Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 February 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.

Cefndir / Background

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

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

Asesiad / Assessment

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

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

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

Since the report was last presented to ARAC in December 2023, 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 is liaising with colleagues in the Quality, Assurance and Safety Team (QAST) and Effective Clinical Practice to understand system capabilities, and any impact this would have on the assurance being provided to committees. An impact assessment and project plan will be presented to ARAC in due course, on completion of this work.

Since the previous report, 7 reports have been closed or superseded on the Audit Tracker, and 20 new reports have been received by the Health Board, as detailed in Appendix 2.

As of 15 January 2024, the number of open reports has increased from 123 to 134. 52 of these reports have recommendations that have exceeded their original completion date, an increase from the 45 reports previously reported in December 2023. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is an increase in the number of recommendations where the original implementation date has passed since the previous meeting, from 166 to 230, noting that 57 of these are a result of the outcomes of the reconciliation exercise between the Audit and Inspection tracker and AMaT, coupled with current operational demands.

The number of recommendations that have gone beyond six months of their original completion date has increased from 47 to 66, as reported in December 2023. The Assurance and Risk Team continues to work with services to address recommendations via local governance arrangements and Improving Together sessions, and escalating any matters of concern to the relevant Lead Executive.

Details on these movements can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR. The table below provides the Audit Tracker detail per regulator. Abbreviations are clarified in the Glossary of Terms section of this SBAR.

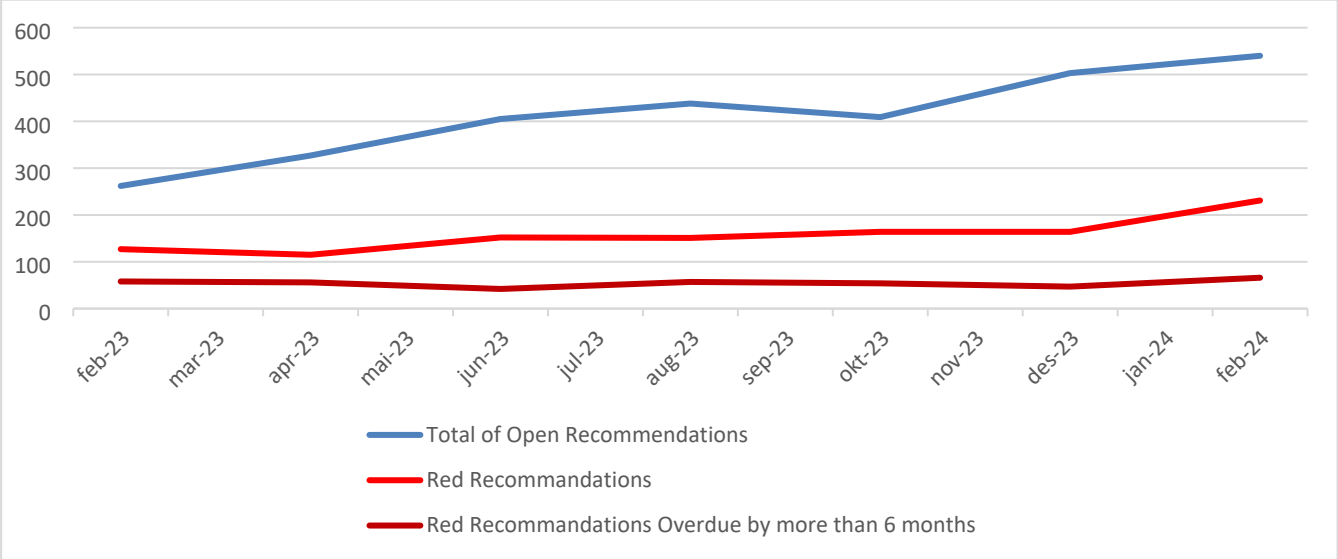
Summary of open reports per Inspectorate

Inspectorate / Regulator	Open reports at ARAC December 23	New reports since December 23	Closed reports since December 23	Open reports at ARAC February 24	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	7	0	0	7	3	6	3
HEIW	2	0	0	2	1	3	0
HIW	13	2	1	14	8	79	9
Independent Review	1	0	0	1	0	1	0
IA	29	4	5	28	17	44	18
Internal Review	0	0	0	0	0	0	0
Llais	3	3	1	5	3	11	6
MWWFRS	41	3	1	43	4	9	0
Natural Resources Wales	2	0	0	2	0	0	0
NHS Wales Cyber Resilience Unit[3]	1	0	0	1	0	9	3
NHS Wales Executive[4]	6	2	0	8	4	9	3
Peer Reviews	9	1	0	10	8	44	20
PSOW - S21	5	4	1	8	0	2	0
PHW	1	0	0	1	1	1	1
Royal Colleges	1	0	0	1	1	3	3
Welsh Risk Pool	1	1	0	2	1	9	0
WLC	1	0	0	1	1	0	0
TOTAL	**123**	**20**	**9**	**134**	**52**	**230**	**66**

1 Reports which have passed their original implementation date
2 Original implementation date noted for the recommendation has passed, or will not be met
3 These recommendations are not included on Appendix 1 due to the sensitive nature of the information.
4 Formerly Delivery Unit.

There are currently **539 open recommendations** (an increase from the 503 reported in December 2023) on the audit tracker, and detailed in Appendix 1 (which includes the 42 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 overleaf 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 last year.



Appendix 1 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 2 details reports which have been added to the Audit tracker since December 2023.

There are 140 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported) (December 2023: 77). Individual recommendations are included in Appendix 3, which details the date at which recommendations became N/K, and the reason why they are N/K.

The 140 N/K recommendations are comprised of:

- 18 recommendations where original completion dates have lapsed to N/K status since the previous report;
- 95 recommendations where the revised completion dates have lapsed to N/K status and awaiting revised completion dates from the services;
- 15 recommendations noted as 'external', and
- 12 further recommendations from a variety of other reports.

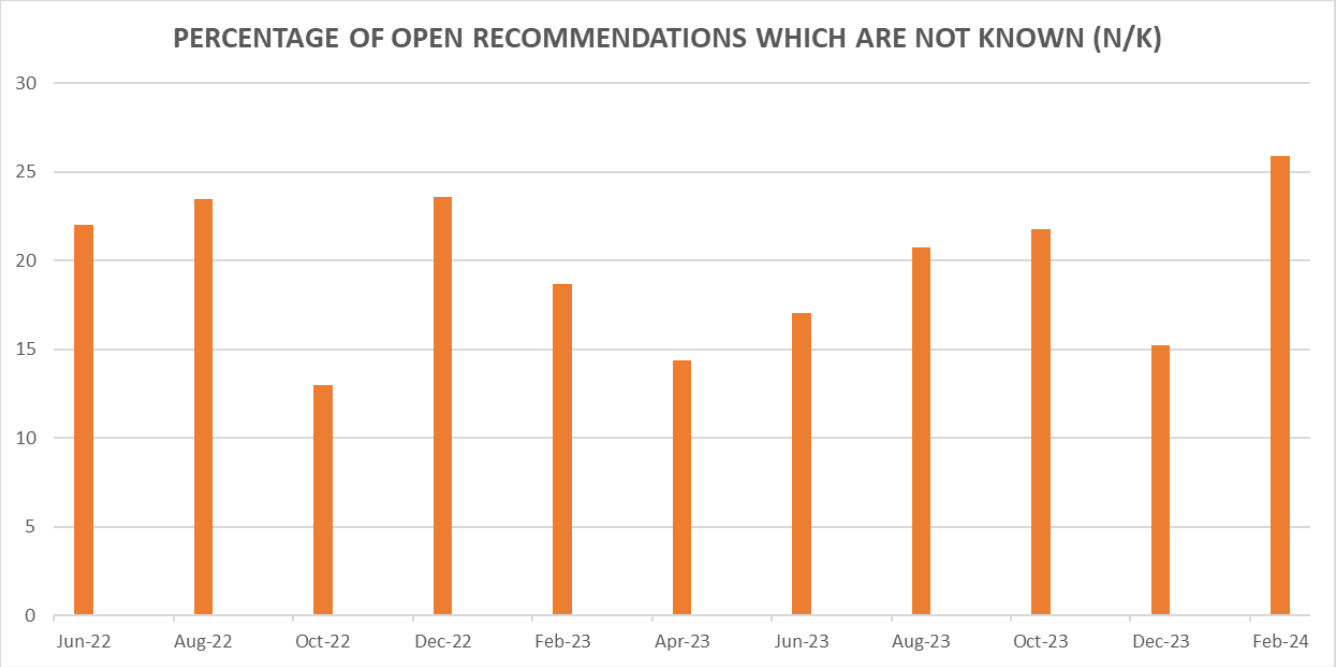
A breakdown is provided below of the N/K recommendations split out by how long overdue they are from their original completion date.

N/K recommendations overdue by	Overdue N/K recommendations at January 2024	Overdue N/K recommendation at November 2023	Trend since previous meeting
1 month	40	21	↑
2 to 3 months	22	23	↓
4 to 5 months	21	13	↑
6 months and over	57	24	↑
Total*	**140**	**81**	

**This 45 is comprised of 9 'external' recommendations and 11 recommendations on the AMaT system which is currently unable to record a revised date field. A request has been made to the National Governance Board of AMaT to establish if a revised date field can be added to the system. Of the remaining 25 recommendations, 10 have Internal Audit follow ups scheduled, with revised dates*

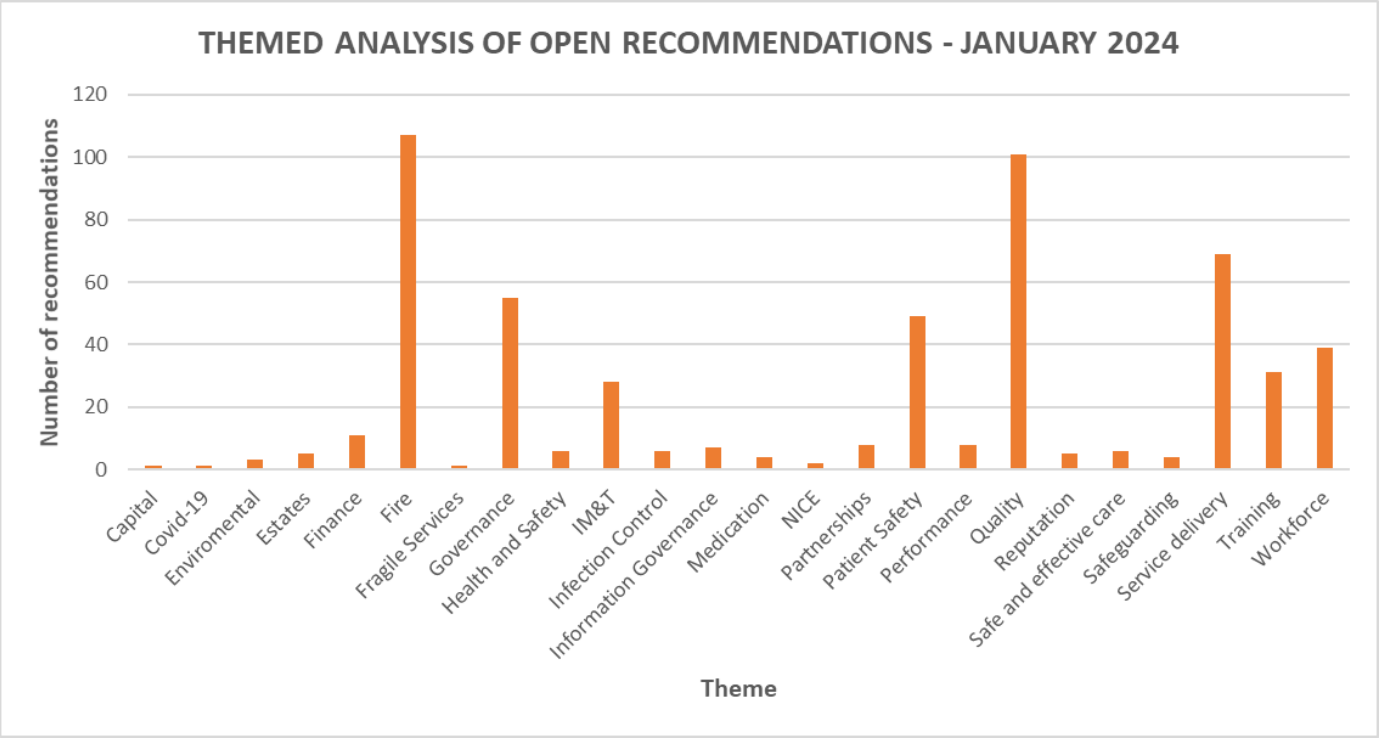
provided where appropriate. The Assurance and Risk team continues to liaise directly with services to establish revised dates where possible, or ensure a reason for is provided for where a revised date cannot currently be given.

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



The Assurance and Risk team continues 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 January 2024, noting that the majority of recommendations relate to the themes of fire, quality, governance and patient safety:



Audit Tracker Summary Per Service / Directorate

A snapshot of the audit tracker activity split by service/directorate as at 15 January 2024 is included from page 10 onwards, including trends since the last report to ARAC in December 2023. 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 do not currently have any open reports on the Audit Tracker:

- Cardiology;
- Carmarthenshire;
- Pathology;
- Performance; 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.

The following trends have been noted since the previous report submitted to ARAC in December 2023 (detail for each service can be found in the table on page 10):

Services with a Concerning Trend

MH&LD

The total number of open recommendations has increased from 55 to 101 since the previous report, 57 of which are now overdue (December 2023: 29). 8 recommendations are noted as being overdue by more than 6 months (December 2023: 6).

The increase of 28 overdue recommendations since December 2023 ARAC is as follows:

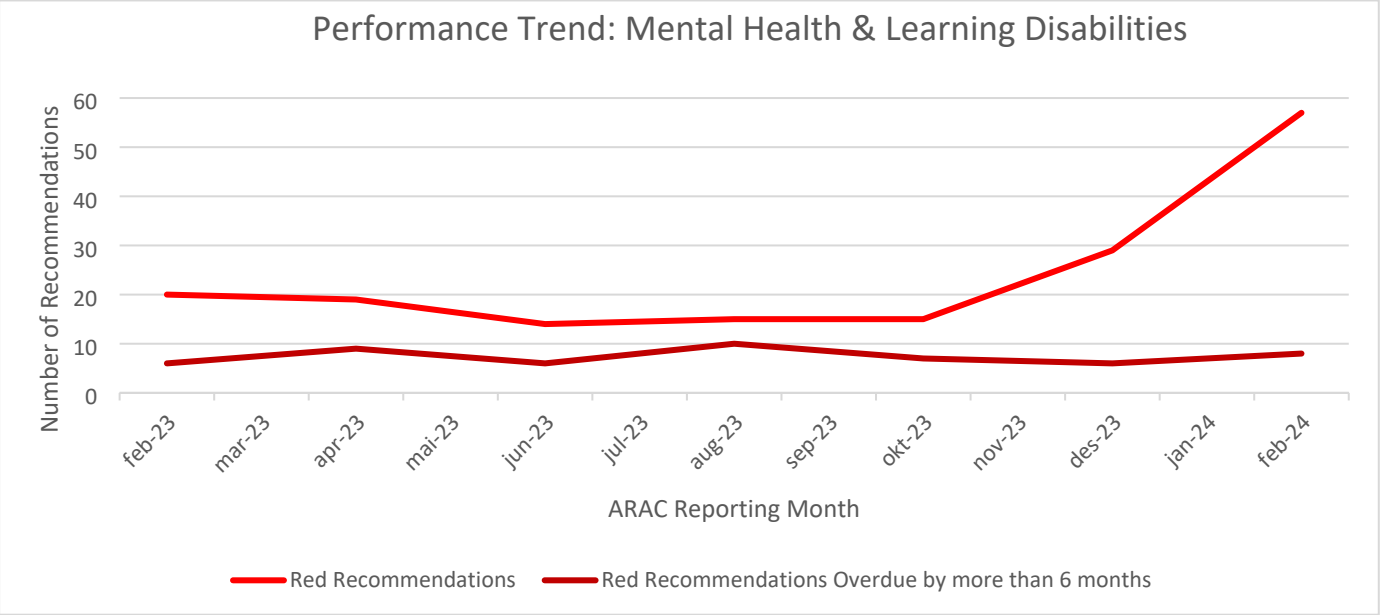
- 8 from the new Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability report- all without revised timescales (N/K), 3 of which have recently lapsed at the end of December 2023 and 5 without management responses noted on AMaT. The Patient Safety and Assurance Manager is meeting with the Assistant Director of Mental Health and Learning Disabilities to establish the remaining management responses to be added to AMaT;
- 7 from the new HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH report – all without revised timescales (N/K), 3 of which recently lapsed in December 2023, and 4 without management responses noted on AMaT. The Patient Safety and Assurance Manager is meeting with the Assistant Director of Mental Health and Learning Disabilities to establish the remaining management responses to be added to AMaT;
- 4 from the re-opened HIW Ty Bryn report- report re-opened at the request of the Director of Nursing, Quality and Patient Experience in September 2023, following discussions with HIW regarding the potential use of the building moving forward;

- 8 from the HIW Mental Health Discharge Review - all which have lapsed at the end of December 2023 without revised timescales (N/K), and
- 1 from the Audit Wales Review of Mental Health and Learning Disabilities Directorate Governance Arrangements. The Director of Mental Health and Learning Disabilities will be presenting a progress update on this review at the February 2024 ARAC meeting.

Of the 57 overdue recommendations, 28 relate to the HIW Mental Health Discharge Review. The Assistant Director of Nursing MH&LD is determining revised timescales, with support from the Interim Director Nursing, Quality & Patient Experience.

The number of overdue recommendations without timescales (N/Ks) has increased from 3 to 34. 14 of these have original timescales which have lapsed since the previous report, 9 are due to management responses not yet being included AMAT (detailed above), and 11 due to no revised timescales being provided by the service via the AMAT system.

While MHLD have not been noted in two consecutive reports to ARAC as one with a concerning trend, this is the third time MHLD has been identified as a service with a concerning variation since April 2023 (previously highlighted in April and August 2023). This is due to the increasing number of overdue (red) recommendations. The Assurance and Risk team continues to work closely with the service to obtain progress updates, and request revised completion dates, however this maybe a service area that ARAC would like to hold a deep dive with.



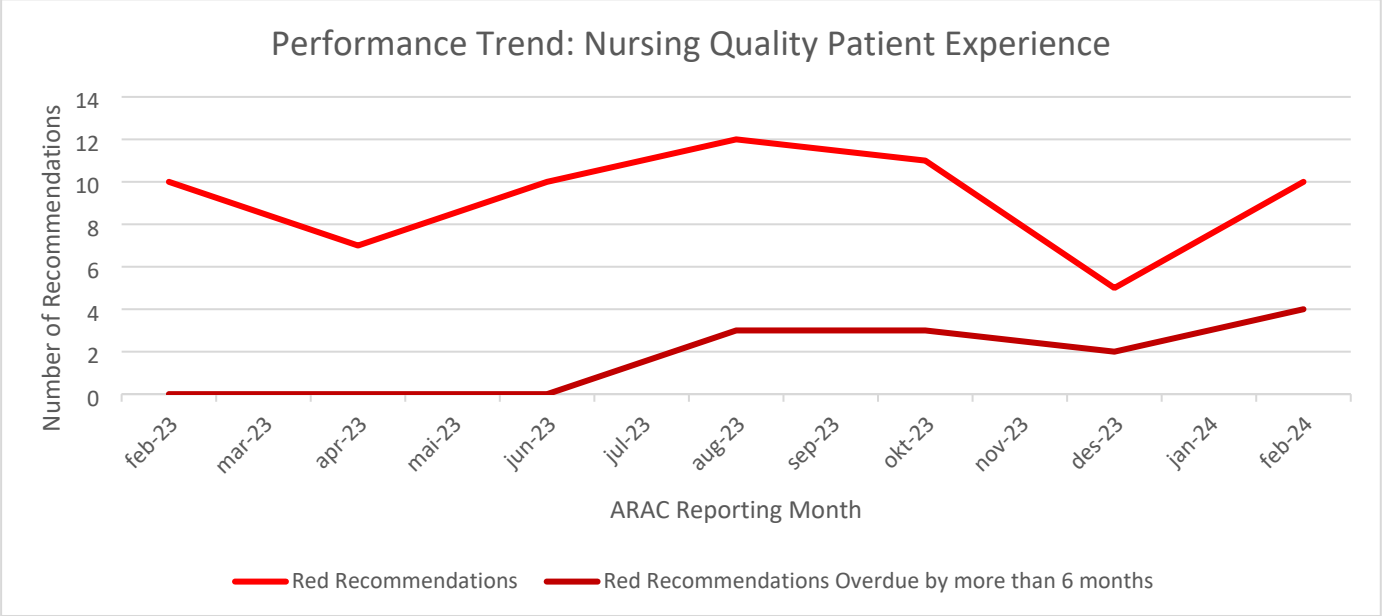
NQPE

The total number of open recommendations has increased from 11 to 17 since the previous report, due to the addition of the new WRP Concerns Assessment report with 6 recommendations. This has resulted in an increase in the number of overdue recommendations, as 5 recommendations from this report lapsed at the end of December 2023, 4 of which have no revised timescales provided (N/K).

The number of overdue recommendations has increased from 5 to 10 since the previous report, 4 of which are overdue by more than 6 months (December 2023: 4). Of the overdue recommendations, 7 have no revised timescales (N/K) (December 2023: 1).

This is the third time NQPE have been identified as a service with a concerning trend since April 2023 (previously highlighted in August and October 2023), due to the increasing number of over

(red) recommendations and the number of recommendations overdue by more than 6 months. The Assurance and Risk team continues to work closely with the service to obtain progress updates and request revised completion dates, however this maybe a service area that ARAC would like to hold a deep dive with.

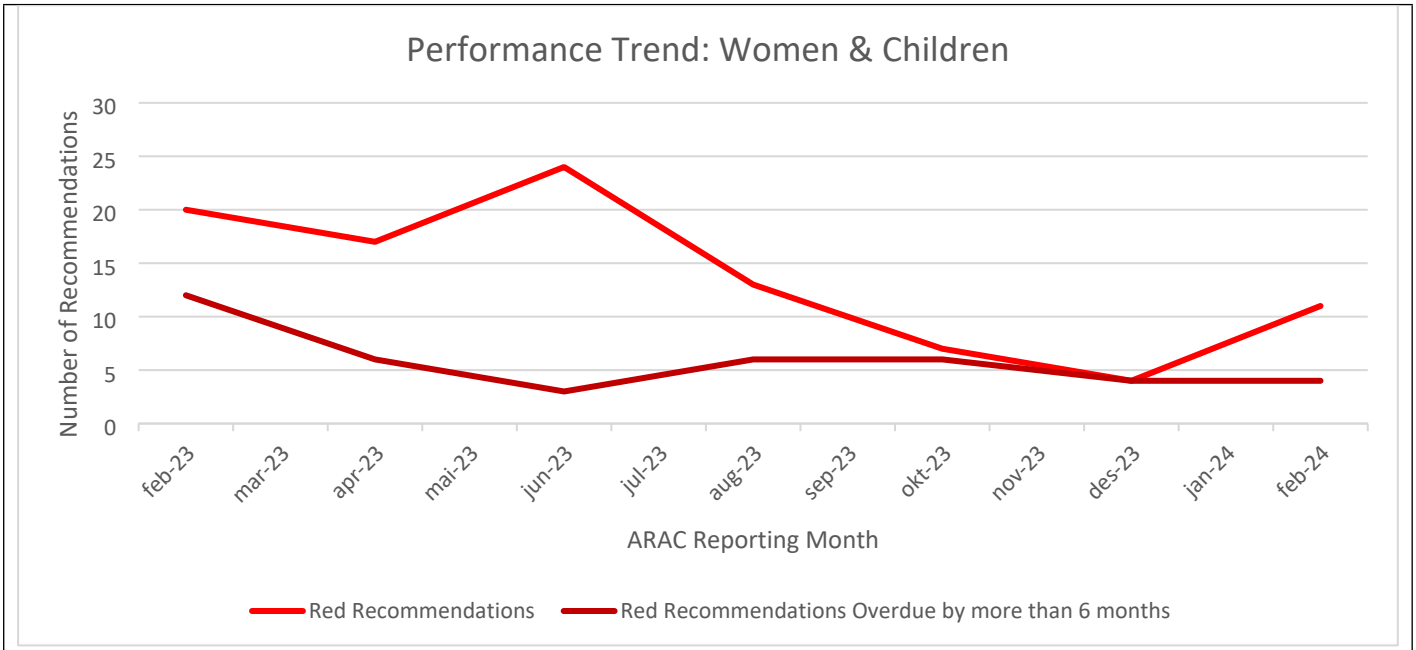


Women & Children

The total number of open recommendations has increased from 12 to 19 since the previous report, due to the addition of 9 recommendations as a result of a recent reconciliation exercise undertaken between the AMAT system and the Central Audit and Inspection Tracker.

The number of overdue recommendations has increased from 4 to 11, with 10 of these having timescales that do not have revised completion dates, and therefore noted as ‘not known’ (N/K). 3 of these N/K recommendations relate to the Congenital Heart Defect Provider peer review report. It is noted that a follow-up review has been undertaken, with findings and recommendations from this review superseding the original, and these will be reflected in the numbers presented to ARAC in April 2024. 6 of the N/K recommendations belong to the HIW report on Bronglais Hospital Maternity Unit and 1 to the Llais West Wales Maternity Services report, and do not have revised timescales for completion.

This is the second time Women & Children have been identified as a service with a concerning trend since April 2023 (previously highlighted in April 2023), due to the increasing number of over (red) recommendations. The Assurance and Risk team continues to work closely with the service to obtain progress updates, request revised completion dates and continue to monitor progress of actions updated via AMaT.



Services with Improved Performance since previous meeting

The service below was previously noted as having a concerning trend to ARAC, however has since demonstrated an improving trend based on current performance:

Digital

Since the previous report presented to ARAC, the number of overdue recommendations has decreased from 16 to 14, and the number of overdue recommendations with a N/K timescale has decreased from 4 to 3. A full review of all recommendations on the Audit and Inspection tracker will be undertaken following the launch and implementation of the ARMIS system, as it is envisaged that this will address many of the remaining open recommendations, with 8 recommendations identified as being subject to closure.

The arrows included in the table below are as follows:

⇧	Increase in number of recommendations / reports
⇩	Decrease in number of recommendations / reports
⇔	No change in number of recommendations / reports

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Acute Services	1 →	1 →	6 →	0 →	0 →	• 1 HIW National Review on WAST - 6 recommendations remain with an 'External' status as they are for WAST consideration. Report to remain open on the audit and inspection tracker until the Director of Secondary Care has provided an update to the Interim Director of Nursing, Quality & Patient Experience for final confirmation to close report .
Cancer Services	1 →	1 →	2 →	2 →	2 →	• 1 Peer Review on Colorectal Cancer – 2 recommendations overdue by more than 6 months, with revised completion dates of March 2024 and January 2025.
CEO Office (Welsh Language)	1 →	1 →	1 →	1 →	1 →	• 1 follow-up IA report on Welsh Language Standards - 1 recommendation overdue by more than 6 months with a revised timescale currently 'not known' (N/K). Since the data was extracted from the tracker for reporting, an update has been received from the service and will be reflected at April ARAC.
Central Operations	3 →	3 ↑	18 ↓	17 →	9 ↑	1 IA report on Record Digitisation – 3 recommendations, 2 of which are overdue by more than 6 months. Revised completion dates have been obtained of January 2024. IA will be undertaking a follow up Records Digitisation audit in Q4 of 2023/2024. • 1 IA report on Records Management – 3 recommendations overdue with revised completion dates of March 2027, 1 of which is by more than 6 months. Following discussion at the Central Operations DITS, approval has been requested from IA to close outstanding recommendations due to the developments within Health Records since initial report presented, and considered obsolete. • 1 Peer Review on Out of Hours – 12 recommendations, 11 overdue, of which 6 are overdue by more the 6 months. 1 recommendation with an 'External' status.
Ceredigion **NEW**	2 N/A	2 N/A	7 N/A	7 N/A	2 N/A	• 1 new PSOW report 202200883 - 2 recommendations overdue with revised timescales which are 'not known' (N/K). • 1 new Llais report on Palliative End of Life Care (issued March 2023) – 5 overdue recommendations with revised timescales that are 'not known' (N/K). Updates have been obtained from the service since data extracted for the report, and progress will be reflected to ARAC in April 2024.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Digital	5 ↑	1 →	24 ↑	14 ↓	6 ↑	• 1 new IA report on Technical Resilience – 5 recommendations with completion dates of May 2024. Due to the sensitive nature of this report, progress of these recommendations will be monitored bi-monthly via the Sustainable Resources Committee (SRC) In-Committee. • 1 IA report on Fitness for Digital – Use of Digital Technology - 1 recommendation which is overdue by more than 6 months without a revised timescale (N/K). • 1 NHS Wales Cyber Resilience Unit report on Cyber Assessment Framework – 12 outstanding recommendations, 9 of which are overdue, with 3 overdue by more than 6 months. Revised timescales range from March 2024 to March 2026. 1 recommendation is on schedule for completion by March 2024, and 2 have an 'external' status. Due to the sensitive nature of this report, progress of these recommendations is monitored bi-monthly via the Sustainable Resources Committee (SRC) In-Committee. • 1 IA report on IT Infrastructure - 5 recommendations, 1 of which is overdue without a revised timescale (N/K), 2 which are overdue (1 by over 6 months) with revised completion dates of May 2024, 1 which is on track for completion by March 2024 and 1 which is noted as 'external'. • 1 IA report on Cyber Security - 1 recommendation reopened by IA who have requested additional work be undertaken to fully complete, overdue by more than 6 months with a revised timescale that is 'not known' (N/K).
Director of Operations	2 →	2 →	7 ↓	5 →	1 →	• 1 WRP report A National Review of Consent to Examination & Treatment Standards in NHS Wales – 4 recommendations overdue, 3 with revised timescales of March 2024 and one without a revised timescale (N/K). 1 recommendation noted as 'external' with revised completion date of February 2024. • 1 AW Review of Quality Governance Arrangements – 1 recommendation overdue by more than 6 months with a revised completion date of September 2024, and 1 recommendation which has an 'external' status with a revised completion date of November 2024.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Estates	47 ↑	6 ↓	114 ↓	10 ↑	0 →	• 3 new Letters of Fire Safety Matters (LOFSMs) with a combined total of 20 recommendations (7 completed and 13 on schedule) with varying dates from January to May 2024. • 1 new IA Estates Condition report – 1 recommendation lapsed at the end of December 2023 without a revised timescales (N/K) (confirmation has been requested from Internal Audit if this recommendation can be closed) and 6 recommendations on schedule with varying dates from January to July 2024. • The number of recommendations has decreased from 146 to 114 (9 of these recommendations are from 4 IA reports, with the remainder from the 4 MWWFRS Enforcement Notices (ENs) and LOFSMs). • The number of overdue recommendations has increased from 9 to 10. 1 of these recommendations is from the new IA Estates Condition report (see detail above). 4 recommendations from 4 LOFSMs have been delayed but due to be completed by end of January 2024. 4 recommendations from 4 LOFSMs have revised completion dates of March 2024 due to fire doors not being repairable and therefore needing replacing. 1 recommendation from 1 LOFSM it forms part of the main GGH fire project. Revised timescale is being clarified with the Estates service. • 1 EN and 12 LOFSMs have all recommendations completed. Assurance and Risk Team awaiting approval from MWWFRS to close report. All MWWFRS reports are overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting. • MWWFRS EN Withybush General Hospital report closed since previous report.
Finance	5 →	3 →	9 ↑	6 ↑	0 →	• 1 new Independent Review on Savings Governance Review – 2 recommendations, 1 of which is overdue without a revised timescale (N/K). • 1 new IA report on Follow-up: Strategic Programme Governance – 4 overdue recommendations without a revised timescale (N/K), this report has superseded the Strategic Programme Governance report and updates have been requested from the service. • 1 Audit Wales report on Audit Wales ISA 260 and Letter of Representation 2022/23 – 1 recommendation with a completion of March 2024. • 1 IA report on Financial Management – 1 overdue recommendation with a revised timescale of March 2024. • 1 IA report on Regional Integration Fund – 1 'external' recommendation.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Governance	1 ↓	0 →	2 →	1 →	0 →	• 1 AW report on Structured Assessment 2022 – 2 recommendations on schedule for completion by September 2024. • 1 IA report Board Oversight Final Internal Audit Report closed since the previous report. • 1 IA report on Escalation Status Actions closed since the previous report.
Long Term Care	2 ↑	1 →	11 ↑	6 ↑	5 →	• 1 IA Deprivation of Liberty Safeguards (DoLS) report – 4 recommendations, 1 of which is without a revised timescale (N/K). This report has been re-assigned from Primary Care to Long Term Care since the last report. • 1 IA Discharge Processes report – 2 'external' recommendations and 5 overdue by more than 6 months without revised timescales (N/K). An IA report on 'Transforming Urgent and Emergency Care (TUEC) Discharge management' is scheduled for presentation to ARAC in February 2024 and will include a follow up of recommendations.
Medical	7 →	6 ↑	26 →	14 ↑	7 ↑	• 1 HEIW report on Revalidation Quality Review – 7 recommendations, 2 are overdue, 1 of which without a revised timescale (N/K) and 1 with a revised completion date of April 2024. • 1 HEIW report on Surgical Specialties, Glangwili General Hospital (GGH) – 2 recommendations, 1 of which is overdue with revised timescale of March 2024. 1 recommendation noted as 'external'. • 1 IA report on Individual Patient Funding Requests – 1 recommendation overdue by more than 6 months without a revised timescale (N/K). • 1 IA report on Job Planning – 4 recommendations are overdue of which 2 are overdue by more than 6 months. A follow-up audit is due to take place in Q4 2023/24. • 1 IA report on NICE guidelines – 2 recommendations are overdue and without a revised timescale (N/K). A follow-up report is due to be presented to February ARAC. To note, since this data was extracted from the tracker for reporting, further updates have been obtained and will be reflected in the next report to ARAC in April 2024. • 1 PHW report on Llwynhendy Tuberculosis Outbreak External Review - 7 recommendations, with 6 noted as 'external' and led by Public Health Wales. Remaining recommendation is overdue by more than 6 months and without a revised timescale (N/K). • 1 RCP report on Visit to Ysbyty Bronglais - 3 recommendations overdue by more than 6 months, of which 1 without a revised timescale (N/K).

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Medicines Management	1 ➔	1 ➔	1 ➔	0 ➔	0 ➔	• 1 AW report on Medicines Management in Acute Hospitals - 1 'external' recommendation.
MH&LD	16 ↑	5 ↑	101 ↑	57 ↑	8 ↑	• 2 new NHS Wales Executive reports with 18 recommendations on schedule, with varying timescales from January to December 2024. • 1 new peer review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability - 7 recommendations with varying timescales from March to June 2024. 8 overdue recommendations without revised timescales (N/K), 3 of which have recently lapsed at the end of December 2023 and 5 without management responses noted on AMaT. • 1 new HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH report - 11 recommendations on schedule with timescales to September 2024. 7 overdue recommendations without revised timescales (N/K), 3 of which recently lapsed in December 2023, and 4 without management responses noted on AMaT. • 1 new PSOW report 202203842 - 1 recommendation on schedule to February 2024. • 1 HIW Ty Bryn report re-opened at the request of the Director of Nursing, Quality and Patient Experience in September 2023, following discussions with HIW regarding the potential use of the building moving forward. 4 recommendations overdue by more than 6 months without revised timescales (N/K).1 AW report on Review of Mental Health and Learning Disabilities Directorate Governance Arrangements – 3 overdue (1 overdue by over 6 months) with revised timescales to July 2023 • 1 DU report on Review of Memory Assessment Services - 1 recommendation on schedule with completion date of March 2024. • 1 DU report on All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults – 1 recommendation on schedule for March 2024, and 1 recommendation overdue which has a revised date of January 2024. • 1 DU report on All Wales Review of Primary & Secondary Mental Health Services for Children & Young People –1 recommendation overdue with a revised date of February 2024. • 1 DU report on Review of Psychological Therapies in Wales - 2 recommendations overdue with revised timescales to March 2024. • 1 HIW report on Mental Health Discharge Review – 3 recommendations on schedule with March 2024 timescales. 28 recommendations overdue, with 8 lapsing in December 2023. 14 recommendations have revised completion dates to April 2024, and 14 without revised timescales (N/K). The Assistant Director of Nursing MH&LD is determining revised timescales, with support from the Interim Director of Nursing, Quality & Patient Experience.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
MH&LD (cont'd)	16 ↑	5 ↑	101 ↑	57 ↑	8 ↑	• 1 HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months, 1 with a revised timescale of March 2024 and 1 without a revised timescale (N/K). Both recommendations are reliant on the completion of Estates work in order to close. • 1 HIW Bryngofal Ward, Prince Phillip Hospital, issued October 2022 - 1 recommendation overdue by more than 6 months with a revised completion date of January 2024. • 1 HIW National Review of Mental Health Crisis Prevention in the Community - all recommendations completed and waiting formal approval via the AMaT system to close. • IA report on Timely Access - 2 recommendations with completion dates of March 2024. • 1 CHC report on S-CAMHS closed since the previous meeting.
NQPE	8 ↑	3 →	17 ↑	10 ↑	4 ↑	• 1 new WRP Concerns Assessment report - 6 recommendations, 5 overdue (4 are without a revised timescale (N/K), 1 with a revised completion date of January 2024) and 1 on schedule with a completion date of March 2024. • 1 CHC report on Accident and Emergency Departments – 2 recommendations overdue by more than 6 months, 1 with a revised completion date of February 2024 and 1 without a revised completion date (N/K) • 1 IA Safety Indicators – Pressure Damage and Medication Errors – 2 overdue recommendations, 1 of which by more than 6 months, both without revised completion dates (N/K). • 1 PSOW report 202102692 – 2 recommendations on schedule with completion dates of January 2024. • 1 PSOW Annual Letter 22/23 – 4 recommendations completed, with evidence to be submitted to PSOW to officially close the report. • 1 IA Patient Experience – all recommendations complete and awaiting formal approval for closure from IA.
Primary Care	1 ↓	1 →	1 ↓	0 ↓	0 ↓	• 1 WLC report on Primary care training and the Welsh language report – 1 'external' recommendation. • 1 IA Deprivation of Liberty Safeguards (DoLS) report –report has been re-assigned from Primary Care to Long Term Care.
Radiology	3 →	1 →	6 ↓	1 ↓	0 ↓	• 1 NRW report on Radioactive Substance Regulation (RSR) Compliance Assessment Report (Sealed Radioactive Sources) – 1 recommendation on schedule for completion by January 2024. • 1 NRW report on RSR Compliance Assessment Report (Unsealed Radioactive Sources) – 4 recommendations on schedule for completion between January and April 2024. • 1 HIW IRMER report GGH – 1 overdue recommendation without a revised timescale (N/K).

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Scheduled Care	9 ↑	6 →	78 ↓	24 →	13 ↑	• 1 new PSOW report 202208731 – All recommendations complete and awaiting formal approval for closure. • 1 Peer Review on GIRFT Ophthalmology Review – 53 recommendations, 1 which lapsed in December 2023 and revised date of January 2024 provided, and 52 on track for completion between February and April 2024. • 1 IA report on Theatre Loan Trays and Consumables – 2 recommendations, 1 overdue with a revised timescale of March 2024 and 1 on schedule for completion by December 2024. A follow-up review of this audit report is due in Q4 2024. • 1 Peer Review on GIRFT General Surgery – 13 overdue recommendations, 8 of which are overdue with revised completion dates of January and March 2024. 4 recommendations overdue by more than 6 months with revised completion dates of January and March 2024. 1 recommendation without a revised completion date (N/K). • 1 Peer Review on GIRFT Orthopaedic Review – 1 recommendation overdue by more than 6 months with a revised timescale of March 2024. • 1 CHC report on Eye Care Services in Wales (March 2022) – 2 recommendations overdue by more than 6 months with revised timescales of March 2024, and 1 'external' recommendation. • 2 DU reports – 5 recommendations overdue by more than 6 months, 2 with revised completion dates of March and December 2024, and 3 without revised completion dates (N/K). • 1 HIW report – 1 recommendation overdue by more than 6 months, without a revised completion date' (N/K).
Strategic Development & Operational Planning	4 →	3 ↑	17 ↓	10 ↑	2 ↓	• 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangement – 1 recommendation overdue by more than 6 months, with revised completion date of March 2024. 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangements – 1 recommendation overdue by more than 6 months, with revised completion date of March 2024. Further progress update will be provided to ARAC in April 2024. • 1 IA report on A Healthier Mid & West Wales Programme – 7 recommendations overdue (1 of which is overdue by more than 6 months) with revised completion dates of January 2024 and March 2024, and 2 recommendations on schedule for completion by January 2024. • 1 IA report on Decarbonisation – 2 recommendations on schedule with completion dates of January and March 2025, and 3 'external' recommendations. • 1 Peer Review – Planning Arrangements in Hywel Dda University Health Board – 2 recommendations overdue with revised completion dates of March 2024.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
USC BGH	1 →	1 ↑	3 ↓	3 ↑	0 →	• 1 IA report on Quality & Safety Governance, BGH – 3 recommendations overdue without revised completion dates (N/K). A follow-up IA is scheduled to be presented to ARAC in February 2024, with progress to be reflected in the next Audit and Inspection Tracker paper in April 2024.
USC GGH	1 →	1 →	3 ↓	3 ↓	2 ↑	• 1 HIW report on the Emergency Unit at GGH – 3 recommendations overdue,2 of which overdue by more than 6 months, without revised completion dates (N/K).
USC PPH	4 →	1 →	9 ↑	8 ↑	0 ↓	• 1 HIW report on PPH Minor Injuries Unit - 6 recommendations overdue (2 of which recently lapsed at the end of December 2023). 5 of these recommendations have revised dates of January and February 2024, and 1 without a revised timescale (N/K). • 1 Peer Review Lung Report, issued January 2020 - 1 recommendation overdue by more than 6 months without a revised timescale (N/K). Respiratory service to agree with Pathology that the outstanding recommendation should be re-assigned to them. • 1 Peer Review on Respiratory Cancer issued June 2016 – 1 recommendation overdue by more than 6 months. Head of Assurance & Risk to confirm with the Director of Operations on to request if this outstanding recommendation can be closed. • 1 PSOW report 202003536 - all recommendations completion, awaiting confirmation from PSOW that this report can be closed.
USC WGH	3 ↑	0 →	51 ↑	21 ↑	0 →	• 1 new Llais report on West Wales Region Engagement – 3 recommendations, 1 of which is currently overdue without a revised timescale (N/K). • 1 HIW report on Emergency Department Withybush General Hospital – 17 recommendations, of which 15 are currently overdue. • 1 HIW report on National Review of Patient Flow – a journey through the stroke pathway – 31 recommendations, of which 5 are overdue without a revised timescale (N/K) and 8 'External' recommendations.

Service	Open reports as at January 24	Overdue reports As at January 24	Total number open recs January 24	Total overdue (red) recs January 24	Of which overdue by more than 6 months	Comments
Women & Children	5 ➔	2 ↑	19 ↑	11 ↑	4 ➔	• 1 new Llais report on West Wales Maternity Services Report – 2 outstanding recommendations, 1 which is on schedule and 1 which has just lapsed and has a revised timescale which is 'not known' (N/K). • 1 PSOW report 202206868 – all recommendations completed and awaiting confirmation of compliance from Ombudsman Case Manager. • 1 IA report on Glangwili Hospital - Women & Children's Development, issued February 2023 – 1 recommendation on schedule for completion by December 2024. • 1 Peer Review on Congenital Heart Defect Provider, issued October 2021 – 5 recommendations, 1 of which is overdue by more than 6 months with a revised completion date of June 2024, 3 overdue by more than 6 months with no revised timescales (N/K), and 1 'external' recommendation. • 1 HIW report on Bronglais Hospital Maternity Unit – 11 recommendations, 5 of which are on schedule and 6 which are overdue and have revised timescales that are 'not known' (N/K). • 1 IA report on Glangwili Hospital Women & Children's Development, (April 2022) closed since the previous meeting. • 1 HIW report on National Review of Maternity Services closed since the previous meeting.
Workforce & OD	1 ➔	0 ➔	6 ➔	0 ➔	0 ➔	• 1 AW report Review of Workforce Planning Arrangements- 6 recommendations with varying timescales to April 2025. • 1 IA report Agency & Rostering closed since the previous meeting.
Total	**134**	**52**	**539**	**230**	**66**	

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

Argymhelliad / Recommendation

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

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

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

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

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

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	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 to be reported to the Digital Scrutiny Group in February and to the Sustainable Resource Committee. Then to the Executive Board in March for approval prior to submission to Welsh Government.
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.
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-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. 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-23~~ 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 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. 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.
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 urgency.	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Dec-23	~~Dec-23~~ 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)
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.
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 want/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. 12/10/2023- linked to the actions above. 12/10/2023- The 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.
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
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.
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	Mar-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.
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.
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-23	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. NCPE 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.
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.
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 Board routinely 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 (OORM'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 plan to progress the planning, which aligns 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	
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~~ N/A	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) To await further guidance from the DHCW around the delivery of this project.
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	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- 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
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~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jun-23~~ Mar-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 OOTC'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 discussions 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.
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 Council 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~~ N/K	Red	28/11/2022 - Funding agreed awaiting screens. 11/07/2023- to be checked with Heads of Nursing if this has been implemented. 15/09/2023- Deputy HON (PPH) confirmed there are no communication screen in MIU in PPH. 06/10/2023- emailed Digital Director (cc'd Director of NQPE) for progress on digital screens and revised date of implementation. 09/10/2023- Digital Director confirmed • The networking for GGH and PPH has been completed and over the next 2 weeks we will the testing the CCTV and Digital Signage before handing over to the service. • The networking team will be starting onsite in WGH and BGH in the next 2 weeks, with an anticipated completion of 6 weeks before a further 2 weeks of resting before handing over to the service.
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	R1. The Health Board needs to thank staff working in the palliative care teams and associated MDT for taking care of patients when often working under extreme pressure.	Service management to ensure feedback received from Hywel's Voice and scheduled regular meetings within each County is actioned and feedback to staff via these methods.	Jun-23	N/K	Red	Awaiting update from QAST
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	R2a. 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.	Ensure weekly Multi-Disciplinary Team (MDT) meetings are held by the Specialist Palliative Care Teams and GP register meetings are held bi-monthly to discuss patients in the last year of life via case reviews. Individual cases are discussed in detail with review and opportunities to reflect from individual cases.	Sep-23	N/K	Red	Awaiting update from QAST
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	Awaiting update from QAST

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	R3a. 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.	Ensure all patients are offered the opportunity to discuss their advance and future care plans.	Sep-23	N/K	Red	Awaiting update from QAST
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	Awaiting update from QAST
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	R3c. 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.	Implement a training package on advance and future care planning Health Board wide with the aim of improving confidence and competence of the whole work force making it everyone's business.	Sep-23	N/K	Red	Awaiting update from QAST
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	R3d. 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.	The Palliative Care & EOL service to schedule ACP training to health, social care, 3rd sector and care home staff, stressing the importance of involving families and carers in these conversations enabling them to take control over their care plan.	Sep-23	N/K	Red	Awaiting update from QAST
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	Awaiting update from QAST
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	R3f. 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.	Develop a Public Health approach to death and dying and demystifying end of life building on the work to develop a Compassionate Cymru.	Sep-23	N/K	Red	Awaiting update from QAST
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	R3g. 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.	Contribute to the development of all Wales Care Decisions Guidance for Last Days of Life partnership leaflet. This sheet is designed to help and support all involved in providing care during the last days of life. The aim is to help us talk more openly together and help us all work more closely, as partners, to deliver the best care that we can at this important time.	Sep-23	N/K	Red	Awaiting update from QAST
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	R3h. 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.	The Palliative & EOL service ensure public awareness is raised about death and dying through Dying Matters Awareness Week. Clear signposting to http://advancecareplan.org.uk/ http://talkcpr	Sep-23	N/K	Red	Awaiting update from QAST
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	R4a. 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	The Health Board Clinical Nurse Specialists (CNS) to contribute to a review and development of a sustainable 7 day CNS service that is fit for the future. This work will be presented to the All Wales National Programme Board.	Sep-23	N/K	Red	Awaiting update from QAST
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	Awaiting update from QAST
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	R4c. 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	The Palliative & EoL Service will implement training and education programmes to enhance the management of symptoms for all staff (particularly for carers and non-specialist staff) and also further support the work underway in accessing medications in a timely fashion in both secondary care and the community.	Sep-23	N/K	Red	Awaiting update from QAST
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	R5a. The Health Board should regularly review the information it provides to people to ensure it contains current/correct information. It should also commit to capturing peoples' experiences as part of routine service development and monitoring	Ensure the service contributes to the All Wales patient experience feedback form, will be linked to the existing CIVICA system.	Mar-23	N/K	Red	Awaiting update from QAST
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	R5b. The Health Board should regularly review the information it provides to people to ensure it contains current/correct information. It should also commit to capturing peoples' experiences as part of routine service development and monitoring	To refresh the information available to patients on the Hywel Dda internet site as well as a scheduled programme of updates to ensure the information provided is up to date.	Mar-23	N/K	Red	Awaiting update from QAST
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-22~~ Dec-24	Red	13/10/2022 - Update from Primary Care: Optometric Advisor as the Diagnostic Treatment Centre (ODTC) contracts have been awarded to two Providers, one in Haverfordwest and the other in Llanelli. The internal process is being finalised between PC and secondary care colleagues and it is anticipated that clinics will start in November 2022. 10/01/2023 - Update from Primary Care: The internal processes have been agreed. ODTCs to use Consultant Connect to save and be able to share the findings with colleagues in HES. Prior to setting this up, the HB Information Governance (IG) team must agree/sign off a Data Processor Data Protection Impact Assessment (DPIA). HES submitted the DPIA to IG in October and despite them requesting an update on multiple occasions, they still do not have a timescale from IG. Unable to provide revised timescale. 16/01/2023 - Update from Rachel Absalom: We are awaiting confirmation from IG that we can progress and, despite repeated emails, have not received this as yet. Revised timescale is therefore unknown. Will continue to chase/raise as an issue. 22/02/2023 - Update from Rachel Absalom: Informed by IG that they would be meeting to discuss on 06/02/2023 but no response received to their requested for an update. Until IG respond, no timescale can be given. 21/03/2023 - Update from Rachel Absalom: No further progress. Still awaiting sign off of/support with a DPIA, which will allow the use of Consultant Connect in the Glaucoma pathway. Without this, we cannot share patient information and therefore, the pathway cannot commence – despite having contractors ready to go. This sign off/support needs to come from our Information Governance Team. We still have not had any correspondence from colleagues in IG, despite multiple emails from various members of the PC and Ophthalmology teams requesting it. 18/04/2023 - SBAR presented at ARAC: No expressions of interest received from providers in Ceredigion – Primary Care Optometry Team liaising with practices in this area. 16/05/2023 - Assurance and Risk Officer contacted Head of IG to ascertain progress and confirm level of input on this recommendation. No response received to date. 08/06/2023 - The DPIA was signed off in March 2023 and the contract went live from 1st June 2023. DITS Response pack June 2023: *ODTC Pathway for Glaucoma patients has last week begun to invite patients to attend an appointment with an optometric practice within primary care* . 23/06/2023 - Awaiting clarification from Head of Optometric Services on the remaining steps to progress this recommendation towards closure. 27/09/2023 - National Optometric implementation is commencing in October 2023. This will take some time to implement fully. Contracts expected to be in place December 2024. Risk to be added to Optometry risk register (Primary Care) around the risk to patient safety. 12/12/2023 - (From ARAC Paper Dec 2023): MAIN CHALLENGES = no expressions of interest received from providers in Ceredigion. Limited interest from other providers in the Carmarthenshire and Pembrokeshire areas. PROGRESS TO DATE: 1) Optometric Diagnostic and Treatment Centres (ODTC) continue in Carmarthenshire and Pembrokeshire on a limited basis allowing HB patients to be monitored in the community and referred to secondary care only if further support is needed. 2) The national Optometrist Contract reform is on a phased implementation with phase 1 rolled out in October 2023 ensuring Optometrists can support secondary care with emergency eye care in the community. The ODTC pathway is identified in phase 2 which is expected in spring 2024 to further support secondary care with its Glaucoma B patients. 3) Additional virtual sessions have been introduced with Glaucoma consultants from SBUHB to review the Glaucoma B patients processed through the ODTC pathway. NEXT STEPS: 1) Scope Glaucoma B patients to attend Friday afternoon screening sessions with technicians to be reviewed virtually in secondary care to deliver an interim process whilst awaiting the ODTC pathway to be further developed. 2) 3 virtual sessions built into SAS doctor's job plans to increase delivery to the Glaucoma pathway by 40 patients per week.
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	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
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~~ N/K	Red	30/09/2022- No official response from IMTP. The UHB has a funded Glaucoma plan and diabetic retinopathy plan, which are both in place. The overarching plan for the whole service is outlined in the IMTP. To clarify with Director of Operations if this recommendation to be closed. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm that this recommendation can now be closed. 9/1/2023 - Dependent on outcome of IMTP - no response yet. 02/03/2023 - Outcome of regional clinical workshop (being held early 2023) will influence long-term model. 18/04/2023 - SBAR presented at ARAC: Further review of Glaucoma plan is scheduled due to lower than anticipated contractual interest from community-based optometrists. Specific action on risk 1664 in terms of holding regional discussion to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - The GIRFT requires us to form an Executive-led implementation board that is expected due to the volume of actions for GIRFT, the majority of this will be included (IVT and diabetic retinopathy are not included but are covered in the Corporate risk). There needs to be consideration of the regional model including the mid-Wales collaborative model ad this needs to be assessed for not only clinical impact, but financial surety. 12/12/2023 - (From ARAC Dec 2023 Paper): CHALLENGES = Delivery of Glaucoma plan restricted by contractual interest from community based optometrists. Delivery of cataract plan restricted by availability of AVH theatre. Challenges around Regional delivery of cataract plan. PROGRESS TO DATE = 1) The Integrated Medium Term Plan (IMTP) was agreed and resourced with medium term plan for Glaucoma and Cataract delivery. 2) A Getting it Right First Time (GIRFT) review undertaken for Glaucoma and Cataract delivery with recommendations made for service improvement. 3) Cataract lists in Amman Valley Hospital (AVH) increased to 7 patients per list to provide more capacity for cataract patients. 4) Complex cataract list in GGH introduced weekly to provide more capacity for complex cases. 5) Additional cataract list introduced on a Friday p.m. bi-weekly to provide more capacity for cataract patients. NEXT STEPS = 1) To continue the delivery of the GIRFT recommendations to assist delivery and increase capacity within the HB. 2) To introduce a treat and extend pathway to the IVT service which will give further capacity to reduce the length of wait. 3) To review current delivery in AVH theatre to potentially release capacity for further cataract operations. 4) To review RACE follow up capacity and introduce SOS/PIFU for suitable patients to further reduce pressure on emergency eye services. 5) To produce a detailed delivery plan for other sub-specialties within the service to ensure all sub-specialities within Ophthalmology have a focus for improvement.
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~~ N/K	Red	30/09/2022- No official response from IMTP. Sustainable monies have been invested into Glaucoma plan and cataracts, however there are still other areas of the service (such as AMD, plastics, paeds, VR, etc.) that require investment. 21/11/2022- Assurance and Risk team to contact Director of Secondary Care to confirm current position of this recommendation and revised date. 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 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-specialities 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.

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~~ N/A	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.
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	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.
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	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 DAMH 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 &PPAG. 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 &PPAG 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.
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 Brongàis, 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.
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.
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	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. SLI 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).
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.
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:. •Night 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. •Day 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. •Cross cover night doctor and Orthopaedic night doctor meet at 8.30pm to handover Orthopaedic outliers (this could be in person/phone call/teams) •Hywel 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 2023 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.
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.
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	R4. Undertake an appraiser recruitment drive, to target specific areas where there is highest need.	Recruitment drive, to take place Oct. Plan for interviews with Deputy RO. 4 Module training for Appraisers to be completed.	Apr-24	Apr-24	Amber	22/12/2023 - Recruitment drive has proved extremely successful and a number of clinicians have expressed an interest in becoming an appraiser. Interviews are ongoing. WE have already appointed 3 appraisers who have completed the relevant training and are ready to be included on the list of appraisers on MARS. This action can be closed.
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	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.
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.
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.
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	R8. Constraints reports taken from MARS to be provided to doctors at the end of each appraisal year.	Constraints task and finish groups have been set up to look at primary and secondary care constraints. Information is collated into a You said - We did newsletter.	Mar-24	Mar-24	Amber	
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/A	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
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.
Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	High	R6. section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ ~~Mar-24~~ Mar-27	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The IG work programme to review storage facilities is ongoing and to date 4 locations have been reviewed, including 2 private providers (Lloyd & Pawlett and Logic Document) and the health records storage facilities based at Dafen and Llangennech in Llanelli. Concerns remain in regards the private storage providers and an SBAR was presented to the Executive Team in October 2022 proposing that the management and storage of all Hywel Dda records be streamlined to one Executive lead. Clearly this is a considerable project to undertake and complete and it will require significant support from a wide range of services and identified IAO's. Work has commenced in terms of developing a project plan and schedule of work, but initial progress has been made by relocating A&E and pharmacy records, with other services to follow. Once all records are relocated to the Health Board storage facilities this will negate any concerns. 28/03/2023 - As the knowledge centre of the organisation where record management is concerned the change would not be severe for the health records service and would simply be an extension of the business model currently operated for the acute patient record, to accept wider record types. This work has already commenced with the relocation of A&E cards for GGH and PPH and Pharmacy records and others will follow over the next 12 months as the digital records project is progressed. 29/11/2023 – As the IG team continue to undertake their review of both external private storage facilities and internal storage facilities the health records service has been extremely proactive in terms of continuing the relocation of records to its secure centralised storage facilities. Through proactive dialogue, with various service leads, across a wide range of Directorates including: Scheduled Care, Unscheduled Care, Therapies, Community, Women & Child Health, the health records service has already supported the Health Board in relocating approximately 136,950 records, 5800 boxes from A&E and Pharmacy (too many records in a box to equate) and also various boxes of charts and theatre registers and 12 filing cabinets, to ease storage pressure and relocate records to an appropriate and secure location. The services already located include: Dietetics, Physiotherapy, Maternity, Mental Health, Maternity, A&E, Long Term Care, District Nursing, Community Nursing, Pharmacy and Oncology. Further dialogue is ongoing with other services and will continue in the future. Again without a full inventory of all records held within these and other services we are dealing with an unknown quantity and the completion of the project will be a few years down the line, but already from the considerable piece of work undertaken in a relatively short timeframe the Health Board is already witnessing the benefits.
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.
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-23~~ ~~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. 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. 10/7/2023- 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.
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-23~~ ~~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.
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.
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.
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.
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 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 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.

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 PGS 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 PGS 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.
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 PGS 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.
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 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 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.
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.
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.
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- UHB have been asked by 4 Nations Falls Group to scope what we currently have in relation to falls training in our Health Board, this is on the agenda for discussion at the Health Board falls group in September 2023. Awaiting 4 Nations/National position on guidance for falls training. Awaiting results of the scoping exercise to identify how we move this forward. 12/10/2023-As part of falls awareness week (w/c 18/09/23) falls training was held on two of the acute sites with excellent feedback. Education programme has been developed to include input from manual handling, pharmacy, therapies, podiatry and practice and professional development with support from QI. A working group will then be set to organise how this will be run on a Health Board basis. All Wales inpatient falls network are looking into mandating an e-learning falls training programme for All Wales. ESR falls package was commenced in Betsi and it is anticipated that this could potentially be the model to adopt. A sub group of the All Wales inpatient falls network is being established to action this which the Quality Improvement Practitioner will be a member of. 28/12/2023- Training day programme set and powerpoints completed with input from therapies, pharmacy, podiatry, PPDN, manual handling and quality improvement. Pilot of training session being run in Ty Nant on 18th January 2024 for a limited number of staff before submitting finalised study day plans to EAGLE panel for approval.
Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	~~Apr-23~~ ~~Jun-23~~ N/K	External	18/05/23 - Actions considered by the TUEC programme Director, further discussion taking place to determine timescales for implementation and congruence with priorities as determined by NHS Executive and delivery of Ministerial Objectives (Urgent Primary Care, SDEC, Discharge Planning Coordination, D2RA and DPOC). Update to be provided in June 2023 07/07/2023 - E-learning package awaiting All Wales rollout. QI practitioners attended simulation training 25/26 May 2023 with a view to incorporating simulation into a practical falls training package for the Health Board. 13/09/2023- UHB have been asked by 4 Nations Falls Group to scope what we currently have in relation to falls training in our Health Board, this is on the agenda for discussion at the Health Board falls group in September 2023. Awaiting 4 Nations/National position on guidance for falls training. Awaiting results of the scoping exercise to identify how we move this forward. 12/10/2023-As part of falls awareness week (w/c 18/09/23) falls training was held on two of the acute sites with excellent feedback. Education programme has been developed to include input from manual handling, pharmacy, therapies, podiatry and practice and professional development with support from QI. A working group will then be set to organise how this will be run on a Health Board basis. All Wales inpatient falls network are looking into mandating an e-learning falls training programme for All Wales. ESR falls package was commenced in Betsi and it is anticipated that this could potentially be the model to adopt. A sub group of the All Wales inpatient falls network is being established to action this which the Quality Improvement Practitioner will be a member of. 28/12/2023- Training day programme set and powerpoints completed with input from therapies, pharmacy, podiatry, PPDN, manual handling and quality improvement. Pilot of training session being run in Ty Nant on 18th January 2024 for a limited number of staff before submitting finalised study day plans to EAGLE panel for approval.
Oct-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 response 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 response 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 response 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 response if the project is monitored via a specific group/sub committee.
Oct-22	2022/23	Internal Audit	IT Infrastructure	Open	Reasonable	Digital	Central Operations	Digital Director	Director of Finance	Low	R6. All data held, and that is about to be created by the digitisation project, should be reviewed and its data-quality dimensions established as per the HMG data quality framework. An assessment of the likely required network capacity should be undertaken to ensure that the network can handle the increased traffic.	The review of scanned images is a component of the Digitalisation of Health Records Project and CITO (our supplier) complies with the relevant ISO certification for health records scanning. The scanning communications take place between the scanning providers and our Azure platform therefore this process sits outside our network. However, network upgrade projects are underway at WGH and PPH hospitals and this will include capacity assessment.	Mar-24	Mar-24	Amber	08/03/2023 - Update from Head of Digital Innovation and Transformation: Preferred solution is cloud-based and therefore not on prem which means it should not impact our network. Expecting report some time in March 2023 (Auditor not raised this question yet). 05/09/2023 - Update from IA: IT audit team are planning a Cloud/Azure migration audit 11/09/2023 - Not aware of any issues from Medical Records regarding access. Not completely live yet. May need to add an additional Rec owner from Medical Records perspective (responsibility for quality of scanned images lies with Head of Medical Records) 08/11/2023 - IT Audit team confirmed the matter (low priority) was a 'mop up' action looking to the future to make sure the service: - consider network capacity (as the more people who want to look at high quality images in the cloud, then the more bandwidth is needed to provide the data flow) - continue to check the quality of the scanned images, and as they develop e-forms, make sure that the data quality is considered as they build the forms.
Oct-22	2022/23	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	N/A	R3. DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	This is agreed and linked to above development of the DAP costings and investment strategy development.	Mar-25	Mar-25	Amber	20/12/22- Internal Audit report states deadline to be aligned to meet targets for 2025 and 2030. 23/01/2023- to be clarified with Director of Strategic Development & Operational Planning if there is secured funding or outline where the funding will be sourced from. 08/09/2023- Internal Audit have started planning and fieldwork will start shortly (report due to be submitted to the December 2023 ARAC meeting), which will include following up on the recommendations of this audit report. 19/12/2023- Follow up to be reported to February 2024 ARAC meeting.
Oct-22	2022/23	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	N/A	R4. NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	This is agreed. There is a requirement for Welsh Government to establish a fixed baseline that will better supports HBs to target set and reduce risk of reporting inaccuracies.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement. 08/09/2023- Internal Audit have started planning and fieldwork will start shortly (report due to be submitted to the December 2023 ARAC meeting), which will include following up on the recommendations of this audit report. 19/12/2023- Follow up to be reported to February 2024 ARAC meeting.
Oct-22	2022/23	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	N/A	R8. Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	This is agreed.	N/A	N/A	External	23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement. 08/09/2023- Internal Audit have started planning and fieldwork will start shortly (report due to be submitted to the December 2023 ARAC meeting), which will include following up on the recommendations of this audit report. 19/12/2023- Follow up to be reported to February 2024 ARAC meeting.

Oct-22	2022/23	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	N/A	R9. In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	This is agreed. The HB to utilise to the WG / PHW Carbon Awareness documentation once this is established.	N/A	N/A	External	20/12/22- Internal Audit report states Subject to external timescales, but this will continued to be monitored. 23/01/2023- Recommendation changed to 'external' and completion date is 'N/A' to the UHB as its for Welsh Government to implement. 08/09/2023- Internal Audit have started planning and fieldwork will start shortly (report due to be submitted to the December 2023 ARAC meeting), which will include following up on the recommendations of this audit report. 19/12/2023- Follow up to be reported to February 2024 ARAC meeting.
Oct-22	2022/23	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	N/A	R15. The Health Board should, as a matter of priority, ensure the following from the Decarbonisation Action Plan is fully realised: Delivery Plan to be developed into detailed and costed departmental actions plans, in areas of transport, procurement, buildings and wider healthcare; and build responsibility for delivery across the organisation through divisional action plans and workstreams aligned with mapped objectives– assigning specific projects as required.	Submitted the Delivery Plan to Board for approval – Board approval provided 29th September. The HB DAP was the few plans to identify early funding need to enable us to deliver early win projects, develop design feasibility that will inform the DAP funding costs and investment strategy going forward. The HB to continue to explore opportunities to secure funding to support this work.	Jan-25	Jan-25	Amber	20/12/22- Internal Audit report states AP plan to align to funding opportunities and be targeted to meet targets for 2025 and 2030. 08/09/2023- Internal Audit have started planning and fieldwork will start shortly (report due to be submitted to the December 2023 ARAC meeting), which will include following up on the recommendations of this audit report. 19/12/2023- Follow up to be reported to February 2024 ARAC meeting.
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.
Dec-22	2022/23	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	~~Mar-23~~ ~~Mar-23~~ ~~Apr-23~~ ~~Sep-23~~ N/K	Red	05/12/2022 - This report superseded HDUHB-2122-12. 19/05/2023 - The timeline for the Discovery Group has slipped having a knock-on effect on the Steering Group. Revised completion date changed to Sept 2023. 11/07/2023 - The Welsh Language and Culture Discovery Process report and action plan was approved at PODCC in June 2023. Plans are in place to establish the Steering Group. 17/08/2023 - Update from PODCC: The WG Strategy: More than Just Words update was provided for information to members. (There was no mention of the Steering Group at the June or August PODCC) 02/10/2023 - Service confirmed it is being reported into the next PODCC meeting. Internal Audit have requested that they consider whether the delay in implementing this Rec should be reported in any papers/groups and, if not, is the Rec ever likely to be established. If this is the case, are there arrangements in place that do the job the steering group would have done? 03/10/2023 - Internal Audit offered to meet with Welsh Language service to discuss this recommendation in more detail. 06/11/2023 - Internal Audit are awaiting clarification if the steering group has been set up. 20/12/2023 - No response received from the service regarding the steering group, IA to email the service for an update.
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 Clarity 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~~ N/K	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.
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	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'To be considered in advance of the Outline Business Case stage'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 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.
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	R3. The terms of reference of the Programme Group should clearly defined activities within and outside of scope.	Agreed.	May-23	Jan-24	Red	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- Updated TOR will be taken to Programme Group in September 2023.
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	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'As required'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024.
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	Red	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.
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	Red	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.
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	Red	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.
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	Red	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.
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	Red	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.
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	Red	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.
Feb-23	2022/23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	Medium	R2. The UHB should liaise with Specialist Estates Services to agree a framework approach to ensuring the SCP completes contractual documentation in a timely manner.	Future assurance – at future contracts	Mar-24	Mar-24	Amber	14/03/2023- IA confirmed this recommendation is for future contracts, and the suggestion of a 12 month deadline (March 2024) would be sensible as there are likely to be more contracts executed with this specific contractor in that period – which should allow us to close the recommendation. 14/12/2023- querying with Internal Audit on when this recommendation can be closed, as there is now alternative procurement being scoped for phase 2, with alternative route to market that is being explored that may take us into a traditional contracts.
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.
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 Strategic Options Appraisal and R1b Business Case delivery first.
Apr-23	2022/23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R1. Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	Spot check audits in relation to Purpose T Risk Assessment and associated Care plans to be undertaken as part of the agreed standardised Audit development framework plan.	Jun-23	~~Jun-23~~ N/K	Red	11/07/2023- To be checked with Heads of Nursing. 12/07/2023- Deputy Head of Nursing, PPH confirmed recommendation completed for PPH. 12/09/2023- AMAT system confirms completed for BGH and PPH. Awaiting confirmation from other sites. 25/10/2023- AMAT systems confirms this recommendation remains outstanding for WGH. No revised date provided on the AMAT system.
Apr-23	2022/23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	High	R3. In line with the patient safety flow chart: • Management review of incidents must be undertaken within 72 hours. If this is not feasible in the short term due to service pressures, an improvement plan should be developed to support achievement. • Incident investigation must be completed within 30/60 days • Investigation of pressure damage incidents must include completion of the focussed review	All areas to develop improvement plans as to how the 72 hour target is to be met with target dates, this will need to be monitored via the Improving Together Meetings	Jul-23	~~Dec-23~~ N/K	Red	12/07/2023- Deputy Head of Nursing, PPH confirmed recommendation completed for PPH. 12/09/2023- AMAT system states confirmation still required from BGH, GGH & MH&LD Directorates. 14/09/2023- Completed for WGH, BGH, PPH. Awaiting confirmation from MH&LD & GGH. 06/10/2023- For MHLD: QSEG Heads of Service report template has been updated to include a summary of incident management data from Heads of Service to enable oversight and scrutiny at directorate level, the directorate Serious Incident Review case tracker will be routinely brought forward to monthly Incident Management Groups to enable an overview of open cases, broken down by stage of process in order to flag any delays or additional support requirements to progress within timescales. A new monthly Serious Incident Leaning Forum is launching within the directorate in October and will also be used to escalate investigation process challenges as necessary. For Acute sites: Improvements are being made in the 72hr review of incidents and improvement plans / actions are part of the Monthly Scrutiny Meetings held on each acute site. A focussed piece of work is being undertaken on clearing historic incidents to improve compliance with 30/60-day investigations. Compliance with 30/60 day investigations have improved but may still appear to be overdue as incidents are not closed until a full review of completed action plans at scrutiny meetings have taken place so may not demonstrate the improvements being made. 06/10/2023- outstanding incidents are discussed monthly but for the action to be closed realistically a timeframe of December 2023 has been received. A meeting is being planned to review incidents not known to services in October 2023 which should help clarify those the teams have left to focus on for the improvement plans required. 25/10/2023- AMAT system shows action is outstanding for MHLD. 28/10/2023- Monthly Incident Management Group has been set up with a schedule of meetings for the year and includes Assistant Director of Nursing, Head of Quality Assurance, Lead Nurse in Quality Assurance Professional Development, Heads of Service and Service Delivery Managers. Serious Incident Learning Forum had its initial meeting in October 2023 and the next meeting is due to take place on 15/10/23. Terms of Reference have been distributed and planning to be approved at the meeting in November. There is in place a schedule of meetings for the year.

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 December 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'.
Apr-23	2022/23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	Medium	R6. A review should be undertaken to analyse and learn lessons of performance issues at this project, so that similar issues and other similar projects can be mitigated at an early stage.	Agreed – a lessons learned exercise will be undertaken covering the performance issues raised above and results used to inform future projects of this type. We will contact NWSSP SES to discuss the facilitation of this exercise given the wider learning possible.	Feb-24	Feb-24	Amber	20/10/2023- discussions being undertaken with WG on lessons learnt, which will be included in the Phase 2 Business Justification Case (BJC) to WG. 06/12/2023- Still on track for Feb 2024.
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 addition to the monthly compliance information sent through to departments by the medical directorate team. Further audit to be undertaken at the beginning of 2024.
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.
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.
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.
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.
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.
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.
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.
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	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 documentation 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)
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	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)
May-23	2022/23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	High	R3. A benefits tracker for the current project(s) should be completed showing expected realisation dates and effects/values. (Either for each project separately, or a combined one for the overall digitalisation programme.) There should be clarity as which part of the whole digitisation programme the benefits are attributable to so as to avoid double counting, and the tracker should include the following: • Benefit owners should be identified • Current baselines should be established and recorded. • Measurement criteria should be clarified and agreed. • Measurement methodology and monitoring, (bpi/automation as appropriate) should be agreed. • Expected benefit delivery schedule should be agreed.	To fulfil Recommendation 1, the current digital benefits realisation framework will be retrospectively applied to the new overarching programme, and it will detail a full benefits plan with associated metrics for tracking said benefits.	Sep-23	~~Sep-23~~ ~~N/K~~ Jan-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 - Benefits Register and Plan in place with appointed owners across strands. New baseline data to be gathered on commencement of in-house scanning. 20/12/2023 - IA confirmed that a follow up audit is due to take place in Q4 (Jan 2024 to March 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	Amber	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)
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.
Jun-23	2022/23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	High	R12. 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 (Matters Arising 7)	Scan for Safety and the related inventory management system (IMS) will be introduced to Theatre Services, Critical Care and Endoscopy shortly starting in Bronglais. If launch and application roll out as aspired, all Theatre locations should be online within 18 months. This will address all stock types and par levels and will be linked to Oracle.	Dec-24	Dec-24	Amber	07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 18/09/2023 - launch of Scan for Safety has been implemented at BGH, and roll out to other sites planned in the period until December 2024 - recommendation therefore in progress and on track with the original completion date. A follow up is due to be undertaken by Internal Audit in Q3/4 of FY 2023/23 25/09/2023 - (Response to Board TOA): The inventory management system "Scan for Safety" has been launched in Bronglais Hospital, with roll-outs across other acute sites scheduled for completion by December 2024. Current consignment locations have been confirmed, and assessment undertaken to agree suitable independent storage areas and due for completion by 27 October 2023. 01/11/2023 - Scan for Safety implantation plan: BGH Critical Care Nov23; BGH Theatres Jan24. Work has commenced on listing inventory for PPH DSU; Critical Care, Endoscopy and Main Theatres to follow.
Jun-23	2022/23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	High	R14. Periodic stock checks should be undertaken to reconcile physical stock balances to the stock record, and identify and investigate any discrepancies. (Matters Arising 7)	Annual stocktakes are undertaken, a review will be undertaken to assess this process and where it interfaces with Theatre stock activity and actions. Scan for Safety and the related inventory management system (IMS) will ultimately address this.	Sep-23	~~Sep-23~~ ~~Oct-23~~ Mar-24	Red	07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4. 18/09/2023 - Current consignment locations have been confirmed, and assessments undertaken to agree to identify suitable independent storage areas, and due for completion by October 2023 due to the complexities encountered at GGH. Discussions are ongoing between Procurement and Theatres to agree optimal audit review processes. Completion date of this recommendation has therefore been revised to October 2023. It is noted that the launch of Scan for Safety has been implemented at BGH, and roll out to other sites planned in the period until December 2024. 01/11/2023 - The structure of the process is complete with a plan etc – to remain under surveillance until the end of March to provide assurance that the audit process is being applied as agreed. All consignment stock segregated from rest and clearly labelled. Site specific folders have been compiled and are being distributed to locations; Folder includes site specific lists, process of audit and locations to record results. Staff briefings have taken place. Team meeting on 11Oct23 confirmed process and timelines. Primary and baseline audit to have been completed by Friday 10th November. It has been agreed that there will be quarterly audits for the next 18 months. Evidence emailed to Internal Audit
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 the team, 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	Amber	30/11/2023 - All current steps and actions are listed on the risk register and will be updated as and when they change.

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	R4. The Mental Capacity Act and Consent Group should ensure that they meet regularly in line with the frequency set out in the terms of reference.	The MCA & Consent Group recognises that it was difficult to schedule all four quarterly meetings last year, due to extenuating circumstances. Every effort will continue to be made to ensure that the meetings go ahead as per the Terms of Reference of the Group. The DoLS Activity report is a standing item on the agenda and will continue to be so. If, for reasons outside our control, it is not possible to hold a scheduled meeting, this will be rearranged as soon as possible. If it is not possible to rearrange the meeting, then agenda items will be carried over to the next meeting. Those requiring urgent action will be consulted upon 'virtually' and approved via Chairman's action.	Sep-23	~~Sep-23~~ N/K	Red	02/11/2023 - Head of consent and Mental Capacity has reassured members that every effort would be made to ensure meetings run as scheduled. 20/12/2023 - IA to check if this has now been implemented.
Sep-23	2023/24	Internal Audit	NICE Guidelines	Open	Limited	Medical	Medical	Clinical Effectiveness Co-ordinator	Medical Director	High	R2: Identify appropriate/nominated contact(s) for each clinical/service area for the Clinical Effectiveness Team to disseminate new/updated NICE guidelines to, and with responsibility for identifying and nominating a lead for each guideline. (Matter Arising 2: Nominated Leads)	To allocate the Directorate Quality and Governance Lead as Stakeholder for all relevant guidelines.	Dec-23	~~Dec-23~~ N/K	Red	20/12/2023 - IA Update - A follow up review of this audit report to be presented at February 2024 ARAC.
Sep-23	2023/24	Internal Audit	NICE Guidelines	Open	Limited	Medical	Medical	Clinical Effectiveness Co-ordinator	Medical Director	Medium	R4. Review the governance reporting arrangements, including the role of the OQSESC, to ensure they are efficient and fit for purpose. (Matter Arising 3: Compliance Monitoring & Assurance Reporting)	To present the SBAR outlining the new reporting arrangements to the following: - Directorate Quality and Governance Groups (dependent on scheduled dates) - OQESC (8th November 2023) - ECPAP (5th September 2023) - CSGG (7th November 2023)	Dec-23	~~Dec-23~~ N/K	Red	20/12/2023 - IA Update - A follow up review of this audit report to be presented at February 2024 ARAC.
Oct-23	2023/24	Internal Audit	Quality & Safety Governance-Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	High	R2a. BGH Directorate's governance arrangements should be reviewed and amended to ensure quality and safety orientated supporting groups or meetings report into the Quality Forum ensuring key issues and risks are brought to the attention of hospital management. Matters Arising 2: Governance Arrangements	Agreed – noting that this will need to be supported by one band 3 additional administration staff to act as a service committee officer. Case for funding to be made via the relevant process.	Dec-23	~~Dec-23~~ N/K	Red	30/11/2023 - (Taken from IA Interim progress update report HDUHB-2323-36): Management confirmed that they are in the process of preparing an SBAR report outlining the business case for the additional Band 3 administrative post required. Progress Status: Management Action Ongoing (target date not due at time of review) – further testing will be undertaken in January 2024. 12/12/2023 - Interim IA report presented at ARAC Dec 2023. Further updates will be provided once Internal Audit have published their follow-up report.
Oct-23	2023/24	Internal Audit	Quality & Safety Governance-Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	Medium	R4. The risk register should be reviewed and updated or amended to reflect current risks impacting the directorate. Matter Arising 4: Risk Register	Agreed – the Risk Register is reviewed; long standing risks will be updated to reflect the latest situation (where these otherwise cannot fully be brought under control).	Oct-23	~~Oct-23~~ ~~Dec-23~~ N/K	Red	13/10/2023 - Review of Directorate level risks completed on 11/10/2023 with Assurance and Risk Team and Action Plans addressed. Review of Service level risks and horizon scanning for new risks scheduled for December. Regular report on agenda at Quality Forum and new Assurance & Risk business partner noted as attendee on future agendas. 30/11/2023 - (Taken from IA Interim progress update report HDUHB-2323-36): The risk register continues to be reviewed on a monthly basis. A review of the Quality Forum minutes and papers for the October and November 2023 meetings confirm reports have been submitted highlighting details of recent review and update of the register. However, a number of risk actions remain outstanding after their target deadline date. Current Status: Management Action Ongoing – further review of the risk register will be undertaken in January 2024. Potential risk of materialisation of identified risks due to poor risk management/mitigation 12/12/2023 - Interim IA report presented at ARAC Dec 2023. Further updates will be provided once Internal Audit have published their follow-up report.
Oct-23	2023/24	Internal Audit	Quality & Safety Governance-Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	High	R5a. Management should seek: work together with the Corporate Quality and Governance Team to identify an approach to reduce the number of open incidents, in particular on the old system, incorporating lessons learned of other acute sites within the directorate, and to develop an action plan and timeline to improve the directorate' position for incidents. Matters Arising 5: Incidents Management	Review of open incidents indicates a large number that are not within remit of BGH. Plan to move these to appropriate management teams to be worked up with central Datix team. Lead Nurse for Quality and Safety to develop plan for incidents within local responsibility.	Nov-23	~~Nov-23~~ N/K	Red	30/11/2023 - (Taken from IA Interim progress update report HDUHB-2323-36): Considerable work is being undertaken to reduce the number of open incidents assigned to BGH. Allocation of open incidents has been spread amongst the managers at BGH and as at 20th November 2023, the number of open incidents have reduced to 173, from the 553 originally reported. A high percentage of those that remain open are allocated on reporting as 'Community Pressure Sores' and management are working together with the Central Governance Team to assign these correctly for clearing. Progress is being closely monitored by the directorate management and progress reported at the Quality Forum meetings. Current Status: Management Action Ongoing (target dates not due at time of review) – further testing will be undertaken by Internal Audit and reported in February 2024. Potential risk of: Root cause of incidents are not addressed, increasing likelihood of recurrence, potentially resulting in patient/staff harm, reputational damage and financial loss. 12/12/2023 - Interim IA report presented at ARAC Dec 2023. Further updates will be provided once Internal Audit have published their follow-up report.
Oct-23	2023/24	Internal Audit	Quality & Safety Governance-Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matthew Willis	Director of Nursing, Quality and Patient Experience	High	R5b. Management should seek: work together with the Corporate Quality and Governance Team to identify an approach to reduce the number of open incidents, in particular on the old system, incorporating lessons learned of other acute sites within the directorate, and to develop an action plan and timeline to improve the directorate' position for incidents. Matters Arising 5: Incidents Management	To consider how the services and locations can be simplified in Datix Cymru to facilitate easier reporting and to work with the Once for Wales concerns management systems team to identify potential solutions.	Jan-24	Jan-24	Amber	30/11/2023 - (Taken from IA Interim progress update report HDUHB-2323-36): Considerable work is being undertaken to reduce the number of open incidents assigned to BGH. Allocation of open incidents has been spread amongst the managers at BGH and as at 20th November 2023, the number of open incidents have reduced to 173, from the 553 originally reported. A high percentage of those that remain open are allocated on reporting as 'Community Pressure Sores' and management are working together with the Central Governance Team to assign these correctly for clearing. Progress is being closely monitored by the directorate management and progress reported at the Quality Forum meetings. Current Status: Management Action Ongoing (target dates not due at time of review) – further testing will be undertaken by Internal Audit and reported in February 2024. Potential risk of: Root cause of incidents are not addressed, increasing likelihood of recurrence, potentially resulting in patient/staff harm, reputational damage and financial loss. 12/12/2023 - Interim IA report presented at ARAC Dec 2023. Further updates will be provided once Internal Audit have published their follow-up report.
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.
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.
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.
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	Amber	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.
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.
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.
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.
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	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 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	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 AAAC in August and October 2023. Internal Audit Conclusion: Action Ongoing
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-23	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	
Oct-23	2023/24	Llais	Llais West Wales Region Engagement Report	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	N/A	R1. Health Board must continue to provide a high standard of care following the 100% increase in bed number following the transfer of patients from Withybush Hospital to South Pembrokeshire	The patients cared for at South Pembrokeshire Hospital are under the care of a multi disciplinary team led by Health Board Consultants from Withybush Hospital. The nursing care provided is subject to All Wales Nursing Audits, as evidence for completion of these standards 2 months of audits will be uploaded to the AMAT system for assurance.	Feb-24	Feb-24	Amber	10/01/2024 - No update via AmaT.
Oct-23	2023/24	Llais	Llais West Wales Region Engagement Report	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	N/A	R4. Health Board to strengthen links with social care services, to raise awareness of patients who may have no family/extended family to help with basic needs such as providing clean nightwear/daywear and toiletries	Senior Nurse Manager to arrange a meeting weekly with social services to discuss discharges for patients and will raise concerns regarding patient who require specific support.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - No update via AmaT.
Oct-23	2023/24	Llais	Llais West Wales Region Engagement Report	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Janice Cole-Williams	Director of Operations	N/A	R5. Health Board to look into working with organisations to provide support and advice for patients with disability issues especially after a stroke. In addition to physical aspects of a stroke, support with house adaptations, benefits and patient rights	To ensure that stroke patients in Pembrokeshire are cared for under a highly experienced multi-disciplinary team who consider rehabilitation and patients individual needs prior to discharge which includes home adaptations via occupational therapists. Patients who require Stroke specific acute care and rehabilitation are to be managed within Withybush Hospital ward 3 from 27/11/23 onwards, however patients who require slow rehabilitation may still be admitted to South Pembs Sunderland ward. All such Stroke patients are discussed in an MDT and evidence of meetings can be provided for assurance	Jan-24	Jan-24	Amber	10/01/2024 - No update via AmaT.
Nov-23	2023/24	Llais	Llais West Wales Maternity Services Report	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphries	Director of Operations	N/A	R6. Communication clearly worked well for some, but Llais knows that poor communication lies at the heart of many poor patient experiences, before during and after an event such as childbirth. Once again, our survey showed that some mums experienced poor communication from staff during their journey. This caused preventable stress during labour. Llais acknowledges that it can happen in settings when staff are busy and under pressure, but in a general sense it isn't acceptable. The Health Board needs to ensure that cultures of good practice around communication shown by many staff are universal and a core value of the department	Planned TEAMS learning session's discussion arranged in January for all staff re civility, cultural awareness and diversity which is led by our Language Group with an MDT membership and approach.	Jan-24	Jan-24	Amber	10/01/2024 - Update from QAST = In progress (no comments/revised date)
Nov-23	2023/24	Llais	Llais West Wales Maternity Services Report	Open	N/A	Women and Children's Services	Women and Children's Services	Lisa Humphries	Director of Operations	N/A	R7. We were interested to hear that NCT classes were difficult to access or not running locally. This made us worried about the level of antenatal and parenting support that mums and partners were getting beyond clinical contact with midwives and other NHS staff. If there were alternative opportunities, we couldn't see these on the Health Board's website. Because of this, we're asking the Health Board to tell us what is available for mums in the three counties, whether signposting is adequate and whether more needs to be put in place with local partners.	Women's Experience Midwife maintains updated parent education information on the internet to keep abreast of any current or new evidence based change in practice.	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - Rec turned back Red based on QAST progress update = Overdue.
Dec-19	2019/20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KB/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-20~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ ~~Nov-23~~ Mar-24	Red	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 11/09/2023- whole project will be completed in October 2023, as reported to HSC. MWWFRS letter dated 21/07/2023 confirms extension to 31/10/2023. 20/10/2023- Slight delay to completion of works to mid November 2023, MWWFRS are aware of this and visit the site on a regular basis for progress updates. 06/12/2023- update to be requested from Major Capital Development Manager. 03/01/2024- All doors addressed apart from one set, the UHB are replacing these doors. Doors are ordered which will take approx. 12 weeks for installation. MH&LD service is aware. The full Enforcement Notice related to this letter has been lifted by the MWWFRS.
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-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22. 20/12/2022- A programme completion date will be developed as the above BJC work is progressed to encompass the work content and complexity of this Phase 2 project. Early indications are that due to the multiple Decant needs of Ward areas the programme may need to be extended as part of the due diligence work within the Business Case. As this becomes more developed, MWWFRS will be fully involved in these discussions so that appropriate changes can be made to the Phase 2 Enforcement dates. This matter has been discussed with MWWFRS who appreciate that a revision may be required to this programme should the nature of the works dictate that an extension to this timeline becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of April 2025 date. 26/04/2023- the UHB has recently presented a reduced scope of works for Phase 2, which the MWWFRS are considering, with a decision likely to be received the second week of May 2023. Subject to this being approved, there will be a significant reduction in cost. 06/12/2023- Completion date moved to October 2025, MWWFRS informed 10/11/2023. MWWFRS to write to confirm their agreement.
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ ~~Feb-23~~ ~~Aug-23~~ Jan-24	~~Jul-22~~ ~~Feb-23~~ ~~Nov-23~~ Jan-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.
Nov-20	2020/21	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire, SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid-November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme, should the nature of the works dictate that an additional period of time becomes necessary. 20/12/2022- It is important to note that Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Regular discussions continue with MWWFRS, including a formal meeting held on 08/12/2022, who appreciate that a revision may be required to the FEN dates should the nature of the works dictate that an additional period of time becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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.
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.	~~Oct-22~~ Mar-25	~~Oct-23~~ ~~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 they are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivery plan for the site is to March 2025. There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.

Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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. BLC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. All remaining doors under future phasing Overarching delivery plan for the site is to March 2025.Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Recommendation moved back from red to amber. 06/12/2023- still on track for this date at present.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 4- R8. All door release devices (including floor pneumatic release devices) should work in accordance with the relevant British standard: BS 7273-4:2015 actuation of release mechanisms for doors and comply with WHTM 05-02 Appendix C: Door Closers and Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. • Diabetic unit • This action should be carried out over the whole site and as part of the fire door survey mentioned in item 1 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22 Mar-24	~~Oct-22~~ Mar-24	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. This recommendation will be picked up in phase 1 as part of the EFAB funding for 2023/24. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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.
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022-AFT survey now completed. Detailed costs obtained for 106 repairable doors. Site review with NWSSP-SES to agree prioritisation of door replacements for EFAB funding. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AJT 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 they 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 Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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 Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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 Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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.
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Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout Blue Block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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 DS7 needs replacing.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms EFAB investment has been requested.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented. 05/12/2023- update to MWWFRS 10/11/2023 confirms this will be completed by November 2023.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they 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	R2. During the inspection breaches in compartmentation were identified •Plant Room (R 11) 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.	Jan-24	Jan-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	R4. All drapes and curtains 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.	Full action plan held by Estates.	Jan-24	Jan-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	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	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	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.
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, 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. •Bl 1164a & 1164b •Bl 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	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.
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 27, 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. •BF55 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; •BF 06 •BF 01 •BF 15 •BF 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, 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. •B35 Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.5).	Full action plan held by Estates.	Mar-24	Mar-24	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, 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. •B241 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.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Templates 8 & 9, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00141802	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •2160 •2176 •2170 The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.8)	Full action plan held by Estates.	Sep-23	Mar-24	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.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 22 - TY Cadell, 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 •Boiler Room (R13) 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.	Jan-24	Jan-24	Amber	06/12/2023- on track.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 22 - TY Cadell, 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 located in: •Corridor wall by Kitchen should be in filled to achieve the same fire resistance as the rest of the wall. 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.	Jan-24	Jan-24	Amber	06/12/2023- on track.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 22 - TY Cadell, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	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. •Secretaries' office (R4) Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Jan-24	Jan-24	Amber	06/12/2023- on track.
May-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters TEMPLATES 10 & 12, PRINCE PHILIP HOSPITAL, DAFEN ROAD, DAFEN, LLANELLI. SA14 8QF BFS/NE/jel/00173901	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The existing windows located in the 30-minute Sub-compartment wall located between: • R4S and RS1 should be re-glazed with fire resisting glazing to a minimum period of 30 minutes fire resisting in accordance with the manufacturer's instructions. The glazing should conform to a relevant standard e.g. WHTM – 05 – 02. BS 476-22:1987 Fire tests on building materials and structures. Methods for determination of the fire resistance of non-loadbearing elements of construction, in terms of integrity for a period of minutes, Compliance with these standards will normally satisfy the requirement. (Estates ref 4.9)	Full action plan held by Estates.	Sep-23	~~Nov-23~~ Jan-24	Red	05/10/2023- Estates action plan confirms more work required to address defect following investigations. Revised completion date November 2023. 06/12/2023- revised completion date of January 2024.
Jun-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 2, PRINCE PHILIP HOSPITAL, DAFEN, LLANELLI. SA15 8QF BFS/NE/jel/00334401	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. During the inspection the self-closing devices on the doors located at. • 1112 A/B Were found to be missing. 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. (Estates ref 4.4)	Full action plan held by Estates.	Sep-23	Mar-24	Red	20/10/2023- More work is needed to address defect. New doors required as doors are not repairable. Revised date of March 2024. 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 26, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The opening in the ceiling located in: •B15 – Switch Room 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.	Jan-24	Jan-24	Amber	
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 26, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R6. The following 30-minute fire resisting door was found to be damaged/defective. These doors must be repaired/replaced. •B09 – Hole in door due to missing lock 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	Amber	
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Confirmation of the fire resistance of panels within Fire Resisting doors should be provided. Any Panels within the door should provide a similar degree of fire resistance as the door. Fire resisting doors need to be fitted with •A self-closing device •Intumescent strips and smoke seals. •three brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Jan-24	Jan-24	Amber	

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	Amber	
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	
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	R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1. •Extend to Cleaners Store Cupboard All work involving the fire alarm should be carried out in accordance with BS 5839-1:2017.	Full action plan held by Estates.	Dec-23	Jan-24	Red	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 revised date of January 2024 due to contractor availability over Christmas 2023.
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	R1. 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.	1) Scope potential Increase in virtual capacity in the HB to virtually review high risk cohort of longest wait patients.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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	R4. Relocate items within the Ward 1 treatment room to improve the rooms safety. There was charging of items and a fridge located next to an oxygen point. This room requires movement of the items to another area and or the oxygen and vacuum point isolating to reduce the risk from fire to an acceptable level.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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 appropiate 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.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD,	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	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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	R9. Ensure all flammable items are stored in an safe manner. Flammable items are required to be stores in a metal flame resistant cupboard.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
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.	Feb-24	Feb-24	Amber	06/12/2023- Head of Estates Risk & Compliance confirmed recommendation is on track.
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 5, 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, 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 •Barkroom 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, 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, 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.	Dec-23	N/K	Red	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.
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	R4. Extend the existing fire detection and warning system by providing automatic smoke in the following areas: •R17 •R19. All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017	Full action plan held by Estates.	Dec-23	Jan-24	Red	04/12/2023- Update to November 2023 MWWFRS meeting states January 2024 deadline. 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 on track for revised date of January 2024.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Padarn, Gwenllian & Stem Corridor, Block 4, 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 in the following areas: •R17 All work involving the fire alarm system should be carried out in accordance with BS5839-1:2017	Full action plan held by Estates.	Dec-23	Jan-24	Red	03/01/2024- Head of Operations to check with Head of Estates Risk & Compliance if this recommendation has been completed. 08/01/2024- Work planned to the end of January 2024.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The opening in the ceiling located in: •R12 •R13 •R48 should be in filled to achieve the same fire resistance as the rest of the ceiling. The fire separation should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Jun-24	Jun-24	Amber	05/12/2023- update to MWWFRS 10/11/2023 confirms June 2024 date.
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 1, 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. Compliance with these standards 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	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. •Ridge (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. •B037 •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; •B08a •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. •B028 •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	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	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	
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	Amber	

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	Amber	
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	Amber	
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	R5. Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: •External route to place of safety 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	Feb-24	Amber	
Dec-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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. •B02	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	R6. Remove existing lock fastenings from door(s) indicated/located: •final exits If the door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	Jan-24	Jan-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.
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	R8. The intumescent strips and cold smoke seals on the following sampled 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. •B0111 •B33 •B007 •B008 •B009 •B014 •B004 •B006 •B039 •B041 •B039 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.	Feb-24	Feb-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	R9. Ceiling tiles in the following areas were found to be missing, they should be replaced: •Corridor 2nd floor 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.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	22/12/2023- Timescales provided by Head of Estates Risk & Compliance.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Sealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R1. Security- Access Control: The operator shall install a system of access control to all doors leading directly from the public corridor to any room within the NM suite.	Advice sought from Heath, Safety and Security Officer for HB.	Jan-24	Jan-24	Amber	Need to get quote.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Sealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R1. Sealed Source Container: The operator shall replace the sealed source container with a new container of more robust construction (e.g. steel). Any door furniture (e.g. locks, hasps, hinges, etc.) will also be suitably robust to delay any potential attempts at removal. If padlocks are used they should be closed shackle type. Note: if the operator wishes to explore the other arrangement to secure the sources then they must discuss these with NRW.	Advice sought from Heath, Safety and Security Officer for HB. Need RPA input. Purchase will be expensive.	Jan-24	Jan-24	Amber	Need to get quote.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Sealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R1. Operator to install secure key safe (including having in place an appropriate written management procedure for the management of keys, codes or other access control measures).	Advice sought from Heath, Safety and Security Officer for HB.	Jan-24	Jan-24	Amber	Need to get quote. To find out whether a policy already exists within HB.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R2. Security- Access Control- The operator shall install a system of access control to all doors leading directly from the public corridor to any room within the NM suite	Advice sought from Health, Safety and Security Officer for HB.	Jan-24	Jan-24	Amber	02/11/2023: Site visit 31/10/23 costings awaited.

Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R3. Adequate Facilities- The operator to understake a review (with support from their RPA/RWA) into the current arrangements at the facility to ensure that there is adequate space to undertake all of the activities permitted by the permit. The review should look at the risks posed to staff, patients and this should include the associated contamination and cross-contamination risks. The review should also consider the other areas of the NM suite (Imaging and Control Room) both of which appeared cluttered and cramped.	Initial discussion 31/10/23 during RPA review. The options are very limited as the injection room is small (approx 3.5m x 3m) and multi-purpose; dispensing radiopharmaceuticals, injecting patients and radioactive disposal and waste store. The control room is also multi-functional.	Apr-24	Apr-24	Amber	02/11/2023: RPA follow-up review scheduled for Jan 2024. Wider discussion on location of NM Suite to a larger footprint to be considered in the event of a future capital bid for replacement gamma camera.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R4. Infrastructure for Accumulation of Radioactive Waste- Decay of radioactive wastes in wooden cupboard beneath dispensing area (injection room) to be decommissioned. Waste to be re-located to a suitable accumulation store	Space is at a premium within Radiology. A suitable existing cupboard has been identified by the RPA, but we need to discuss the possibility of re-purposing this space with the Lead Radiographer. A steel storage unit may also be required.	Apr-24	Apr-24	Amber	02/11/2023: Awaiting costings from colleagues at SB (recently purchased equipment for new NM suite in Morriston Hospital).
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R4. Infrastructure for Accumulation of Radioactive Waste- Operator to provide separate free-standing, foot operated, shielded metal bins for the storage of 1-123 and tc99m solid wastes.	There are a few options but shielded metal bins are expensive. Will this purchase need a capital bid?	Apr-24	Apr-24	Amber	02/11/2023: Initial quote for 1 shielded bin from BrightTec Technologies was £1400 + VAT. Further discussion is needed as to whether the I-123 sharps and soft waste can be housed together, therefore only 3 bins required.
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R4. Infrastructure for Accumulation of Radioactive Waste- Decommissioning of the 1-123 and tc99m decay boxes (yellow wooden boxes)	Replacement lead-lined non wood decay boxes are expensive. At least 2 would be required.	Apr-24	Apr-24	Amber	02/11/2023: Awaiting costings from colleagues at SB (recently purchased equipment for new NM suite in Morriston Hospital).
Sep-23	2023/24	Natural Resources Wales	RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R9. Root Cause Review (contamination events) - Operator to undertake a review of contamination events in order to ascertain the root cause/s behind the incidents. Any recommendations from the review should be implemented.	An informal review has been undertaken. A formal RPA audit will follow.	Apr-24	Apr-24	Amber	02/11/2023: RPA audit scheduled January 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	Liz Carroll	Director of Operations	N/A	R1. The HB should review access pathways and processes to ensure they are equitable for ASD and ADHD.	Task & Finish Group to be established with clear Terms of Reference.	Jan-24	Jan-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	Liz Carroll	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	Liz Carroll	Director of Operations	N/A	R2. The HB should review processes to facilitate the delivery of dual ADHD and ASD assessments.	Task & Finish Group to be established with clear Terms of Reference (part of R1 T&F Group	Jan-24	Jan-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	Liz Carroll	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	Liz Carroll	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.	Awaiting Management response from service.	Jan-24	Jan-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	Liz Carroll	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.	Task & Finish Group to be established with clear Terms of Reference (part of R1 T&F Group)	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	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	Liz Carroll	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.	Task & Finish Group to be established with clear Terms of Reference	Jan-24	Jan-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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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.	Task & Finish Group to be established with clear Terms of Reference	Jan-24	Jan-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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	
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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	Liz Carroll	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	
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.
Oct-21	2021/22	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External	03/07/2023 - (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. 12/01/2024 - No further update on external implementation
Oct-21	2021/22	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-23~~ ~~Aug-23~~ ~~Oct-23~~ Jun-24	Red	30/11/2022 - Initially unable to agree additional Echo technician capacity due to existing constraints in capacity- however, discussions and solutions are being revisited with Echocardiology team and Cardiology SDM. Unable to assign a date at this time. 19/01/23 - Discussion under way with Cardio-Respiratory department who would need to identify resources. Potential revised date to be identified after this discussion. 04/04/2023 - No capacity available at this time. Discussions are ongoing. Potential requirement for funding and recruitment. 26/09/2023 - No available capacity held by current HB employees, but x2 physiologists identified within adult department with interest in paediatric physiology. In early stage of ECHO training. Funding will be required to make this a directorate – specific role- to be revised as a part of workforce modelling. Network to review all avenues for Echo Tech support. 12/01/2024 - The consultants are undertaking ECHOs i the absence of the ECHO techs and we are in the process of upskilling neonatal leads to undertake ECHOs. This is dependent on availability of the trained doctor. No further update on Echo Tech support aspect from the network (service lead is following up on this).

Oct-21	2021/22	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	~~Nov-23~~ ~~Oct-23~~ N/K	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 LHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact. 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. 12/01/2024 -
Oct-21	2021/22	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	~~Nov-23~~ ~~Oct-23~~ N/K	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 LHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact. 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.
Oct-21	2021/22	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment.	Response requested from lead officer.	Nov-22	~~Nov-23~~ ~~Oct-23~~ N/K	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 LHB 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.
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.
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.
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	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 Orthopaedic 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. 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	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 recommendation 12. An EQuIP 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-assesment EQIIP project. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. A Task and Finish Group has been established to standardise the Pre-assessment process across the Health Board - increasing efficiency and the flow of patients across the HB to where theatre and surgical staff capacity exist, thereby utilising resources more effectively. An all Wales group is also being established to assist facilitation of Regional work
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	Red	30/06/2022 - Pre-operative assessment pathways subject to current review in line with NHS Wales IP&C guidance 09/06/2023 - Pre-operative assessment pathways are subject to current review in line with NHS Wales IP&C guidance and is being undertaken through an EQuIP project. This is not a rate limiter for Orthopaedics. 25/09/2023 - EQIIP project in pilot phase, with the aim of standardising all documentation 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.
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 March 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 March 2024 provided to coincide with the plan being submitted to WG.
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 Integrated 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	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 explained during the DITS session
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	R3. There appears to be lack of clarity on shift regarding business continuity and escalation. Action: Develop an escalation plan with clear routes and methods of escalation. Communicate this with all operational staff.	Existing escalation plans will be reviewed such that they are tailored to meet the localised needs across each of the three counties and will embrace the SOPs already developed and in service. Pre shift escalation systems are already in place with the new rates of remuneration for sessional doctors (Jan-23) which includes flexibility to increase capacity in targeted way as has been seen over Bank Holiday periods and during the Adastra outage. This includes the application of targeted rates along with shift bundling.	Sep-23	~~Sep-23~~ Mar-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - implementation of this recommendation is dependant on the rollout of Salus, which is ongoing as at August 2023. Revised timescale to reflect project timeframes. 04/12/2023 - With the exit from the Salus project the national emphasis has been to renew the contracts with Advanced to continue using Adastra. Following this announcement plans underway to utilise the SharePoint system developed during the Adastra outage as a Business Continuity system should Adastra be lost for any reason (planned or unplanned) for a prolonged duration. A schedule of refamiliarisation is being put into place to ensure seamless transition between systems. Internally work continues to adopt processes to allow continuity of service if other IT/phone lines are lost.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review options for consolidation of bases.	Bases have been consolidated overnight from five to three since 2020 in the interests of patient safety and better management of expectation. This temporary service change remains under review as the underlying intention remains to operate from five bases. Latterly shift fill has not shown any significant improvement. Key to improving this is to develop the MDT model such that the interested medical parties in the numbers available can be spread across five centres.	Sep-23	~~Sep-23~~ Mar-24	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 significant levels of reduced capacity due to the dominant locum workforce availability.

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	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.
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 Practise at WAST.	Jun-23	~~Jun-23~~ ~~Sep-23~~ Mar-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 changes 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
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	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. 04/12/2023 - Work ongoing to integrate with other systems utilising ACPs but plans needed to ensure OOHs are able to develop a MDT with these colleagues
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	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.
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	R8. Staff advised that they don't have protected time to undertake clinical supervision. Action: Review provision of protected time for supervision activity	Management team identifying opportunities to facilitate protected time for supervision whilst accepting majority of doctors are sessional/ locum and so will require additional payment for such sessions.	Jun-23	~~Jun-23~~ ~~Dec-23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Discussions are ongoing in terms of the operationalisation of protected supervision. Review of the current clinical workforce model is ongoing, which will address the concerns on protected time. This may be further impacted by the implementation of Salus, therefore revised timescale provided of December 2023. 16/08/2023 - review has been undertaken for GPs, and communication to be sent to GPs and clinical workforce to reinforce acceptable practice and completion of supervision on shift. This also links with the requirement to review the clinical leadership and MDT to support this action. 04/12/2023 - The supervision of GPSTs, pharmacists and Advanced Practitioners continues in OOHs. There have been no further concerns raised regarding supervision with a number of doctors formally asking to be able to provide more opportunities to support developing colleagues without additional pay. There would not be a move to enhance pay further for anyone supervising a clinical colleague based on information from other HBs that this is not common practice and supervision is undertaken voluntarily and has never been remunerated. It is expected that, mentorship and feedback occurs within shift time so remuneration is not appropriate.
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	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.
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: Recruitment of GPs to be moved away from medical recruitment and placed within OOH.	Review arrangements which involves risk considerations will be undertaken and a preferred approach which works for the HB will be established.	Dec-23	~~Sep-23~~ Mar-24	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - service have met with Workforce and Primary Care colleagues, however further discussions required with Executive Leads around the onboarding process. 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 - Recruitment of GPs continues to be undertaken by Medical Workforce. The delays are less over recent months however the process continues to be different to Managed Practice and so doctors continue to be required to go through two onboarding processes when interested to work for OOHs and HB Managed Practice.
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	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.
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	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.
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	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.
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	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.
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.
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
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.
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	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.
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.
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 ~~week~~days. 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. 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. 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.
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 inpatient day case and outpatient procedures.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ Jan-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).
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	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).
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	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.
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	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.
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	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.

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	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.
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.
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	Red	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
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	Feb-24	Amber	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 .
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.
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R4. Risk screening matrix for emergencies would be developed by the team in keeping with the NICE 2022 guidance, Step Together and NHS England Right Care Toolkit. The immediate focus would be on safety to ensure people in the service and those coming into the service are safe. Suggested actions include contacting SUDEP Action and asking for the permission for use of the SUDEP and seizure safety checklist for all people in the service. This would also act as a surrogate measure for risk change. (Short term plan (6 months))	To consider the responses from across Wales and develop a risk screening matrix for implementation in HDUHB.	Jun-24	Jun-24	Amber	
Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R5. Consider allocating a pharmacist to work with the clinical team to understand and guide on drug and complex prescribing in this population. It would be helpful to have treatment protocols developed for high-risk individuals. (Short term plan (6 months))	To appoint a non-medical prescriber pharmacist and consider responsibilities for this post.	Dec-23	N/K	Red	11/01/2024- Advice sought from Professor. Professor advises focus how they can help achieve the 3 star service model aspired for. So, ideally their role needs to be seen alongside the other clinicians (epilepsy specialist nurse/neurologist/LD consultant) and closing any gaps created in that triangulation. Pharmacist appointed in October 2023. Professor's advice shared with supervisor of pharmacist. Meeting arranged to progress this. No revised date provided on AMAT.
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 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	Amber	11/01/2024- 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	
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	R9. A dedicated named service manager or equivalent to facilitate governance and operational developments of the proposed new team. (Medium term plan (6 months to a year))	To delegate the oversight of the service development to the current Service Manager for LD and ensure that escalation mechanism are clear.	Dec-23	N/K	Red	11/01/2024- no update provided on AMAT.

Jun-23	2023/24	Peer Review	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	R10. Consider a suitable model of care for delivering the epilepsy and ID clinical care. Ideally recruiting a specialist ID consultant with competency in epilepsy is desirable. However, there is significant challenges of such specialists being available. In such a situation: a. Consider the existing work force and supporting those psychiatrists working in the current ID service interested in physical health care in developing epilepsy skills and competencies. This should naturally be done as part of service re-design and include suitable job planning (based on work activity) and resource for any potential interested person. There needs to be good peer group and Continued Professional Development arrangements made. b. Offer similar opportunities to neurologists or GPs interested in this clinical area as in point a. above. (Medium term plan (6 months to a year))	To consider options for cover by a specialist LD consultant with interest in epilepsy.	Mar-24	Mar-24	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	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	
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	R11. It is worth the Health Board considering linking with the NHS England Midlands and Lancashire commissioning support unit. They have run a similar improvement programme (along with my involvement) following the death (SUDEP) of a vulnerable individual, Mr Clive Treacy, who had an intellectual disability and epilepsy. Eleven Integrated Care Boards have worked together to identify the areas of improvement. The learnings from this exercise can be incorporated going forward to the local situation. ttps://sudep.org/article/reviewfindsdeath-clive-treacey-potentiallyavoidable. There is a good learning template developed with engagement with national charities SUDEP Action and Epilepsy Action. (Medium term plan (6 months to a year))	To meet with NHS England Midlands and Lancashire commissioning support unit to explore whether they can support with improvement programme.	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	R12. Collateral service needs, such as expertise in specific genetic syndromes, specialism in newer ASMs, emerging technology, transition, working with primary care, paramedic engagements etc., would require updated policies. (Medium term plan (6 months to a year))	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
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	R13. Inter-service working will benefit from suitable policies, service terms of references and suitable business plans to ensure adequate service sustainability. (Medium term plan (6 months to a year))	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
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	R14. It is very important that future developments are co-produced ensuring input from patient and families. The lived experience of PwID and epilepsy and their families is essential to help shape future meaningful services. (Medium term plan (6 months to a year))	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
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	R15. Developments need a robust set of audit measures in keeping with best practice including NICE epilepsy guidelines 2022, Step Together and the NHS England Right Care epilepsy toolkit. This would ensure evidence is gathered around quality and provision of an epilepsy service specialising in support adults with intellectual disability. (Medium term plan (6 months to a year))	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
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	R16. It is important as part of the sustainability and resilience of the service that there is adequate provision for cross cover of the professionals in the service to account for planned and unplanned leave. This is particularly relevant in roles such as a dedicated epilepsy nurse specialist. (Medium term plan (6 months to a year))	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R1. Set up an Ophthalmology Steering Group to include representation from the whole pathway multidisciplinary team and executives across the health board, with resourced clinical leadership and project management time, to ensure that these recommendations are implemented and embedded, along with any other improvements the health board identify themselves. This group should have strong links with any regional ophthalmology steering group. We recommend that it is established without delay.	Executive GIRFT meeting to be established	Apr-24	Apr-24	Amber	16/11/2023 - GIRFT review in regular Opthalmology Business meeting. First meeting undertaken 20th October 2023. Executive oversight GIRFT meeting for all specialities in discussion. 02/01/2024 - Executive GIRFT meeting to be established.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack /Marta Barreiro Martins	Director of Operations	N/A	R3. Review the line management structure and explore whether a MDT cataract or whole ophthalmology surgical team across all areas (OP, day case, theatres, preop, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care	1) Workforce review to be undertaken by head of nursing and Senior Nurse Manager 2) Workforce development plan to be written and implemented.	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 eligible 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	Amber	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-operative assessment (starting 7th November 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	Aug-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 (EQIIP) 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 undertaken by 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	R10. Consider using the daycase unit corridor rooms for pre-ops.	1) Scope staffing needed to deliver IVT service through OPD in AVH. 2) Secure funding for staff needed to deliver IVT service through AVH OPD 3) Recruit staff into post. 4) Train staff to deliver IVT service through AVH OPD.	Apr-24	Apr-24	Amber	AVH rooms to be scoped to house IVT service to free further theatre capacity for cataract patients. 02/01/2024 - Constraints currently due to WGH RAAC, options for delivery of IVT services back in Pembrokeshire 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	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	R13. Identify and line up HVLC suitable patients who can rapidly be identified and pulled onto HVLC lists.	1) Identify patients on waiting list for validation against criteria for HVLC lists. 2) Clinically validate patients and formulate a suitable cohort for HVLC. 3) Agree a pre-assessment process for this cohort of patients.	Apr-24	Apr-24	Amber	27/09/23 Preliminery meeting with Ophthalmology co-ordinators to further streamline processes as outlined by GIRFT.
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	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	Nov-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	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	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	Amber	27/09/23 - Regional post secured for Glaucoma patients. 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 HDLHB 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 HDLHB 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 increased 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	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	R30. Review the documentation against the GIRFT guidance and example booklet, remove all unnecessary data collection and incorporate all relevant documents into one booklet which is lean and supports the new processes. This is urgent.	1) Review current documentation booklet and circulate for consultation. 2) Submit booklet to Working Controlled documentation group. 3) Undertake staff training. 4) Introduce new booklet.	Apr-24	Apr-24	Amber	27/09/23 Review of this booklet is now underway with consultation from all stakeholders across site.
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	Amber	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	R32. Confirm the data on the % of post-ops returning to hospital and ensure going forward reliable performance data is available, Increase the number of post-ops discharged to optometry so only the truly complex need to return to hospital for a postop visit.	1) Discuss with Consultants which cataract patients need review in secondary care. 2) Develop protocol for discharge to primary care. 3) Educate doctors on new discharge pathway. 4) Introduce new discharge pathway.	Apr-24	Apr-24	Amber	Recent review of data shows 56.5% patients being brough back for FU after cataract. Clinical team awareness raised. Review of coding to be undertaken and monthly report requested from being brought back for a FU. Regular report requested to monitor improvement.
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	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 undertake 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 ophthalmology 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	Nov-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	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	Amber	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.
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	Amber	Currently 8 Optometrists hold a higher certificate with another 15 Optometrists 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 stratification. 2) Optometrists to support with completing risk stratification. 3) Glaucoma Consultants to assist with completing risk stratification 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 categories 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	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	R4S. 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	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	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	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	R5.2. 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	Amber	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	R5.3. 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	R5.4. 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 attending 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	R5.5. 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	R5.7. Ensure patients are not solely prioritised for surgery based on waiting times, and that clinical urgency and risk of harm from delays are taken into account.	1) Continue to utilise Glaucoma categories to identify booking priority. 2) Map recovery plan in line with demand and capacity work undertaken.	Feb-24	Feb-24	Amber	Patients are treated in priority order, however lists are adjusted to include high risk longest wait patients as well.
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	R5.8. 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 improve 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	Amber	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	R5.9. 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.
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 further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
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 further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
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 model and 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 further meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
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	R4. The local TB service has improved but still has inadequacies. In particular, cross-cover arrangements need to be in place for annual, sick and study leave in order to prevent delays in treatment. Pharmacy and administrative support needs improvement. Succession planning for the TB Specialist Nurse also needs to be clear	Development of a resilience plan for both future outbreaks and maintaining current TB case management. Agree a plan for Pharmacy, administrative and Specialist nursing support required for TB management.	Jun-23	~~Jun-23~~ ~~Jul-23~~ N/K	Red	26/06/2023 - A revised completion date of July 2023 was been provided by the service lead. 17/08/2023 - from QSEC August 8th Minutes: The Assistant Director of Public Health introduced the Tuberculosis (TB) External Review Action Table. A further discussion will take place with the Medical Director regarding a future update to QSEC and it was recognised that further work is required on the action table to provide detail of the outcomes and completion status. The Board Secretary advised that the Public Health Wales actions will be updated following their Quality and Safety Committee in October 2023. 04/10/2023 - A new pathway for TB screening has been agreed, cross cover has been organised and training in place. The service has also discussed additional support from the Health Board's Sampling and Vaccination team if needed for screening.
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.
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 planned WG/PHW have not provided a completion date for this recommendation to date.e for the end of May 2023 with plans to submit and present this in June 2023.
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.
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	~~Mar-21~~ ~~Mar-23~~ N/K	Red	23/03/2022- GM working closely with other sites of the Health Board to ensure safe services, e.g. through channels such as the senior Ops team meetings. Good collaboration between community and acute services. GM looking at scheduled care elements. Real challenges in terms of tertiary level pathways and getting the right patient in the right place for the right clinical supervision. Exploring joint consultant posts with Powys and Betsi, however progress has been significantly hampered due to Covid. This is in the recovery phase and the UHB has restarted this process with neighbouring Health Boards post Covid. Clinical advisory group for Mid Wales in place which started pre-Covid. Working with Powys to establish optimal flow for their patients using Hywel Dda services, and how to work together to deliver care. This is less developed with Betsi. GM is hopeful to make significant progress and have a programme of work in place by March 2023. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med-ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Quarterly commissioning meetings in place with Powys to develop pathways, and the Mid Wales Clinical Advisory Group in place which explores joint appointments with Powys, surgical pathways and identify improvements. The site also works collaboratively with other Health Board sites, and links with clinical groups and peer reviews. Site lead advising that recommendation can be closed from the Lead Executive. 20/04/2023 - BGH would need more resources if further work would be required for this, especially in terms of the Scheduled Care pathways and Commissioning. Recommendations to be presented to the Director of Operations for approval to close. 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	Director of Operations	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 Executive 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	Director of Operations	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	Director of Operations	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 :- 1. We need to build on the excellent HEIW visit and 100% unanimous recommendation for education at BGH 2. Supervision of the trainees – who will fulfil this role, it's different to FP supervision 3. What clinics are there that the trainee will be able to have access to? 4. There will need to be a geriatric component in Year 1 – how will this be delivered? 5. 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?
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	Director of Operations	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	~~Sep-23~~ Mar-25	Red	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting this recommendation to be closed as lack of funding does not allow this recommendation to be fully implemented. There is however a designated RESUS officer just for Ceredigion, which has helped provide more RESUS training dates. Due to lack of funding BGH are discussing opportunities to access training space through the University Medical School. 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close. 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. 10/10/2023 - The medical education team have funded the development of a dedicated clinical skills and simulation lab in the medical education centre and further developments are planned for a viewing room which will enhance the simulation experience further for our student and trainees. Clinical skills and simulation tutors have been employed on an ad hoc basis, a clinical skills co-ordinator has been appointed, along with a medical education teaching fellow to help facilitate the learning in the lab and wider across the hospital site. Further upgrade work is also planned with new IT equipment as well as the modernisation of existing work spaces. This includes upgrading the classroom which is used by other health professionals when available, including the resus team. Revised completion date March 2025.
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.
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~~ N/K	Red	11/05/2023 - The existing policy has been given a formal extension by CWCDG until 10/08/2023, whilst the review is undertaken. 15/06/2023- lead officer has contacted Consultant Haematologist for an update. 07/09/2023- This policy sits with Pathology. The Chair of the Blood Transfusion Committee has responded to say that they are working on the update and hope to get it approved at the Blood Transfusion Committee meeting in October 2023. 28/09/2023- Ownership of this policy sits with the Blood Transfusion Committee. The policy was given a formal extension by CWCDG until 10/08/2023, whilst a review was undertaken, however this timescale was overrun due to the need to prioritise the update of the more clinically urgent Major Haemorrhage Procedure. Chair of the Blood Transfusion Committee has provided assurance that the policy remains fit for purpose. The review and update are in progress and the intention is for the revised policy to be approved at the October meeting of the Blood Transfusion Committee. On track for revised date of October 2023. 26/10/2023- The latest review of this policy is still in progress, the task and finish group took place 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.
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	External	15/06/2023- lead officer provided revised date of September 2023, as they hadn't anticipated 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.
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.	Process for uploading documentation and naming conventions to be included in Toolkit/SOP.	Dec-23	~~Dec-23~~ Jan-24	Red	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R1. HDUHB should ensure that all relevant documentation related to a record is uploaded to the Datix Cymru system and a standard naming convention is used to allow for ease of reference for all staff.	Clarity re access to privileged information and audit trail to be discussed at network.	Mar-24	Mar-24	Amber	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R2. It would add further value to the process for preparing and approving responses if HDUHB develops a formalised approval and signature process for responses.	The authorisation of responses process is already being addressed and will be approved by the LLSC in December.	Dec-23	~~Dec-23~~ N/K	Red	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R4. HDUHB Should consider documenting the process to ensure early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	This will be incorporated into the complaints handling toolkit.	Dec-23	~~Dec-23~~ N/K	Red	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R4. HDUHB Should consider documenting the process to ensure early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	Redress and Complaints Staff to attend national training.	Dec-23	Dec-24	Amber	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	R5. HDUHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice.	SOP is being drafted and will be reviewed by the Listening and Learning Sub-Committee in December.	Dec-23	~~Dec-23~~ N/K	Red	
Oct-23	2023/24	Welsh Risk Pool	WRP Concerns Assessment	Open	Reasonable	Nursing	Nursing	Louise O'Connor/ Cathie Steele	Director of Nursing, Quality and Patient Experience	N/A	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	
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	
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	

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	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~~ N/K	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
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	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 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.
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.
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	
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.
Jan-22	2021/22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	High	HIW requires assurance from the health board that: • Every effort is made to gather patient voice data on their views of the service provided by the setting. • Patients are able to provide feedback on their experiences of physical restraint.	Develop an Easy Read version of the Patient Experience Questionnaire, linked to the friends and family test	Apr-22	~~Apr-22~~ ~~Jun-22~~ N/K	Red	21/12/2021 - on track for completion by April 2022 20/01/2022 - On track for completion by April 2022. This pilot form was devised September 2021 and used once (prior to patient moving and subsequent closure of unit). We will continue to use once reopened, and review. The intention is that the form will be used on site and post-discharge. Feedback will be captured and presented to MHLD QSE on a bi-monthly basis. Dream Team (group of individuals with Learning Disabilities who help inform our service development) have agreed to support gathering patient experience data post discharge. With regards to providing feedback on their experiences of physical restraint, MHLD is in communication with the Reducing Restricted Practice Lead to consider what would be the most effective method of capturing this detail for those with a learning disability. 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 - form ready to be used once unit reopens. Complete. 01/10/2024- AMAT states recommendation as overdue. Last update on AMAT: Update 23/11/23 service user experience questionnaire in place and ready to use. Development of an Easy read underway. Copy uploaded.
Jan-22	2021/22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	High	HIW requires details of how the health board will improve the skill set and knowledge of staff at the setting to ensure the patient group cared for at the setting are done so appropriately and in line with best practice.	A full training needs analysis will be completed once the inpatient model has been developed and approved. This work is currently ongoing.	Feb-22	~~Feb-22~~ ~~Dec-22~~ N/K	Red	21/12/2021 - Workshop held to scope new service model, further work ongoing to develop a service specification, workforce plan and training needs analysis. 20/01/2022 - Draft service specification for approval at written control group 25th January 2022 (approved). 26/01/2022 - All staff in work completed fire training and dedicated time to be secured for returning staff. Staff training plan in place currently booking speakers will commence mid-February. 27/01/2022 - Training needs analysis has been drafted and currently out for consultation with staff. 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 - All staff currently in work have completed fire training, and dedicated time is to be secured for returning staff. Staff meet fortnightly to update on progress being made on training. 28th March 2022 – Update, training programme is underway, inclusive of but not limited to, medication management and mental health act training. Service specification is on hold whilst staff visit other areas of good practice to inform purpose of unit. The service specification will them be amended and go through approval processes which will inform the training package further. QAST update 11/07/22, awaiting outcome of service specification, which will inform the training package further. QAST update 07/09/22 dependant on approval and finalisation of service specification. Completion date Dec 2022. 09/12/2022- A review of the Learning Disability Service has been undertaken and there has been some restructuring within the directorate. Further updates will be provided to the Board in due course with ongoing liaison with the Community Health Council. A new Head of Learning Disability and Adult In-Patient Services is in place. Whilst the unit has been closed to in-patients there has been a dedicated bed on Morlais Ward. Head of Quality & Governance will review the open actions within the HIW action plan with a view to closing the actions that are no longer relevant. 10/01/2024- last update on AMAT states: Update Sept 23, site being considered for patient use, action being revisited.
Jan-22	2021/22	HIW	Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Head of Learning Disabilities / Director of Mental Health & LD	Director of Operations	High	The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.	Staff wellbeing are developing a structured programme of support for the staff ongoing, these will be in the form of reflect and act sessions. These are opportunities to listen to staff and learn from their experiences be able to understand what underlying needs there are, and look at how best to support.	Feb-22	~~Feb-22~~ ~~Jun-22~~ ~~Dec-22~~ N/K	Red	21/12/2021 - Planned, commencing in January 2022 Relationships Manager supporting HoS to look at other ways to improve support for staff. 26/01/2022 - Workforce and Organisational Development are conducting 1:1 meeting with staff, and this will be a continual process so as to allow staff to air concerns. In addition, fortnightly staff meetings are being held with good attendance, and staff are also being asked to comment and shape the future service model. Workforce modelling has commenced, with draft job roles and descriptions being defined. Once finalised, these will be required to go through the formal health board processes for approval. 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 - Workforce and Organisational Development are conducting 1:1 meeting with staff, and this will be a continual process so as to allow staff to air concerns. In addition, fortnightly staff meetings are being held with good attendance, and staff are also being asked to comment and shape the future service model. Workforce modelling has commenced, with draft job roles and descriptions being defined. Once finalised, these will be required to go through the formal health board processes for approval. QAST update 11/07/22 no further update received. QAST update 07/09/22 no update received. QAST update 01/11/22 Workforce and Organisational Development supporting staff, fortnightly staff meetings are being held with good attendance, and staff are also being asked to comment and shape the future service model. Workforce modelling has commenced, with draft job roles and descriptions being defined. Once finalised, these will be required to go through the formal health board processes for approval. 09/12/2022- A review of the Learning Disability Service has been undertaken and there has been some restructuring within the directorate. Further updates will be provided to the Board in due course with ongoing liaison with the Community Health Council. A new Head of Learning Disability and Adult In-Patient Services is in place. Whilst the unit has been closed to in-patients there has been a dedicated bed on Morlais Ward. Head of Quality & Governance will review the open actions within the HIW action plan with a view to closing the actions that are no longer relevant. 10/01/2024 last update on AMAT: update Sept 23 site being considered for patient use, action being revisited
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	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

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	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	To engage with the estates and the Mental Health Teams regarding creating a safe space to review Mental Health patients in the department	Jun-23	~~Jun-23~~ ~~Jul-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23, new date for completion updated. QAST update 07/09/23 all actions chased 10/08/23 no update / new target date supplied. QAST update 30/10/23 This is an on-going challenge. Open and collegiate working relationship with Mental Health colleagues and high-risk patients escalated. Significant numbers of MH patients requiring A&E input have complex medical needs necessitating medical input. Meeting arranged with Senior MH Colleagues to discuss these issues across both GGH & PPH. Update 20/12/23 live deferring of patients via NHS 111 option 2 to suitable locations for assessment (24/7) Patients all risk assessed and those medically fit are directed to assessment locations, those not medically fit to attend A&E and then risk assessed and placed in a monitored space. Whilst surge management in place, areas are under review for CAHMs and MH locations in A&E, but limited sue to surge.
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~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update received. QAST update 30/10/23 Awaiting quotation from Estates for refurbishment of staff facilities and seeking Charitable Funds support to fund the refurbishment. Update 20/12/23 partial refub taken place, awaiting painting of room and chartable funds for lockers.
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	R23. The health board is required to provide HIW with details of the action taken to ensure audit activity in the unit is fully completed in accordance with the health board's policy.	To ensure that medical staff within the department are supported to and undertake regular clinical audit.	Apr-23	~~Apr-23~~ ~~N/K~~ ~~Jun-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 All actions chased 10/08/23 no update or target date supplied.
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	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. Update 19/12/23 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. Physical Health checklist developed for inpatient pathway and awaiting approval. Plan for implementation on paper 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 c)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- 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	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	Red	10/10/2023-Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity however now impacted by long term absence in team. Revised timescale 31/01/24. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	Further Actions: g)And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Feb-24	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	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.
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)Roll roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	Jan-24	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	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	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	Red	10/10/2023-revised date of February 2024, to coincide with recommendation 7. QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R15. The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	Further Action j)Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R16. The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.	Please see response to recommendation 15.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R17. The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	Further Action as per Recommendation 15.	Dec-23	N/K	Red	QAST update 30/10/23 no update received from service on action. 11/12/2023- following conversations with the Patient Safety and Assurance Manager, additional information contained in the Health Board Action(s) section of the improvement plan has been moved from the management response column to the admin column of the audit tracker, therefore only the further actions raised are included in the management response column of the audit tracker.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	Further Actions l)Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Sep-23	~~Jan-24~~ Apr-24	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 &PPAG 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.
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.
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	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	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	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	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. 30/11/23 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.
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	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.
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.
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.
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.
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.
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 31/1/23. 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.
May-23	2023/24	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	N/A	R40. The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	Further Action ff)Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	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.
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	R1. Whilst efforts were made to improve the comfort of patient on trollies for extended periods. Surge patients are kept, for the most part, on trollies with limited pressure relieving equipment available. By the nature of these patients being generally older and acutely unwell, they are more susceptible to pressure damage, as well as falls, when on this equipment for longer stays.	All nursing staff including HCSW to receive update training on pressure damage management. Training to be provided by the TVN service and records of attendance to be kept by the Senior Sister.	Sep-23	Feb-24	Red	Update Oct 23- there have been training sessions on pressure damage management that has been delivered by the TVN service. They have trained 31% staff so far and there is further training booked for November 2023 awaiting to confirm the date. Aiming for completion by 01/12/23. Update 21/12/23 All nursing staff including HCSW to receive update training on pressure damage management. Training to be provided by the TVN service and records of attendance to be kept by the Senior Sister. Should be completed by 31/02/24.
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	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.
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	R9. Whilst HIW acknowledges the national flow pressures, we were concerned with the lengths of stay these patients experienced on the Unit. We noted stays of up to 5 days.	To develop an MIU escalation SOP which will include the escalation and transfer of patients.	Sep-23	~~Dec-23~~ Jan-24	Red	05/10/23- aiming for completion by 31/12/23 QAST update 01/09/23 Escalation flow chart completed and approved by Head Nurse PPH, 05/10/23 aiming for completion by 31/12/23 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.
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	R16. The health board must ensure that confidence amongst staff in the application of DOLS processes is strengthened.	DoLs training to be completed by all staff. Timescale influenced by frequency of the face-to-face training sessions.	Feb-24	Feb-24	Amber	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.

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	R17. The health board must review the storage of equipment and other items on the unit to ensure ease of access and to enable effective cleaning in all areas.	Undertake a comprehensive review and analysis of equipment requirements, ordering and storage of equipment and supplies.	Dec-23	~~Dec 23~~ N/K	Red	Update 21/12/23 Undertaken a comprehensive review and analysis of equipment requirements, ordering and storage of equipment and supplies.
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	R17. The health board must review the storage of equipment and other items on the unit to ensure ease of access and to enable effective cleaning in all areas.	Seek alternative area in MIU to store larger pieces of equipment to rationalise the amount stored in the unit	Dec-23	~~Dec 23~~ N/K	Red	Update 21/12/23 Seek alternative area in MIU to store larger pieces of equipment – the service currently have 2- 3 examination couches in unit, this depends on how many medical patients are in the unit. Contact made with Estates to seek somewhere to store at least 2 couches.
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	R17. The health board must review the storage of equipment and other items on the unit to ensure ease of access and to enable effective cleaning in all areas.	Scope the re-purposing of existing rooms to find a solution for the storage issue.	Dec-23	~~Dec 23~~ N/K	Red	Update 21/12/23 rooms have ben decluttered, discussions underway re 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	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.
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	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.
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Unscheduled Care (BGH)	Head of Midwifery	Director of Operations	N/A	R1a. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	Lead Anaesthetist and the Lead Anaesthetist for Obstetrics for BGH have been informed as a priority and have provided assurance that compliance will be met at the earliest opportunity	Aug-23	~~Aug 23~~ N/K	Red	28/09/2023 - Verbal confirmation from Kathryn Greaves in W&C Gov meeting that the recommendations on this report are all completed. (Difficulty logging on to AmaT system so they still show as incomplete). Chase this with QAST team at next update request. 10/01/2024 - Rec turned back Red base on QAST Update = 4/9/23: scheduled two dates for anaesthetic skills update for 8 anaesthetists. Training completed as planned all except 2 who have been prioritised and scheduled to attend the first PROMPT training dates. Overall the training days have been excellent with good engagement from all participants, we have had interactive learning and discussion throughout the sessions. We have 4 anaesthetists that are compliant with PROMPT so this leaves only 2 outstanding and one is booked to attend the first PROMPT session of the new programme at the end of September. (No revised date given)
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	R1b. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	PROMPT Wales have been contacted and an additional PROMPT facilitator training place for an Obstetric Anaesthetist from BGH has been confirmed this will increase the number of anaesthetic facilitators available for PROMPT training in BGH.	Sep-23	~~Sep 23~~ N/K	Red	28/09/2023 - Verbal confirmation from Kathryn Greaves in W&C Gov meeting that the recommendations on this report are all completed. (Difficulty logging on to AmaT system so they still show as incomplete). Chase this with QAST team at next update request. 10/01/2024 - Rec turned back Red based on QAST Update = Overdue (No revised date given)
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Scheduled Care	Head of Midwifery	Director of Operations	N/A	R1c. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	Given the nature and value of PROMPT training, it is essential that it is MDT and therefore session take place on a monthly basis. The Health Board acknowledges that to achieve the outcomes they must be SMART and therefore, this will take several months to achieve compliance	Sep-23	~~Sep 23~~ Mar-24	Red	28/09/2023 - Verbal confirmation from Kathryn Greaves in W&C Gov meeting that the recommendations on this report are all completed. (Difficulty logging on to AmaT system so they still show as incomplete). Chase this with QAST team at next update request. QAST Update 09/11/23 - the service have advised they are aiming for 31/03/24 as a completion date. 10/01/2024 - Rec turned back Red based on QAST update = Update 09/11/23 the service have advised they are aiming for 31/03/24 as a completion date.
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	28/09/2023 - Verbal confirmation from Kathryn Greaves in W&C Gov meeting that the recommendations on this report are all completed. (Difficulty logging on to AmaT system so they still show as incomplete). Chase this with QAST team at next update request. 10/01/2024 - Rec turned back Red based on QAST update = Not started
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	R3a. 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	Appropriate patient information leaflets in place so women are able to make informed decisions/ choices about their care and treatment plans.	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	Amber	11/01/2024 - QAST Update = None.
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	Amber	11/01/2024 - QAST Update = None.
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	R4b. 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	There is a programme in place to ensure all equipment is appropriate and reviewed regularly and investment made where needed to update	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R5a. The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	Vacancy factor of 1.8wte has been recruited to which will further support the staffing requirements of the service	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = Position recruited to, awaiting onboarding proses for a start date.
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	R5b. The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	Community midwives support the acute obstetric unit based on the bespoke nature of the service and will respond and support during periods of high acuity only. Community hours are collated monthly to understand usage and impact and shared with the senior midwifery team.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R5c. The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	A RAG rated escalation flow chart is in place during high periods of acuity to ensure appropriate escalation for support from the community midwives who have their base on Gwenllian Ward.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R5d. The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	Community midwives take part in the annual PROMPT training and complete both the community and obstetric PROMPT course to ensure skills and practice supports the low risk and high risk requirements of both clinical areas of practice.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R5e. The health board should review the on call rota process (for midwives) to ensure that appropriately skilled midwives are available to support the obstetric unit in times of increased acuity	A new programme of skills and drills will include the community midwifery team to support their ongoing need to maintain obstetric skills required to support high acuity and these are scheduled throughout the year	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
Aug-23	2023/24	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Scheduled Care	Head of Midwifery	Director of Operations	N/A	R6a. The health board should review and risk assess the system for on call theatre scrub nurses for obstetric emergencies.	1 scrub nurse is on site 24/7, a second scrub nurse on call is operated after 20:00hrs and is called when theatre is required for obstetrics.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R6b. The health board should review and risk assess the system for on call theatre scrub nurses for obstetric emergencies.	An options appraisal process and risk assessment was undertaken to ensure the safety and cover for theatres out of hours to support the obstetrics requirements due to emergencies.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R7a. 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	Ultrasound Control Group in place to support workforce planning which will address the Health Boards ability to comply with national guidance for fetal growth monitoring in pregnancy, noting the national shortage of sonographers across Wales and the UK.	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R7b. 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	Where growth concerns are identified, fetal growth surveillance is increased and provided in line with guidance	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	Amber	11/01/2024 - QAST Update = None.
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	R7d. 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	Radiology have recruited additional sonographers in addition to increasing training places for radiographers to undertake obstetric ultrasound scanning.	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R7e. 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	DATIX reporting of concerns with missed growth are reported and investigated jointly with Radiology.	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R7f. 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	Risk held on Service, Directorate and Corporate Risk Register and reviewed in line with governance processes	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R8a. The health board should review consultant presence across unit and with a view to increasing visibility and ensuring that all staff and patients feel safe and supported.	Monitor using the QR reporting tool consultant representation at daily safety huddle / daily handover meetings.	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.

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	R8b. The health board should review consultant presence across unit and with a view to increasing visibility and ensuring that all staff and patients feel safe and supported.	Monitor using the acuity tool the consultant presence on the unit for morning and evening handover and ward rounds	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R8c. The health board should review consultant presence across unit and with a view to increasing visibility and ensuring that all staff and patients feel safe and supported.	Confirm Consultant base location are available and accessible for direct communication for advice and patient review at all times	Nov-23	~~Nov 23~~ N/K	Red	11/01/2024 - QAST Update = None.
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	R9a. The health board should deliver evaluate and further develop of this training neonatal care training.	The practice educator for neonates is working closely with the BGH team and the Midwife who has been involved in supporting training, on neonatal care, in Gwenllian ward. There will be local simulation training arranged in conjunction with the annual NLS updates for all staff and a 6 monthly programme for all band 7 staff. This will be led by the practice educator neonatal nurse and practice development Midwifery team as well as by the local medical lead forneonates in BGH.	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update = None.
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	R9b. The health board should deliver evaluate and further develop of this training neonatal care training.	An Excel spreadsheet has been developed to support tracking of medical compliance with mandatory training	Jan-24	Jan-24	Amber	11/01/2024 - QAST Update. The ANP has attended additional training in Cardiff to up skill in neonates.
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	Amber	11/01/2024 - QAST Update = None
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	Amber	11/01/2024 - QAST Update = None
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	R11. The health board should monitor attendance and review and evaluate effectiveness of new Skills and Drills training. The health board should ensure that obstetric medical staff can demonstrate appropriate skill levels in managing rare complex obstetric emergencies.	A new programme of skills and drills will include the community midwifery team to support their ongoing need to maintain obstetric skills required to support high acuity and these are scheduled throughout the year.	Oct-23	~~Oct 23~~ N/K	Red	11/01/2024 - QAST Update = None. No revised date provided.
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.	Continue HDdUHB stroke leads collaborative working with the National Stroke Programme Board and the NHS Executive. HDdUHB has representatives attending all national stoke groups.	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	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.
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 HDdUHB 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.
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.
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.	Consideration of the use of Red Flag training available for receptionist	Dec-23	~~Dec 23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R17. WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	The Health Board has systems in place for pre-alerts for stroke patients. Performance will reviewed on a quarterly basis through the Stroke Steering group the Health Board's performance against this target.	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	R19. Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	All ED staff will be reminded of the importance of ensuring all patients are triaged within the 15 minute wait time (including patients on ambulances awaiting handover) through site PNF meetings, ED team meetings and directorate governance / quality, safety and experience meetings.	Dec-23	~~Dec 23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R19. Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Where compliance with the 15 minute triage time has not been possible, staff will be reminded through the same meetings as above to ensure that that explanations are clearly documented within the patient record.	Dec-23	~~Dec 23~~ N/K	Amber	10/01/2024 - update via the AMaT system - Correspondence sent to ED managers and ED Consultant to engage with all staff members regarding documentation of non compliance to the triage target Update from BGH 14/12/23 continue to document any 15min triage compliances for stroke – at present no evidence as the compliance has not been breached as our FAST +VE patients tend to go straight to CT not via ED
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	R19. Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Regular spot checks of patient records (patients presenting with strokes / all patients) will be commenced in November 2023 to monitor compliance and have assurance that the recording of triage times and rationale where this has not been met has been documented and any themes escalated through quality, safety and experience meetings.	Nov-23	~~Nov 23~~ N/K	Red	10/01/2024 - update via the AMaT system - Stroke ward manager and Stroke CNS will action regular spot check audits of documented non compliance of the 15 min triage A audit outcomes will be reported through PNF and Bronglais quality forum
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	R20. Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Dec-23	~~Dec 23~~ N/K	Red	10/01/2024 - No update via the AMaT system.
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	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.	As part of the clinical services plan, a scoping review of current CNS and ANP / ACP stroke specialist services across the acute sites will be commenced in November 2023.	Jan-24	Jan-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	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.
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	R25. All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.	The HB has considered the implementation of AI. There is a task and finish group set up and meet on a weekly basis to plan and implement the system.	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	R28. Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.	Gold standard is for all patients to be thrombolysed on the stroke unit. Across the HB, this is usually undertaken by trained medical on-call or Stroke team staff. To reflect those less frequent occasions where patients have to be thrombolysed in ED, frequent training is provided for ED staff. Review of training coverage will be monitored quarterly via the Stroke Steering Group.	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	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 / Lori 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.
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	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.	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	
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	Feb-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	R4. The health board must make sure that temperature checks are consistently recorded on St Nons ward	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet.
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	R5. The health board must ensure that mandatory compliance rates are improved. Staff completion rates of Immediate Life Support and mandatory training on both wards must be improved	To ensure mandatory training compliance is encouraged and monitored at a ward, service and directorate level.	Jan-24	Jan-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	R5. The health board must ensure that mandatory compliance rates are improved. Staff completion rates of Immediate Life Support and mandatory training on both wards must be improved	A review of service wide resuscitation training needs to be undertaken and plan developed to improve compliance	Jan-24	Jan-24	Amber	11/01/2024- Detailed report produced to highlight resuscitation training compliance at a team level. Mapping of training needs by site undertaken and contact person by site identified. Information shared with Resuscitation Training Lead to develop a plan for site based training delivery.

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	R6. The health board must review staffing levels to ensure they meet the demands of the patient group.	Inpatient establishment review work in progress in partnership with Head of Nursing for Professional Standards and Regulation and Inpatient Senior Nurses. Meetings to be held with ward managers to provide updates on this work for cascade to wider team members.	Jan-24	Jan-24	Amber	11/01/2024- Meetings to update ward managers on establishment review work diarised for 19th January 2024.
Oct-23	2023/24	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	N/A	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	Feb-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	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	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.	Request to be made to estates to review and improve storage within the occupational therapy room	Dec-23	N/K	Red	11/01/2024- We have made a prompt declutter of the OT room - I am in conversation with ward manager about getting better storage facilities in our 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	
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	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 will review thermostat covers and ensure suitable covers are replaced in patient rooms on St Non ward	Jan-24	Jan-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	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	R12. The health board must ensure that out of date medication is disposed of and that clinical waste bins are available in clinical rooms	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet
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	R14. The health board must ensure that menu options include gluten free options of more variety of choices for patients.	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet
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	R15. The health board must ensure that checks are undertaken on the patients fridge and that no out of date products are stored in the fridges.	N/K	N/K	N/K	Red	11/01/2024- AMAT has no action against this recommendation as yet
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	Feb-24	Amber	11/01/2024- Membership identified for the task and finish group and dates for initial meeting are being scoped.
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	Feb-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	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.	Guidance in relation to consideration of use of CTO when leave is granted for more than 7 days to be incorporated within the Health Boards Section 17 Policy. A reminder of guidance and documentation needs will be discussed at the Psychiatric Medical Staffing Committee in January 2024.	Jan-24	Jan-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	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	
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.
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	R2. Increase the frequency of audits, walkaround and / or spot check activity related to IPC to ensure that improvements are implemented and sustained.	Frequent unannounced spot checks over next 6 months to ensure improvements/standards are maintained.	Sep-23	~~Sep-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)	Estates	Senior Nurse Manager	Director of Operations	N/A	R2. Increase the frequency of audits, walkaround and / or spot check activity related to IPC to ensure that improvements are implemented and sustained.	Recruitment of domestic staff vacancies	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)	Estates	Senior Nurse Manager	Director of Operations	N/A	R2. Increase the frequency of audits, walkaround and / or spot check activity related to IPC to ensure that improvements are implemented and sustained.	Ensure that hotel facilities audits are undertaken once a month, in the company of a senior sister.	Aug-23	~~Aug-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	R8. The health board must ensure that there is sufficient supply of pillows and blankets to ensure patient comfort.	Information to be displayed on ED linen trolley to remind staff that additional blankets are available at the linen room.	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	R8. The health board must ensure that there is sufficient supply of pillows and blankets to ensure patient comfort.	Senior Nurse Manager to review & audit on a monthly basis the actions above	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	R9. The health board must continue to focus on and review the privacy and dignity needs of patients as changes to use of surge areas are implemented	Curtains rails to be erected in cubicle areas where "doubling up" is necessary to support surge patient flow demand.	Nov-23	~~Nov-23~~ N/K	Red	10/01/2024 - update via the AMaT system - Update 21/12/23 additional curtain rails in cubicle areas installed. (Partially complete).
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	R11. The health board must ensure that all delayed transfers are recorded as required and in a timely manner.	All delays of transfers of care within the department are recorded on CAS card/nursing records. The department navigator to escalate to the CSM at 4, 8 12 hour marks. This is also reported & discussed at the bed/site safety meeting at 08:30.12:15 & 15:00 hours. Spot-checks to be undertaken by SNM over a 6 week period to review compliance.	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	R12. The health board is advised to measure the effectiveness of the proposed changes to the ED in light of the challenges identified during the course of the inspection.	The proposed changes to the ED department have been discussed in an extraordinary meeting on 31/10/23 and will be reviewed in hospital quarterly Governance meetings and in our monthly ED meetings	Nov-23	~~Nov-23~~ Dec-24	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	R15. The health board must ensure that there is a suitable mental health assessment room available within the ED, which is subject to a risk assessment prior to use.	To ring fence the designated mental health room to support availability of suitable ligature free environment as part of SBAR.	Oct-23	~~Oct-23~~ ~~Nov-23~~ N/K	Red	10/01/2024 - update via the AMaT system - Update 29/11/23 discussions underway with regard to identifying an appropriate room - for assurance patients are not left alone in room Update 21/12/23 ligature assessment taken place in room identified. Awaiting approval of plan. (Partially complete)
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	R15. The health board must ensure that there is a suitable mental health assessment room available within the ED, which is subject to a risk assessment prior to use.	Ligature Risk Assessment to be completed for environment.	Oct-23	~~Oct-23~~ N/K	Red	10/01/2024 - update via the AMaT system - Update 21/12/23 assessment undertake in MH room. (Partially complete)
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.	Environmental spot audit to be undertaken over a 6 week period to monitor compliance	Dec-23	~~Dec-23~~ N/K	Red	10/01/2024 - update via the AMaT system - Updated 21/12/23 evidence from service completion. (Partially complete)
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	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.	Introduce electronic symbiotix menu selection pilot to the department. Pilot expected to run from November 23, to be evaluated in 6 months' time.	Jan-24	Jan-24	Amber	10/01/2024 - update via the AMaT system - Update 21/12/23 allocated to cl to move forward.
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	R22. The health board must ensure that staff feedback provided throughout the report is reflected upon, ensuring that robust actions are taken where required.	Monthly department team meetings to discuss completed actions / seek staff views.	Mar-24	Mar-24	Amber	10/01/2024 - update via the AMaT system - Update 21/12/23 team meetings taken place, evidence to be sent.
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	R23. The health board is recommended to strengthen senior nurse management and leadership in the ED (Senior Sister / Charge Nurse).	Department induction to be provided to all new senior sisters/charge nurse	Jan-24	Jan-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	R23. The health board is recommended to strengthen senior nurse management and leadership in the ED (Senior Sister / Charge Nurse).	All Senior Sisters/charge nurse to attend STARS / other recognised Management and Leadership course to promote knowledge, skills and development.	Jan-24	Jan-24	Amber	10/01/2024 - update via the AMaT system -Update 21/12/23 staff nominated to attend STAR programme, awaiting confirmation.
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	R24. The health board should ensure that there are robust interim arrangements in place for the induction and on-going support of new staff.	All new doctors undertake department Health Board induction Programme.	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	R24. The health board should ensure that there are robust interim arrangements in place for the induction and on-going support of new staff.	Joint Department Induction pack to be developed for all staff to be made available for support.	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	R25. The health board should ensure that formal methods to provide feedback, such as Putting Things Right, is prominently displayed throughout the department.	All staff to be provided with access to the learning from events folder.	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	R26. The health board must strengthen its complaint response times complaints in accordance with the established timeframes.	Monthly department complaint meeting to be arranged with Putting Things Right team to promote timely responses to promote working collaboratively to meet time frame targets.	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	R26. The health board must strengthen its complaint response times complaints in accordance with the established timeframes.	To arrange training for the senior sisters in obtaining monthly reports from the CIVICA system. These reports will be shared with the wider ED team.	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	R27. The health board should ensure that staff are made aware of patient feedback in order to aid learning.	Knowing how we are doing Board to be updated monthly and results visible and discussed at monthly Health Care Standard scrutiny meeting. Improvement action plans completed for areas of concern, with sharing of good practice.	Dec-23	~~Dec 23~~ N/K	Red	10/01/2024 - No update via the AMaT system
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.

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	Public Service Ombudsman (Wales)	202102692	Open	N/A	Nursing	Nursing	Amanda Davies/Rebecca Temple-Purcell	Director of Nursing, Quality and Patient Experience	N/A	R5. Provide the Ombudsman with evidence that it has reviewed the way in which patients with a diagnosis of bipolar disorder are monitored and reviewed by the CMHT, including documenting and responding to changes in behaviour noted by clinical staff or family/significant others.	The CMHT and Liaison Service Specifications (currently in the process of being ratified) will demonstrate what has been implemented and the model that the teams are already working to, it includes guidelines on changes in patient presentation and the NICE guidelines for 'Bipolar Disorder – assessment and management'.	Jan-24	Jan-24	Amber	16/10/2023: For discussion at MHLD QSE Meeting on 16/10/2023, this case is included in the report of Ombudsman cases and SBAR.
Jul-23	2023/24	Public Service Ombudsman (Wales)	202102692	Open	N/A	Nursing	Nursing	Mandy Rayani	Director of Nursing, Quality and Patient Experience	N/A	R6. Provide the Ombudsman with evidence that it has reviewed its policy and procedures for discharging patients during the night including robust consideration of the potential risks posed to staff, patients and their families or carers.	Management Response held with PSOW.	Jan-24	Jan-24	Amber	16/10/2023: Due January 2024.
Aug-23	2023/24	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	N/A	R6. Nurses should receive, as appropriate, training on the use of urinary catheters and bladder washouts.	Action plans held with Ombudsman Liaison Manager	Feb-24	Feb-24	Amber	16/10/2023: This recommendation is due 18/02/2024.
Aug-23	2023/24	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	N/A	R7. Undertake an audit to ensure nursing documentation is in line with that set out at d) and provide follow-up training/feedback if necessary.	Action plans held with Ombudsman Liaison Manager	Feb-24	Feb-24	Amber	16/10/2023: This recommendation is due 18/02/2024.
Aug-23	2023/24	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	Paul Smith Clive Weston	Director of Nursing, Quality and Patient Experience	N/A	R8. Undertaken a sample audit of TOE documentation to ensure that they are in line with BSE guidelines.	Action plans held with Ombudsman Liaison Manager	Feb-24	Feb-24	Amber	16/10/2023: This recommendation is due 18/02/2024.
Nov-23	2023/24	Public Service Ombudsman (Wales)	202203842	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Olivia Barker/ Amanda Davies/ Peter Gills	Director of Nursing, Quality and Patient Experience	N/A	R3. Review the CMHT records, of where the complainant was a patient, for any other patients who might have been prescribed an antipsychotic (such as quetiapine) and have needed an ECG, to ensure they have not experienced the same issues as the patient. If any are identified, the Health Board should take appropriate action to remedy each situation.	Action plans held with Ombudsman Liaison Manager	Feb-24	Feb-24	Amber	
Nov-23	2023/24	Public Service Ombudsman (Wales)	202200883	Open	N/A	Ceredigion	Ceredigion	Peter Skitt	Director of Nursing, Quality and Patient Experience	N/A	R1. Apologise to the complainant for the failing that identified in the PSOW final report in relation to the way in which the patient had been discharged from the Palliative Care Team.	Reflect on the findings of the Ombudsman's report and draft an appropriate apology letter	Dec-23	~~Dec-23~~ N/K	Red	Awaiting update from PSOW team
Nov-23	2023/24	Public Service Ombudsman (Wales)	202200883	Open	N/A	Ceredigion	Ceredigion	Peter Skitt	Director of Nursing, Quality and Patient Experience	N/A	R2. Share this report with the Palliative Care Team to reflect on its findings and remind it of the importance of clear discussions with Patients when discharging them from its services.	Action plans held with Ombudsman Liaison Manager	Dec-23	~~Dec-23~~ N/K	Red	Awaiting update from PSOW team

Reports opened on the Audit Tracker since ARAC December 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
HIW: St Non, St Caradog, Canolfan Bro Cerwyn WGH	Director of Operations	19	Quality, Safety and Experience Committee
Internal Audit: Estates Condition	Director of Operations	8	Audit and Risk Assurance Committee
Internal Audit: Technical Resilience Final Report	Director of Finance	5	Audit and Risk Assurance Committee
Internal Audit: Follow-up: Strategic Programme Governance	Director of Strategic Development and Operational Planning	4	Audit and Risk Assurance Committee
Internal Audit: Sealing of Contracts Review	Director of Corporate Governance	Advisory review, no recommendations raised	Audit and Risk Assurance Committee
Llais: Palliative End of Life Care	Director of Primary Care, Community and Long Term Care	5	Quality, Safety and Experience Committee
Llais: West Wales Maternity Services Report	Director of Operations	7	Quality, Safety and Experience Committee
Llais: West Wales Region Engagement Report	Director of Operations	5	Quality, Safety and Experience Committee
MWWFRS: Letter of Fire Safety Matters Premises: Block 10, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	9	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters Premises: Template 13, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Director of Operations	6	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters Premises: Ashgrove Medical centre, Thomas Street, Llanelli. SA15 3JH	Director of Operations	5	Health and Safety Committee
NHS Wales Executive: Children and Young Person's Neurodevelopmental Services All Wales Review	Director of Operations	9	Quality, Safety and Experience Committee

NHS Wales Executive: Review of Psychology & Psychological Interventions for Children and Young People	Director of Operations	9	Quality, Safety and Experience Committee
Peer Review: Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	Director of Operations	16	Quality, Safety and Experience Committee
PSOW: 202203842	Director of Operations	3	Listening and Learning Committee
PSOW: 202208731	Director of Operations	3	Listening and Learning Committee
PSOW: 202200883	Director of Operations	2	Listening and Learning Committee
PSOW: 202102804_202103036	Director of Nursing, Quality and Patient Experience	2	Listening and Learning Committee
WRP: WRP Concerns Assessment	Director of Nursing, Quality and Patient Experience	7	Quality, Safety & Experience Assurance Committee
Total		**124**	

Reports re-opened on the Audit Tracker since ARAC December 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
HIW: Ty Bryn 1 November 2021 (Publication date 19 January 2022)	Director of Operations	14	Quality, Safety and Experience Committee
Total		**14**	

Reports closed on the Audit Tracker since ARAC December 2023

Report name	Lead Executive/Director
HIW: National Review of Maternity Services- Phase 1, issued November 2020	Director of Operations
Internal Audit: Agency & Rostering	Director of Workforce & OD
Internal Audit: Board Oversight Final	Director of Corporate Governance
Internal Audit: Escalation Status Actions	Director of Corporate Governance
Internal Audit: Sealing of Contracts Review	Director of Corporate Governance
Internal Audit: Strategic Change Programme Governance	Director of Finance
Llais: S-CAMHS	Director of Operations
MWWFRS: Enforcement Notice Premises: Withybush General Hospital	Director of Operations
PSOW: 202102804_202103036	Director of Nursing, Quality and Patient Experience

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Medicines Management in Acute Hospitals (June 2015)	1 External	June 2016	1 external – awaiting funding confirmation from Welsh Government (WG)	Medicines Management	One 'external' recommendation relating to electronic prescribing/discharging. Systems have been approved on a national framework and is currently awaiting confirmation of funding. The business case due to be reported to the Digital Oversight Group in February 2024. 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 January 2024.
Community Health Council - Accident & Emergency Departments in the Hywel Dda Health Board area (November 2022)	1	December 2023	1 – revised completion date lapsed	Nursing	Timescales are currently being requested from the Digital Director in regard to when the communication system will be installed on the new screens, with updates to be reflected to ARAC in April 2024.
Community Health Council - Eye Care Services in Wales, issued March 2020	1 External	June 2022	1 external – awaiting update on national system roll out	Scheduled Care	The Health Board is still awaiting a "go live" date from the national Eyecare project team following delays in the rollout of the Electronic Patient Record (EPR) platform. Digital Health and Care Wales (DHCW) have commenced a review of how the EPR can be delivered across Wales, with a plan to restart the "Open Eyes" project in April 2024. A regional approach to roll out the 'Open eyes' project with Swansea Bay has been agreed and the service are currently awaiting further guidance from the DHCW around the delivery and timescales of this project.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Community Health Council - Palliative End of Life Care (March 2023)	5	September 2023	5 – original completion dates lapsed	Ceredigion	Progress on this report is logged via the AMaT system and monitored by QAST. The report was added to the Audit & Inspection tracker in December 2023 during a reconciliation exercise with AMaT. Since data was extracted from the tracker for reporting, further updates have been received from the service, with 2 of these recommendations now being complete. These updates will be reflected in the numbers to be reported to ARAC in April 2024.
Delivery Unit - All Wales Review of progress towards delivery of Eye Care Measures (September 2019)	3	December 2023	3 - revised completion dates recently lapsed	Scheduled Care	The Service Deliver Manager for Ophthalmology presented an Ophthalmology Deep Dive report to ARAC in December 2023 highlighting the challenges and progress to date on this report, as well as outlining the next steps required to complete these recommendations. The Assurance and Risk Team are seeking revised completion dates for these recommendations which will be reflected in the numbers to be reported to ARAC in April 2024.
HEIW - Revalidation Quality Review Report (July 2023)	1	December 2023	1 - revised completion date recently lapsed	Medical	The Assurance and Risk Team are seeking progress updates and a revised completion date, which will be reflected to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - Bronglais Hospital Maternity Unit (August 2023)	6	November 2023	6 – QAST awaiting revised timescale	Women and Children's Services	Since the previous ARAC meeting in December 2023, the total number of recommendations for this report has increased from 2 to 11 on the Audit & Inspection as a result of the reconciliation undertaken with AMaT. Progress updates and revised timescales are currently being sought from the service via the Quality Assurance and Safety Team (QAST), with updates to be reflected to ARAC in April 2024.
HIW - Emergency Department, Withybush General Hospital, Hywel Dda Healthboard. Inspection date: 21, 22, 23 August 2023	14	October 2023	9 - Original completion dates lapsed Since previous meeting 5 – Original completion dates lapsed	Unscheduled Care (WGH)	Progress updates and revised timescales are currently being sought from the service via the QAST, with updates to be reflected to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - Emergency Unit, GGH 05, 06 and 07 December 2022 (Publication date 17 March 2023)	3	September 2023	1 - QAST team awaiting update 1- Estates completing refurbishment work 1- QAST awaiting revised timescale	Unscheduled Care (GGH)	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
HIW - Mental Health Discharge Review (May 2023)	14	October 2023	8 – Original completion dates lapsed since previous meeting 6- QAST awaiting revised timescale	Mental Health & Learning Disabilities	Timescales are currently being requested from the service via QAST. The Assistant Director of Nursing MH&LD is determining revised timescales, with support from the Interim Director Nursing, Quality & Patient Experience.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - National Review of Patient Flow – a journey through the stroke pathway (September 2023)	5	December 2023	5 - Original completion dates lapsed	Unscheduled Care (WGH)	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
HIW- Prince Philip Hospital Minor Injuries Unit (June 2023)	1	December 2023	1- Original completion date lapsed	Unscheduled Care (PPH)	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
HIW - St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	1	December 2023	1- QAST awaiting revised timescale	Mental Health & Learning Disabilities	Estates advised in December 2023 via the AMAT system that a start date for these works will be provided. Updates to be reflected to ARAC in April 2024.
HIW- St Non, St Caradog, Canolfan Bro Cerwyn WGH (October 2023)	7	December 2023	3- Original completion dates lapsed 4- No managem-ent responses on AMaT	Mental Health & Learning Disabilities	At the date of data extraction, management responses were not on the AMaT system, however confirmation has since been received that the Patient Safety and Assurance Manager is meeting with the Assistant Director of Mental Health & Learning Disabilities to establish the remaining management responses for addition to the system. These updates to be reflected to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW- Thematic Review of Ophthalmology 2015/16 issued January 2016	1	December 2023	1 – revised completion date lapsed since previous meeting	Scheduled Care	The Service Deliver Manager for Ophthalmology presented an Ophthalmology Deep Dive report to ARAC in December 2023 highlighting the challenges and progress to date on this report, as well as outlining the next steps required to complete these recommendations. The Assurance and Risk Team are seeking revised completion dates for these recommendations which will be reflected in the next report to ARAC.
HIW- Ty Bryn 1 November 2021 (Publication date 19 January 2022)	4	December 2022	4- report re-opened. QAST awaiting revised timescale	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
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	1	September 2023	1 - original completion date lapsed	Radiology	Progress updates and revised timescales are currently being sought from the service via the QAST, with updates to be reflected to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Independent Review - Savings Governance Review	1	October 2023	1 – original completion date lapsed	Finance	This recommendation relates to establishing comprehensive operational planning, finance, governance and project management support for scheme leads, and is reliant on an action assigned to the Strategic Development and Operational Planning Directorate. The Assurance and Risk Team will be seeking an update and a revised completion date on this recommendation which will be reflected in the next paper to ARAC in April 2024.
Internal Audit- Cyber Security (November 2022)	1	December 2023	1 – revised date lapsed since previous meeting	Digital	The action to create a centralised mailbox is now complete, however a standard operating procedure (SOP) is required to fully implement the recommendation. The Assurance and Risk Team will be seeking an update and revised completion date on this recommendation which will be reflected in the next paper to ARAC in April 2024.
Internal Audit – Deprivation of Liberty Safeguards (DoLS) (August 2023)	1	September 2023	1 - Original completion date lapsed	Primary Care	Internal Audit are awaiting confirmation from the service if this recommendation has now been implemented. Progress against this recommendation will be reflected in the next paper to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit – Discharge Processes	7 (2 External)	August 2023	2 – 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 February 2024. This report will include following up on all the recommendations in the Discharge Processes report, and updates will be reflected in the next paper to ARAC in April 2024.
Internal Audit- Estates Condition	1	December 2023	1- Original completion date has lapsed	Estates	Confirmation has been requested from Internal Audit if this recommendation can be closed, and updates will be reflected in the next paper to ARAC in April 2024.
Internal Audit - Falls Prevention and Management	1 External	June 2023	1 – External	Nursing	All Wales inpatient falls network are looking into mandating an e-learning falls training programme on an All Wales basis and a sub group of the All Wales inpatient falls network is being established to action this. The service has developed a training day programme, with a pilot of the training session being run in Ty Nant on 18th January 2024 for a limited number of staff before submitting finalised study day plans to EAGLE panel for approval.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Fitness For Digital - Use of Digital Technology	1	September 2023	1 – revised timescale has lapsed	Digital	Confirmation has been sought from the Digital Director as to whether this recommendation is proceeding as planned. Updates will be reflected in the next paper to ARAC in April 2024.
Internal Audit - Follow-up: Strategic Programme Governance	4	July 2023	4 – Original completion dates have lapsed	Finance	This follow-up report has superseded the previous Internal Audit Strategic Programme Governance report, progress updates and revised completion dates on this report have been requested and will be reflected in the next paper to ARAC in April 2024.
Internal Audit - Follow-up: Welsh Language Standards	1	September 2023	1 - revised timescale has lapsed	CEOs Office (Welsh Language)	Since data was extracted from the Audit & Inspection tracker, an update has been received from the service detailing that assurance on compliance with Welsh Language Standards will be reported to People, Organisational Development and Culture Committee (PODCC) through the current reporting structure, rather than through a steering group as initially proposed. Confirmation has been requested from Internal Audit if this recommendation can be closed, with updates to be reflected in the next paper to ARAC in April 2024.
Internal Audit - Individual Patient Funding Requests	1	November 2023	1 – revised completion date lapsed	Medical	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 Individual Patient Funding Requests (IPFR) spend. Once the report is available this will be shared at the IPFR Panel and evidence submitted to Internal Audit for formal approval of closure.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - IT Infrastructure	2 (1 External)	October 2023	1 – revised completion date lapsed 1 - external	Digital	It is anticipated that the proposed launch of ARMIS (asset management and cyber security system) in 2024 could supersede the management responses as initially included in the report. Updates will be reflected in the next paper to ARAC in April 2024.
Internal Audit- Job Planning	3	December 2023	3 – revised completion dates 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.
Internal Audit- NICE Guidelines (September 2023)	2	December 2023	2 - original completion date lapsed since previous meeting	Medical	A follow up review of this audit report is due to be presented at February 2024 ARAC which will detail progress against existing recommendations raised. Updates will reflected in the next paper to ARAC in April 2024.
Internal Audit - Quality & Safety Governance- Bronglais General Hospital	3	December 2023	3 – original completion dates lapsed since previous meeting	Unscheduled Care (BGH)	A follow-up Internal Audit report is being presented at ARAC in February 2024, with updates to be reflected in the next paper to ARAC in April 2024.
Internal Audit - Regional Integration Fund (RIF)	1 External	September 2023	1 – revised completion date lapsed since previous meeting	Finance	The Memorandum of Understanding has been discussed at December Integrated Executive Group (IEG) and reported to each Board meeting. This recommendation is now awaiting for progress to take place with the Local Authority. Recommendation status has changed from 'Red' to 'External' to reflect this structure.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Safety Indicators – Pressure Damage & Medication Errors	2	December 2023	2 – original completion dates lapsed	Nursing	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
Llais - West Wales Maternity Services Report (November 2023)	1	December 2023	1 – original completion date lapsed	Women and Children's Services	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
Llais - West Wales Region Engagement Report (October 2023)	1	December 2023	1 – original completion date lapsed	Unscheduled Care (WGH)	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.
MWWFRS - Letter of Fire Safety Matters Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	1	December 2023	1 – original completion dates lapsed	Estates	It has been agreed with MWWFRS that this recommendation forms part of the main GGH fire Project. Revised timescale is being clarified with the Estates service, with updates to be reflected to ARAC in April 2024.
Peer Review - Congenital Heart Defect Provider, issued October 2021	4 (1 External)	October 2023	1 - External 3 – revised dates lapsed	Women and Children's Services	Since the extraction of data for reporting, the Assurance and Risk Team have received a follow-up review to this report, with recommendations which expand on those contained in the original report. Timescales for completing these recommendations range to June 2024. Progress updates and revised dates based on the follow up report will be reflected in the next report to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Getting It Right First Time (GIRFT) General Surgery Review	1	December 2023	1 – revised date lapsed since previous meeting	Scheduled Care	Since the reporting data was extracted from the Audit & Inspection tracker, this recommendation has been changed to 'external' status as it is awaiting the rollout of a national E-consent programme and therefore currently outside the gift of the Health Board to be implemented. This will be reflected in the report to ARAC in April 2024.
Peer Review - Hywel Dda UHB Lung Report, issued January 2020	1	January 2020	1 – workforce challenges	Unscheduled Care (PPH)	A risk regarding the fragility of this service has been added to the Respiratory risk register, due to a single handed consultant delivering the lung cancer service Health Board wide (1655: Fragility of Lung Cancer Service). In addition, there is no consistent pathology diagnosis due to significant staffing issues, resulting in a lack of Pathology input at Multi-Disciplinary Team (MDT) meetings, to which this recommendation refers to. The Respiratory service is to seek agreement with Pathology to transfer ownership of the recommendation to that service.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Out of Hours	5 (1 External)	September 2023	1 - External 3 - Original completion date lapsed 1 – revised completion date lapsed since previous meeting	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. The Assurance and Risk Team will be seeking progress updates and revised completion dates on the 4 recommendations, with updates to be reflected in the report to ARAC in April 2024.
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	8	December 2023	3 - Original completion date lapsed 5- No manage-ment responses yet provided on AMaT	Mental Health & Learning Disabilities	Progress updates and revised timescales are currently being sought from the service via QAST, with updates to be reflected to ARAC in April 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review – Respiratory Cancer (June 2016)	1	July 2016	1 – awaiting confirmation for closure	Unscheduled Care (PPH)	Assistant Director of Assurance and Risk and Head of Assurance & Risk to confirm with Director of Operations closure of this recommendation, as the strategic review noted within the original management response has now taken place and the service have recruited a locum consultant to support the previous lone working consultant.
Public Health Wales - Llwynhendy Tuberculosis Outbreak External Review	7 (6 External)	July 2023	6 external – original completion date lapsed 1 - revised completion date lapsed	Medical	6 recommendations have been given an 'external' status and are led by Public Health Wales (PHW). PHW will be providing an update to the Health Board's Public Health Consultant's team on how the risks of the Tuberculosis outbreak will be managed whilst public and professional awareness is raised. PHW have to date not provided an expected date for their updates. For the remaining recommendation, a new pathway for TB screening has been agreed, cross cover has been organised, and training is in place. The service has also discussed additional support from the Health Board's Sampling and Vaccination team if needed for screening.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Public Service Ombudsman (Wales)-202200883	2	December 2023	2 – original completion dates lapsed	Ceredigion	Updates on this report are currently being requested from the service via the Ombudsman Case Manager, with updates to be reflected to ARAC in April 2024.
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 April 2024.
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	1	October 2023	1 – service unable to provide revised timescale at this time.	Director of Operations	Work on updating the Transfusion Policy is ongoing. Blood Transfusion Manager is liaising with pharmacy regarding the procedures relating to drug prescription and issue. The Blood Transfusion Manager is not able to provide a date of publication at this stage.
Welsh Risk Pool-Concerns Assessment	5	December 2023	5 – revised completion date lapsed since previous meeting	Nursing	Progress updates and revised timescales are currently being sought from the service from the Assistant Director of Legal Services & Patient Experience, with updates to be reflected to ARAC in April 2024.
Total number of N/K Recs	**140**				