We also have a very fragile workforce with several vacancies so would be unable o safety staff such an area.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R50. Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Regular spot checks of patient records (patients presenting with strokes / all patients) will be commenced in December 2023 to monitor compliance and have assurance that the recording of discharge where this has not been met has been documented and any themes escalated through quality, safety and experience meetings	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Estates	Senior Nurse Manager	Director of Operations	N/A	R1. Ensure that IPC practises within the department are strengthened and environmental issues escalated to ensure that the risks to patients, staff and visitors are mitigated	Issue related to roof/gutter temporarily rectified by Estates, but requiring further maintenance to resolve.	Sep-23	~~Sep-23~~ N/K	Red	10/01/2024 - No update via the AMaT system. 30/01/2024- Update via AMAT system - 30/01/2024 Roof covering requires major capital expenditure. surveys underway, business case to be developed. Expected April 2024 Temporary water collection system and drain divert created to enable full use of the space. Completed October 2023 Update 15/02/24 issues escalated, capital investment required to resolve, warranty being explored, and remedial actions and IPC being monitored in the meantime.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R16. The health board must ensure that where oxygen is required that it is prescribed as appropriate	Memo to remind all staff that oxygen must only be administered if prescribed other than an in an emergency.	Nov-23	~~Nov-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.

Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Memo to remind staff to complete the Manchester triage tool pain assessment.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Retrospective baseline audit to be completed to determine compliance of use of Manchester triage tool pain assessment.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Spot checks to be completed weekly for 6 weeks to monitor compliance	Mar-24	Mar-24	Amber	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	Quality Improvement team to complete pain RA audit to monitor compliance	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R17. The health board must ensure that pain management is consistent for all patients within the ED.	To engage with clinical colleagues and specialist team to ensure that assessments & prescribing of analgesia is carried out in a timely manner.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R18. The health board must ensure that the sluice room and the area of the ED used by WAST colleagues is safe, secure and free of hazards at all times.	Memo to remind staff not to overfill Sharps box and poster to be displayed.	Oct-23	~~Oct-23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Nursing	Senior Nurse Manager	Director of Operations	N/A	R21. The health board must ensure that there is a system in place to identify to staff patients who require assistance eating or any dietary/allergen requirements.	Remind staff that allergen requirements are to be discussed with hotel services selection of daily menu choices.	Oct-23	~~Oct-23~~ N/K	Red	10/01/2024 - No update via the AMaT system
Nov-23	2023/24	Public Service Ombudsman (Wales)	202202950	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Louise O'Connor/ Luke Lenton	Director of Nursing, Quality and Patient Experience	N/A	R3. Should provide the Ombudsman's office with a copy of its complaints handling toolkit.		Apr-24	Apr-24	Amber	Copy of the complaint handling toolkit Due 10/04/24

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Feb-23	2022/23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	Low	R3. Management should undertake a lessons learnt review of the project following completion.	An interim lessons learnt exercise was undertaken in 2021. A Capital Governance Review was also undertaken in 2021 which has picked up on learnings from previous audit reports on the scheme. A lessons learnt exercise will be carried out 6-12 months after scheme completion in line with best practice.	Dec-24	Dec-24	Amber	16/03/2023- Lessons learnt review will take place when construction activity is complete. Target date December 2024. 08/01/2024 - Work has commenced on this exercise and a report will be presented to the Capital Sub-Committee in March 2024.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R10. All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External	03/07/2023 - (Taken from DITS response pack June 2023): Peer review revisited in June 2023- updated position to be submitted to HB formally in next few weeks. CHD Network have advised that there is no HB action required at this time although we are mitigating the risk with the following actions: Transferring patients all have a detailed letter. There is no template currently in place. Health Board still awaiting receipt of the standardised national template. Unable to progress the recommendation until received, therefore status amended to External. In addition, access to "Cardiobase" for Cardiff- based cases has now been formally secured for all HD PECs to allow them to review care plans for CYP across the HB's. Follow-up report noted: Do join MDTs if appropriate. Related to all children. To note there is a Communication of Patient Information T&F Group.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R7. Each designated paediatrician with expertise in cardiology will attend (in person or by VC link) the weekly network MDT meeting at least six times per year, and must also attend the annual network meeting. This requirement will be reflected in job plans.	Job plan review	Mar-22	Jul-24	Red	June 2023 (Centre's comments) - Annual Network meeting forms a part of current SPA allocation. MDT 6 times per yearto be added to PEC job plans as they are updated. June 2023 (Review notes and actions) - Aiming to have in place by end of July when will change to green. Looked at all sessions to work towards 20% in job plans incorporating additional clinic activity (DCC) and education (SPA). 07/02/2024 - SDM to incorporate into Job Plans by July 2024. GGH is complete.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R9. Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health professionals.	Job plan review	Mar-22	Jul-24	Red	Centre's Comments - PEC cover maintained for all cardiac centres. All PECs undertake sufficent clinical duties to meet the 20% desired contribution to CHD activity. All PECs participate in network activity. Review notes and actions 2023 - Aiming to move to green (see A15) Local database supports clinic's activity and helps provide evidence for monitoring/job plan development. 08/02/2024 - PEC cover maintained for all cardiac centres. All PECs undertake sufficent clinical duties to meet the 20% desired contribution to CHD activity. All PECs participate in network activity. By July 2024 PECS to have visits to tertiary centres.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R12. Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	Nov-24	Red	June 2023 - Centre's comments: Unable to secure dedicated individual due to capacity issues within the adult team- however, one individual with interest continues to work closely to support PEC. Funding would be required to make this a directorate dedicated role. Review notes and actions 2023: x2 physiologists identified within adult department with interest in peadiatric physiology. In early stage of ECHO training. Action: (SC/LH) To investigate ECHO tec support available (underway). 07/02/2024 - Discuss with network, explore sources of funding and support from Adult cardiology services. Risk to be considered. Arrange meeting with Adult service SDM (Nick to do by July 2024). Overall rec = November 2024
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R21. 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	Jul-24	Red	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. 26/09/2023 - A CYP working group has been established which is chaired by Dir of Ops and psychology provision is being assessed by that group. The health board is currently undergoing a Psychological Therapies Review being undertaken by the NHS Executive. The outcomes of that a review are not yet available. There is an ambition to deliver psychology services from a local service perspective. Despite successful recruitment of 1 x WTE Health Psychologist in 2022 the psychology team is very small, and further reduced due to maternity leave. The capacity of the Health Psychology Team remains constrained in terms of ability to manage additional conditions. From a network perspective, regional provision will improve when new posts in place however some constraints will remain due to maternity leave within the service. Referrals can be made to Bristol for patients requiring tertiary (surgical) intervention- and that service will also increase capacity with new appointments. Review notes and actions 2023: Healthboard review is ongoing. Regional provision will improve when new posts in place however some constraints will remain due to maternity leave within the service. Referrals can be made to Bristol and that service will also increase capacity with new appointments. 07/02/2024 - HB have commissioned psychology review from NHS Executive received Nov 2023. There is a gap in service. Health Psychology requirements are being considered as part of the review. SDM taking part in HB review. Pathway to UHW psychology provision is in place to support tertiary patients and remains intact.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R22. Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	Jul-24	Red	A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group. There is an ambition to deliver psychology services from a local service perspective. There has recently been some successful recruitment to the psychology team -but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. NB: Pathway to UHW psychology provision is in place to support tertiary patients- and remains intact. 08/02/2024 - Cardiff have new psychologist in place, waiting list being addressed for tertiary pathways (most seriously unwell have access to the services). Complete for tertiary care. HB have commissioned psychology review from NHS Executive received Nov 2023. There is a gap in service. Health Psychology requirements are being considered as part of the review. SDM taking part in HB review. Pathway to UHW psychology provision is in place to support tertiary patients- and remains intact.

Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R23. 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	Jul-24	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. 26/09/2023 - A CYP working group has been established which is chaired by Dir of Ops and psychology provision is being assessed by that group. The health board is currently undergoing a Psychological Therapies Review being undertaken by the NHS Executive. The outcomes of that a review are not yet available. There is an ambition to deliver psychology services from a local service perspective. Despite successful recruitment of 1 x WTE Health Psychologist in 2022 the psychology team is very small, and further reduced due to maternity leave. The capacity of the Health Psychology Team remains constrained in terms of ability to manage additional conditions. From a network perspective, regional provision will improve when new posts in place however some constraints will remain due to maternity leave within the service. Referrals can be made to Bristol for patients requiring tertiary (surgical) intervention- and that service will also increase capacity with new appointments. 07/02/2024 - Update required from Head of Midwifery"
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R24. All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	Jul-24	Red	Review notes and actions 2023: Centre to await outcome of dental review and confirm rating. 07/02/2024 - Awaiting response from Dental service in Primary Care. Pathways do exist into Swansea/Cardiff for at-risk patients/needing surgical intervention. Local provision still awaiting response. Primary Care to be noted as supporting service - Associate Medical Director for Dental to provide update.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R38. Congenital Heart Networks must demonstrate arrangements to minimise loss of patients to follow-up during transition and transfer. The transition to adult services will be tailored to reflect individual circumstances, taking into account any special needs. 'Lost to follow-up' rates must be recorded and discussed at the network multidisciplinary team meeting.	Network to link up audit evidence to include Helen Wallis' audit from 2019 patient lists.	Jul-24	Jul-24	Amber	June 2023 - Work is underway across the Network to look into this issue. New Action: Network to link up audit evidence to include Helen Wallis' audit from 2019 patient lists.
Jun-23	2023/24	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	R39. The Children's Cardiac Transition Nurse will work as a core member of the children's Cardiac Team, liaising with young people, their parents/carers, the Children's Cardiac Nurse Specialist, ACHD Specialist Nurse and wider multidisciplinary team to facilitate the effective and timely transition from the children's to adult services.	All Wales Transition guidance will inform approach.	Jul-24	Jul-24	Amber	Action: Service to link with transition nurse and map out how to reach full compliance within the next 9 months. 08/02/2024 - New consultant starts April 2024. Participation of adult cardiologist being explored. Risk of referrals for transition being lost now mitigated.
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R10a. The health board should develop and implement a system for tracking mandatory training levels for all clinical staff across the unit to ensure that they can address low levels of mandatory training compliance in a timely way	An Excel spreadsheet has been developed to support tracking of medical compliance with mandatory training	Jan-24	~~Jan-24~~ N/K	Red	11/01/2024 - QAST Update = None 22/02/2024 - No further updates on AMaT 01/03/2024 - No further updates on AMaT
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R10b. The health board should develop and implement a system for tracking mandatory training levels for all clinical staff across the unit to ensure that they can address low levels of mandatory training compliance in a timely way	Monitoring will sit with the Directorate Quality, Safety and Experience Meeting which meets on a monthly basis.	Jan-24	~~Jan-24~~ N/K	Red	11/01/2024 - QAST Update = None 22/02/2024 - No further updates on AMaT 01/03/2024 - No further updates on AMaT
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R2. The health board is required to provide HIW with details of the action taken: •to promote patient safety in the interim until compliance has improved.	Awaiting management response	Sep-23	~~Sep-23~~ N/K	Red	Recommendation not on AMaT
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R3b. The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits and informed patient consent should be gained	Audit compliance with the use of and documentation of care plans that evidence women having access to the information to make informed decisions/choices	Jan-24	~~Jan-24~~ N/K	Red	11/01/2024 - QAST Update = None. 01/03/2024 - No updates currently on AMaT
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	N/A	R4a. The health board should review the clinical governance arrangements related to the neonatal stabilisation room to ensure that the service and staff that provide care are appropriately led, governed and supported	The Governance of the Neonatal room will remain within the Maternity portfolio with support from the Senior Neonatal Nurse and Clinical Director for Hywel Dda and the Local Paediatric medical team in BGH	Jan-24	~~Jan-24~~ N/K	Red	11/01/2024 - QAST Update = None. 22/02/2024 - Update taken from AMaT = The Governance of the Neonatal room will remain within the Maternity portfolio with support from the Senior Neonatal Nurse and Clinical Director for Hywel Dda and the Local Paediatric medical team in BGH 01/03/2024 - No further updates currently on AMaT
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Radiology	Head of Midwifery	Director of Operations	N/A	R7c. The health board must provide details of plans to mitigate the risks of not following national guidance regarding antenatal scanning as well as plans to increase antenatal scanning capacity for all women in line with guidance	HEIW funding secured to train to midwifery sonographers, programme commencing in January 2024	Jan-24	~~Jan-24~~ Jan-25	Red	11/01/2024 - QAST Update = None. 22/02/2024 - Update taken from AMaT = Unable to complete. Midwives HEIW funded places secured - due to commence in Jan 2025

Date of report	Financial Year	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule	Progress update/Reason overdue
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	High	R1. We found that there is no clear, overall implementation plan to support the Health Board's 10-year workforce strategy. The Health Board should ensure its refreshed workforce strategy is supported by a resourced implementation plan, which is clear about delivery priorities. There should be a Page 31 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health Board clear programme approach to delivery with outcomes set out so that progress and the impact of the plan's delivery can be effectively monitored.	The 10-year workforce strategy was developed in 2018-19 and is due to be refreshed to take account of the changing strategic context and challenges faced by NHS Wales i.e. Post COVID, Cost of Living Crisis etc and actions related to workforce shifted focus. There was an implementation plan aligned to our 10 Year Strategy covering the first 3 years, however, the development of people aligned to strategic intent is an iterative process, we evolved our approach as we matured and integrated workforce planning within our structures and built capability. The Strategic Workforce Implementation Plan was adapted through subsequent iterations of our Workforce Planning process/Annual Plan as we began to focus on the most critical gaps in our workforce i.e. Nursing Workforce Implementation Plan. The Nursing Workforce Plan has demonstrated progress and impact as per the metrics developed and monitored as part of our Performance Dashboard. We will continue to build on the work noted above and we will continue to define the shape of the workforce we feel is best placed to meet the agreed demands faced within the financial envelope available to the Health Board, as needed seeking efficient and effective resource utilisations in the short medium and long term. Multiple scenarios may be required.	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	Medium	R2. We found that there are several regional transformation projects at various stages, which have workforce implications and will need regional workforce modelling and plans. The Health Board should ensure these are adequately reflected in workforce plans to ensure it has the resources needed to support their development.	We are alert to ensuring that the needs of the Regional Workforce Planning activity is met, and are reflecting on how best we can approach this. At present, this is being absorbed through ARCH, Mid & West Wales Group and the Regional Board for Workforce. Resources for a) modelling and planning the workforce and b) associated workforce pipeline developed to ensure resource for delivery of the programmes themselves will be explored in partnership with other HB's and wider partners. A joint solution would be preferable however mitigations of risk may need to be introduced in the interim.	Apr-25	Apr-25	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	Medium	R3. We found that service leads generally understood their role in workforce planning but operational pressures did not allow them sufficient time to 'think strategically' to develop solutions. The Workforce Planning Team should develop a process to ensure services Page 32 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health Boardroutinely receive support with workforce planning, for example through adopting a workforce planning business partnering model.	WOD does not have a Business Partnering Model we have 3 distinct teams which deliver on supporting cultural development (ODRM's); our operational workforce colleagues who facilitate change (OCP processes) and the workforce planning team. We are working collaboratively across WOD and with service leads to test our approaches to supporting services in the short, medium and long term. An evaluation will be undertaken and a paper on value of approaches in March 2024.	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	Medium	R4. We found that the Health Board is strengthening workforce planning capability through a range of training initiatives, some of which are still in development. Training is central to ensuring staff have the capability to support good workforce planning, as such the Health Board should develop an evaluation framework to measure the success of its training programme.	The approach to evaluation is in progress and a report reflecting the approach and outcomes will be undertaken in line with recommendation and actions under R3 above	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	High	R5. We found that in the absence of a clear implementation plan supporting the 10-year workforce strategy, it is difficult to gauge the progress and impact of its delivery. We recognise that the Health Page 33 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health BoardBoard is refreshing its workforce strategy. But in the interim it should update the People Organisational Development and Culture Committee twice a year on: A. progress against the key outcomes for success outlined in the workforce strategy; and B. how actions are having an impact on reducing workforce risks, specifically by developing a set of measurable impact measures for the Workforce Strategy.	Please note commentary in relation to R1 above and references to gauging progress and impact. In the interim, specifically in relation to A: we will be appraising the PODCC committee and introducing SPPEG to the requirements of the workforce plans in progress and developing, which align to our current and evolving strategic approach and implementation plans. Specifically in relation to B, again this is in progress through a number of pieces of work on Workforce Risk Assessment & Intervention Framework; Development of Intelligence and Metrics linked to Workforce Performance and further organisational alignment to the HB's Benefit's Realisation Tool will be sought to ensure an integrated strategic & operational approach to workforce planning and measurement of impact.	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	High	R6. The Health Board benchmarks its workforce performance metrics with other health bodies in Wales, but there is potential to benchmark with similar bodies outside of Wales. The Health Board should look to other health organisations with similar demographics, geography, and challenges, both to benchmark performance and seek good practice.	The Health Board has undertaken scoping to assess relevant health organisations on a local and international scale, this is referenced in a number of HB documents. Further work is ongoing as part of continuous improvement to our approach to workforce planning.	Apr-24	Apr-24	Amber	

Reports opened on the Audit Tracker since ARAC February 2024

Report name	Lead Executive/Director	Number of recommendations	Final report received at
Audit Wales: Primary Care Follow-up Review – Hywel Dda University Health Board	Director of Primary Care, Community and Long Term Care	2	Audit and Risk Assurance Committee
Audit Wales: Structured Assessment 2023- Hywel Dda University Health Board	Director of Corporate Governance	5	Audit and Risk Assurance Committee
HIW: Clinical Review into the Death of a Service User in HMP Parc	Director of Operations	1	Quality, Safety and Experience Committee
Internal Audit: Decarbonisation, issued February 2024	Director of Strategic Development and Operational Planning	4	Audit and Risk Assurance Committee
Internal Audit: Follow-up: Theatre Loan Trays & Consumables Final Internal Audit Report	Director of Operations	2	Audit and Risk Assurance Committee
Internal Audit: Follow-up: Bronglais General Hospital Quality & Safety Governance Final Internal Audit Report	Interim Director of Nursing, Quality and Patient Experience	3	Audit and Risk Assurance Committee
Internal Audit: Follow-up: NICE Guidance Final Internal Audit Report	Medical Director	Open and closed since last ARAC	Audit and Risk Assurance Committee
MWWFRS: Letter of Fire Safety Matters Premises: North Road Clinic, North Road Aberystwyth Ceredigion SY23 2EG	Director of Operations	13	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters Premises: Block 11, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	10	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters	Director of Operations	7	Health and Safety Committee

Premises: Elizabeth Williams clinic, Mill Lane, Llanelli. SA15 3SE			
MWWFRS: Letter of Fire Safety Matters Premises: Template 14, (Pathology, Mortuary), Prince Phillip Hospital, Dafen, Llanelli, SA15 8QF	Director of Operations	8	Health and Safety Committee Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters Premises: Block 1, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	12	Health and Safety Committee
Peer review: Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Director of Operations	10	To be confirmed
PSOW: 202202950	Interim Director of Nursing, Quality and Patient Experience	3	Listening and Learning Committee
PSOW: 202208381	Director of Operations	2	Listening and Learning Committee
PSOW: 202103161	Director of Operations	2	Listening and Learning Committee
PSOW: 202108316	Director of Therapies and Health Sciences	3	Listening and Learning Committee
PSOW: 202203822	Medical Director	4 *Open and closed since last ARAC report*	Listening and Learning Committee
Welsh Government: Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales	Director of Primary Care, Community and Long Term Care	61	Strategic Development and Operational Planning Committee
Total: 19			

Reports closed on the Audit Tracker since ARAC February 2024

Report name	Lead Executive/Director
Internal Audit: Follow-up: Welsh Language Standards	Director of Communications
Internal Audit: Glangwili General Hospital Fire Precautions Works: Phase 1	Director of Operations
Internal Audit: Withybush General Hospital - Fire Precautions Phase 1	Director of Operations
Internal Audit: Theatre Loan Trays & Consumables	Director of Operations
Internal Audit: NICE Guidelines	Medical Director
Internal Audit: Follow-up: NICE Guidance Final Internal Audit Report	Medical Director
Internal Audit: Quality & Safety Governance- Bronglais General Hospital	Interim Director of Nursing, Quality and Patient Experience
Internal Audit: Decarbonisation, issued October 2022	Director of Strategic Development and Operational Planning
Natural Resources Wales- RSR Compliance Assessment Report (Sealed Radioactive Sources)	Director of Operations
Natural Resources Wales- RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Director of Operations
Peer Review: Congenital Heart Defect Provider, issued October 2021	Director of Operations
PSOW: 202102692	Director of Nursing, Quality and Patient Experience
PSOW: 202003536	Director of Operations
PSOW: 202206868	Director of Operations
PSOW: 202208731	Director of Operations
PSOW: 202200883	Director of Operations
PSOW: 202203822	Medical Director
Total: 17	

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 - Report re-opened in February 2024	Governance	The Assurance and Risk Team are seeking progress updates on the 2 recommendations re-opened as a result of the review of recommendations raised in previous Structured Assessments as part of the 2023 Structured Assessment review, presented to ARAC in February 2024. It is noted that since the data was extracted for this report, further progress updates have been obtained from the Executive Director of Strategy and Planning, and these will be reflected in the next paper to ARAC in June 2024.
Community Health Council - Palliative End of Life Care (March 2023)	3	September 2023	Awaiting service update via AMaT	Ceredigion	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
HEIW - Revalidation Quality Review Report (July 2023)	1	December 2023	1 – Revised completion date lapsed	Medical	The Assurance and Risk Team are seeking progress updates and a revised completion date, which will be reflected to ARAC in June 2024.

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HIW- Ty Bryn 1 November 2021 (Publication date 19 January 2022)	1	December 2022	Awaiting service update via AMaT	Mental Health & Learning Disabilities	This report was re-opened at the request of Director of Nursing, Quality and Patient Experience in September 2023, following discussions with HIW regarding the potential use of the building moving forward. Recommendation relates to ensure appropriate maintenance of the building in order to prevent the risk of harm to patients and staff. However, site usage is currently being considered, and plans regarding patient care are being reviewed.
HIW- St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	1	December 2023	Awaiting service update via AMaT	Mental Health & Learning Disabilities	Estates have advised an estimated start date for works of mid April 2024, however it is not clear when the recommendation will be fully implemented. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
HIW - Bronglais Hospital Maternity Unit (August 2023)	4	November 2023	Awaiting service update via AMaT	Women and Children's Services	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.

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HIW - Mental Health Discharge Review (May 2023)	27	October 2023	12 - Awaiting service update via AMaT 15 – AMAT system queries	Mental Health & Learning Disabilities	The Assistant Director of Nursing MH&LD is determining revised timescales, with support from the Interim Director Nursing, Quality & Patient Experience. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024. 15 recommendations relating to AMAT system queries are being addressed with support from QAST team.
HIW - National Review of Patient Flow – a journey through the stroke pathway (September 2023)	3	December 2023	Awaiting service update via AMaT	Unscheduled Care (WGH)	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
HIW- Prince Philip Hospital Minor Injuries Unit (June 2023)	3	December 2023	Awaiting service update via AMaT	Unscheduled Care (PPH)	The service require support from colleagues in MHLD in order to progress and close these actions, with a meeting scheduled for February 2024. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.

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HIW - Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	5	October 2023	Awaiting service update via AMaT	Unscheduled Care (WGH)	Progress on this report is logged via the AMaT system. Progress updates and revised timescales are currently being sought from the service via the QAST, with updates to be reflected to ARAC in June 2024. Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
HIW- St Non, St Caradog, Canolfan Bro Cerwyn WGH (October 2023)	7	December 2023	Awaiting service update via AMaT	Mental Health & Learning Disabilities	The service have provided progress updates for 4 of the 7 recommendations via the AMaT system, however no revised completion dates were included within the updates. Progress updates and revised timescales are required from the service, with updates to be reflected to ARAC in June 2024.
HIW- Clinical Review into the Death of a Service User in HMP Parc	1	September 2023	Awaiting service update via AMaT	Mental Health & Learning Disabilities	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	1	September 2023	Awaiting service update via AMaT	Radiology	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.

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Independent Review - Savings Governance Review	1	October 2023	1 – Original completion date lapsed	Finance (with support from Strategic Planning team)	A revised timescale has not yet been provided for this recommendation, which relates to establishing comprehensive operational planning, finance, governance and project management support for scheme leads. Progress of the recommendation is reliant on an action assigned to the Strategic Development and Operational Planning Directorate. The Assurance and Risk Team will continue to request updates and a revised completion date on this recommendation, which will be reflected in the next paper to ARAC in June 2024.
Internal Audit – Discharge Processes	8 (3 External)	August 2023	3- External 5 - revised completion dates lapsed	Long Term Care	An internal audit report on 'Transforming Urgent & Emergency Care (TUEC) Discharge management' is being undertaken and due to be presented to ARAC April 2024. This report will include following up on all the recommendations in the Discharge Processes report, with updates to be reflected in the next paper to ARAC in June 2024.
Internal Audit - Job Planning	3	December 2023	3- Revised completion date lapsed	Medical	A follow up review of this audit report is due to take place in Q4 of 2023/24, with progress updates and revised completion dates to be reflected in future reports to ARAC once finalised.

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Internal Audit - Falls Prevention and Management	1 External	June 2023	1 – External	Nursing	This recommendation relates to the development and implementation of a falls prevention and management training programme which should form part of the Health Board's Falls Strategy. However its implementation is reliant on working with the All-Wales Inpatient Falls Network in developing a mandatory e-learning falls training programme, the pilot of which is currently being trialled before submitting final plans to EAGLE panel for approval. Progress update and revised timescales are currently being sought from the service, with updates to be reflected to ARAC in June 2024.
Internal Audit – Fitness For Digital – Use of Digital Technology	1	September 2023	1- Revised completion date lapsed	Digital	A revised completion date has not yet been provided for this recommendation, which relates to the Health Board moving data from on-premises to the cloud by creating a Regional Data Repository. A Strategic Options Appraisal was due to be completed by February 2023 followed by a "Case for Change" business case in September 2023, with delivery of the project expected to be completed in March 2024. Progress will be sought from the Digital Director, with updates to be reflected to ARAC in June 2024

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Internal Audit- Cyber Security (November 2022)	1	December 2023	1 – Revised completion date lapsed	Digital	A revised completion date has not yet been provided for this recommendation, which relates to the creation of a central mailbox to manage all cyber alerts. The mailbox has now been established but the Assurance and Risk Team are awaiting confirmation as to whether a standard operating procedure (SOP) is in place in order to fully complete this recommendation. Updates and a revised completion date will be reflected in the next paper to ARAC in June 2024.
Internal Audit – IT Infrastructure	2 (1 External)	October 2023	1 – Original completion date lapsed 1 – External	Digital	Revised dates have not yet been provided for these recommendations. It is anticipated that the launch of ARMIS (asset management and cyber security system) will supersede the management responses as initially provided. ARMIS has been procured, with rollout to commence in April 2024 and a 6-month plan to become “business as usual”. Revised dates and updates will be reflected in the next paper to ARAC in June 2024.
Internal Audit – Regional Integration Fund (RIF)	1 External	September 2023	1 – External	Finance	This recommendation, which contains an action for the Health Board to finalise a Memorandum of Understanding which clearly sets out the key roles and responsibilities for the governance and accountability arrangements for the Regional Integration Fund for the next financial year, was assigned an ‘external’ status in December 2023 as the Health Board is awaiting progress with the Local Authority.

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Internal Audit – Deprivation of Liberty Safeguards (DoLS) (August 2023)	1	January 2024	1 – Original completion date lapsed since previous meeting	Long Term Care	Internal Audit are considering evidence provided by the service to close this recommendation, which will be reflected in the next paper to ARAC in June 2024.
Internal Audit – Follow-up: Strategic Programme Governance	4	August 2023	4 – Original completion dates lapsed	Finance (with support from Strategic Planning)	Progress updates and revised completion dates on this report have been requested to be reflected in the next paper to ARAC in June 2024.
Internal Audit- Estates Condition	2	December 2023	1 – Original completion dates lapsed 1 – Original completion dates lapsed since previous meeting	Estates	Confirmation is currently being sought from IA in order to close these recommendations, with updates to be reflected in the next paper to ARAC in June 2024.

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NHS Wales Executive- Children and Young Person's Neurodevelopmental Services All Wales Review	1	January 2024	Original completion date lapsed since previous meeting	Mental Health & Learning Disabilities	Progress update and revised timescale are currently being sought from the service, with updates to be reflected to ARAC in June 2024.
NHS Wales Executive- Review of Psychology & Psychological Interventions for Children and Young People	2	January 2024	Original completion dates lapsed since previous meeting	Mental Health & Learning Disabilities	Progress updates and revised timescales are currently being sought from the service, with updates to be reflected to ARAC in June 2024.
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	3	December 2023	2- Original completion date lapsed since previous meeting 1- Awaiting service update via AMaT	Mental Health & Learning Disabilities	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.

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Peer Review – Follow up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	1 External	October 2023	1 - External	Women and Children's Services	The Congenital Heart Defect Network have confirmed there is no further action required by the Health Board at this time for this recommendation until a standardised national template is agreed and made available. In the interim, other actions have been put in place to ensure the high quality of information exchanged when children and young people are transferred between different networks.
Peer Review - Hywel Dda UHB Lung Report, issued January 2020	1	September 2023	1 – Original completion date lapsed	Unscheduled Care (PPH)	A risk regarding the fragility of this service has been added to the Respiratory risk register (1655: Fragility of Lung Cancer Service). With a current risk score of 6 reflecting current management processes and one additional consultant in Lung Cancer. There is no consistent Pathology representation at Multi-Disciplinary Team (MDT) meetings due to significant staffing issues, however, Consultants are happy to discuss cases outside the MDT to avoid delays in diagnosis. The Lung Cancer MDT Lead has advised that this recommendation is not within their gift to resolve. The Respiratory Service are liaising with the Pathology Service for confirmation that this outstanding recommendation can be re-assigned.

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Peer Review - Out of Hours	4 (1 External)	September 2023	1 - External 3 - Revised completion date lapsed	Central Operations	1 recommendation has an 'external' status and is awaiting national guidance to be been received. Once received, the development of a policy that support clinicians to undertake tasks related to remote prescribing will be undertaken. Updates have received on the 3 recommendations however revised timescales are dependent on confirmation of the acute services restructure, as well as changes to the WAST front end Clinical Assessment programme. The Assurance and Risk Team will be seeking further progress updates and revised completion dates, with updates to be reflected in the report to ARAC in June 2024.
Peer Review - Getting It Right First Time (GIRFT) General Surgery Review	1 External	December 2023	1- External	Scheduled Care	The implementation of this recommendation is currently outside the gift of the Health Board and has therefore been given an 'external' status as the service await the rollout of a national E-consent programme. Any further updates will be reflected in the report to ARAC in June 2024.
Peer Review – Respiratory Cancer (June 2016	1	July 2016	1 – Original completion date lapsed	Unscheduled Care (PPH)	The strategic review noted within the original management response has taken place and the service have recruited a locum consultant to support the previous lone working consultant. Confirmation is required from the Director of Operations to formally approve the closure of this recommendation. This has been the position since reporting to ARAC in December 2023.

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Public Health Wales - Llwynhendy Tuberculosis Outbreak External Review	6 External	July 2023	3 external – original completion date lapsed 3 external – original completion date not known.	Medical	6 recommendations have been given an 'external' status and are led by Public Health Wales (PHW) with support from Welsh Government. Updates have been provided by PHW including the development of the TB elimination strategic action plan, however revised dates have not been provided.
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	1	March 2023	1 - revised completion date lapsed	Medical	The Assurance and Risk Team have requested updates on these recommendations, with updates to be reflected to ARAC in June 2024.
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	1 External	October 2023	1- External	Director of Operations	WRP confirmed in October 2023 that they are developing a new EIDO Patient Information platform which will enable the health board to develop its own searchable database of local procedure specific consent leaflets. The Assurance and Risk Team will be seeking progress updates and revised completion dates for migration to the new platform.

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Welsh Risk Pool- Concerns Assessment	1	December 2023	1- Awaiting service update via AMaT	NQPE	Progress updates and revised timescales are required from the service on AMaT, with updates to be reflected to ARAC in June 2024.
Total number of N/K Recs	**107**				