Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 December 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Asesiad / Assessment

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

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead
Amber	Recommendation is currently in progress, and within the agreed timeframe for implementation
Red	Recommendation is in progress, but has exceeded its agreed timeframe for implementation (i.e. overdue)
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Since the previous report, 12 reports have been closed or superseded on the Audit Tracker, and 25 new reports have been received by the Health Board, as detailed in Appendix 2.

As of 6 November 2023, the number of open reports has increased from 110 to 124. 45 of these reports have recommendations that have exceeded their original completion date, an increase from the 40 reports previously reported in October 2023. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is a slight increase in the number of recommendations where the original implementation date has passed since the previous meeting, from 164 to 166. However, the number of recommendations that have gone beyond six months of their original completion date has reduced from 54 to 47, as reported in October 2023.

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

	Open reports at ARAC October 23	New reports since October 23	Closed reports since October 23	Open reports at ARAC December 23	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	7	0	0	7	3	5	3
Llais[3]	3	0	0	3	2	4	3
Llais / HIW Contractors	0	0	0	0	0	0	0
Coroner Regulation 28	0	0	0	0	0	0	0
Counter Fraud Authority	0	0	0	0	0	0	0
DU	6	0	0	6	2	7	5
HEIW	3	1	2	2	1	2	0
HSE	0	0	0	0	0	0	0
HIW	10	3	0	13	7	42	7
HTA	0	0	0	0	0	0	0
Independent Review	2	0	1	1	1	1	0
IA	29	6	6	29	13	42	15
Internal Review	0	0	0	0	0	0	0
MHRA	0	0	0	0	0	0	0
MWWFRS	31	10	0	41	6	9	0
Natural Resources Wales	0	2	0	2	0	0	0
NHS Wales Cyber Resilience Unit[4]	1	0	0	1	0	11	2
Peer Reviews	8	1	0	9	6	33	9
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	6	2	3	5	0	0	0
PHW	1	0	0	1	1	1	0
Royal Colleges	1	0	0	1	1	3	3
Other (External Consultant)	0	0	0	0	0	0	0
WLC	1	0	0	1	1	0	0
Welsh Risk Pool	1	0	0	1	1	4	0
TOTAL	**110**	**25**	**12**	**124**	**45**	**164**	**47**

1 Reports which have passed their original implementation date
2 Original implementation date noted for the recommendation has passed, or will not be met

3. From 1 April 2023 Llais replaced the seven Community Health Councils (CHCs).
4 These recommendations are not included on Appendix 1 due to the sensitive nature of the information.

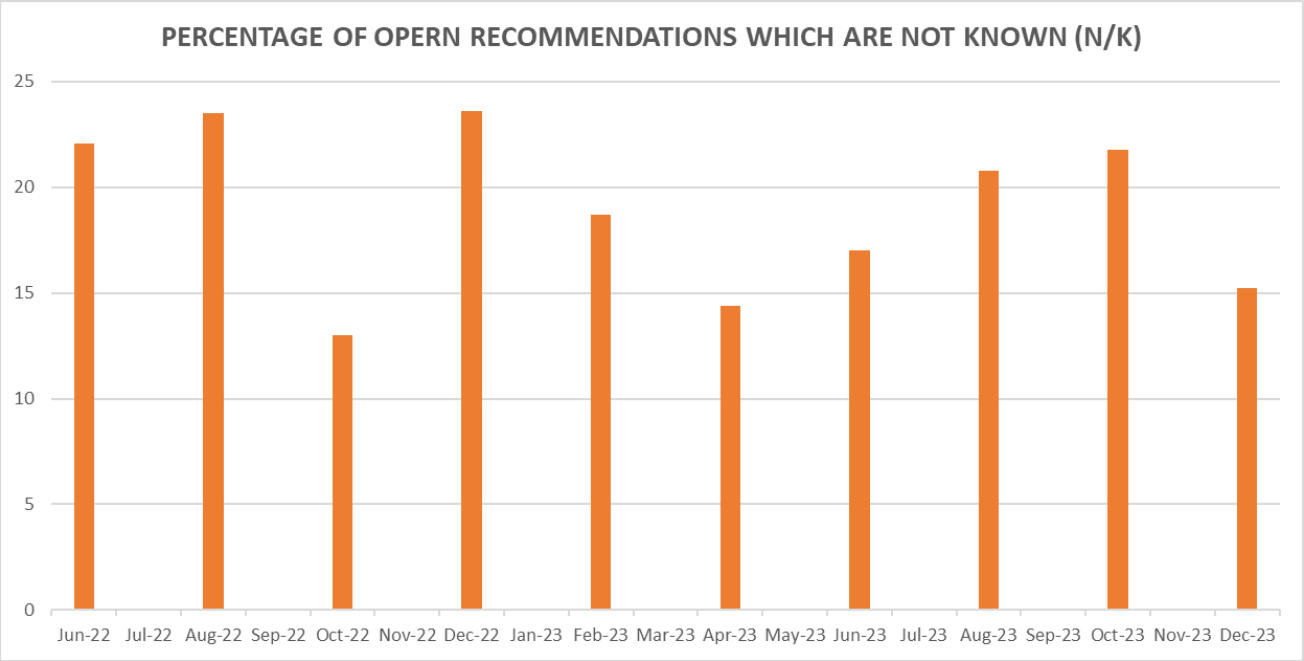
There are currently **503 open recommendations** (an increase from the 409 reported in October 2023) on the audit tracker, and detailed in Appendix 1 (which includes the 39 recommendations that are considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation). These recommendations are marked as 'External' in the RAG status column.

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 October 2023.

There are 77 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported), representing 15% of open recommendations currently on the Tracker. This is decrease on the 89 recommendations reported in October 2023, which represented 22% of open recommendations at the point of reporting. Individual recommendations are included in Appendix 3, which details the date at which recommendations became N/K, and the reason why they are N/K.

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

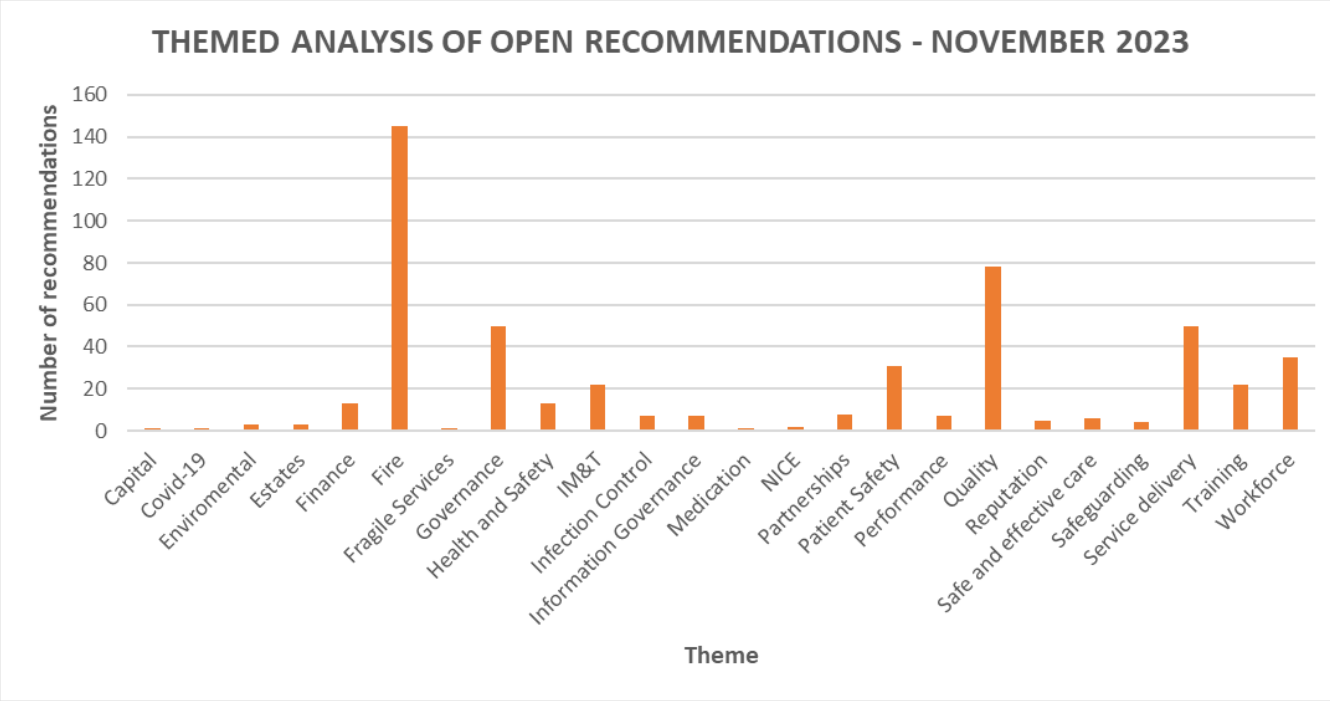


The 77 N/K recommendations are comprised of:

- 19 recommendations which have recently lapsed to N/K status since the previous report;
- 9 recommendations where the revised completion dates have lapsed to N/K status since the previous report and we are awaiting revised completion dates from the services;
- 3 recommendations where the Assurance and Risk team are awaiting confirmation for closure from the appropriate Lead Director;
- 23 recommendations noted as 'external', and

- 23 further recommendations from a variety of other reports. The Assurance and Risk team continue to liaise with services to obtain progress updates and revised completion dates where applicable, and will also utilise the Improving Together sessions to further support this process.

Below is a chart providing a thematic analysis for all open recommendations on the Audit Tracker as at November 2023, 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 6 November 2023 is included on page 6, including trends since the last report to ARAC in October 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;
- Ceredigion;
- Pathology;
- Pembrokeshire;
- 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 October 2023 (detail for each service can be found in the table on page 6):

Services with a Concerning Variation

Digital

The total number of open recommendations has decreased from 23 to 21 since the previous report; however, the number of overdue recommendations have increased from 15 to 16, 5 of which are now overdue by more than 6 months. There are also 7 recommendations which are now overdue without revised timescales. 11 of the overdue recommendations relate to the Cyber Assessment Framework Report, 2 of which are greater than 6 months. Details of this report are omitted from Appendix 1 due to the sensitive nature of its content; however, the recommendations are reviewed by the Sustainable Resources Committee in-committee on a bi-monthly basis. A further 5 overdue recommendations relate to 3 IA reports for which revised timescales are required.

The Assurance and Risk team continues to work closely with the service to obtain progress updates, and request revised completion dates. The Head of Assurance and Risk has met with the Digital Director to discuss outstanding recommendations, and service leads will review whether recommendations remain appropriate. Where required, executive approval will be sought to confirm the closure of recommendations.

Services of Improving Trend

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

NQPE

The service's focus on completing recommendations has resulted in a continuous improving trend. Since the previous report, the number of open recommendations has reduced from 24 to 11, the number of overdue recommendations reduced from 11 to 5, and of those overdue by more than 6 months from 3 to 2.

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 November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	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. Report to remain open on the audit and inspection tracker until the Director of Secondary Care has provided an update to the Director of Nursing, Quality & Patient Experience for final confirmation of report closure. • 1 IA report on Service Reset and Recovery closed following confirmation from Internal Audit.
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 which is 'not known' (N/K).
Central Operations	3 →	1 →	19 →	17 ↑	3 →	• 1 Peer Review on Out of Hours – 12 recommendations, 11 of which are overdue with revised completion dates ranging from December 2023 to March 2024, and one with an 'External' status. • 1 IA report on Records Management – 3 recommendations overdue by more than 6 months, 2 of which have revised completion dates of March 2024 and 1 recommendation with a revised timescale which is 'not known' (N/K). IA will be undertaking a follow up Records Management audit in Q3/4 of 2023/24. • 1 IA report on Record Digitisation – 4 recommendations, 3 of which are overdue without a revised timescale (N/K). The Record Digitisation report has been reassigned from Digital, and revised timescales are being requested from the service.
Digital[1]	4 →	1 →	21 ↓	16 ↑	5 ↑	• 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 – 14 recommendations, 11 of which are overdue, with 2 overdue by more than 6 months and 2 without revised timescales (N/K). 1 recommendation on schedule for completion by March 2024, and 2 with an 'external' status. 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) and both have revised completion dates of May 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 of December 2023.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
Director of Operations	2 ➔	2 ➔	8 ➔	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 on schedule with December 2023 and 1 recommendation noted as 'external' with revised completion date of December 2023. • 1 AW Review of Quality Governance Arrangements – 1 recommendation overdue by more than 6 months (Assurance and Risk Team confirming with Director of Operations if the recommendation can be closed) and 1 which has an 'external' status with a revised completion date of November 2024.
Estates	44 ➔	8 ➔	146 ➔	9 ➔	0 ➔	• 10 new LOFSMs have been received since the previous report. • The number of recommendations has increased from 110 to 146 (3 of these recommendations are from 3 IA reports, with the remainder from the 5 MWWFRS Enforcement Notices (ENs) and 36 Letters of Fire Safety Matters (LOFSMs)). • The number of overdue recommendations has increased from 2 to 9. 6 of these recommendations (1 from an EN and 5 from 3 LOFSMs) have been delayed but due to be completed by end of November 2023. 3 recommendations from 3 LOFSMs have revised completion dates of March 2024 due to fire doors not being repairable and therefore needing replacing. • 1 EN and 8 LOFSMs have all recommendations completed. Assurance and Risk Team awaiting approval from MMWFRS before closing the reports on the audit tracker. All MWWFRS reports are overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting. • IA reports WGH Fire Precautions Works: Phase 1 has been closed since the previous report.
Finance	5 ➔	3 ➔	7 ➔	4 ➔	0 ➔	• 1 Audit Wales report on Audit Wales ISA 260 and Letter of Representation 2022/23 – 2 recommendations, one of which has been reassigned to Workforce & OD and is overdue. Since the numbers for this report were agreed, the Director of Workforce & OD has confirmed the recommendation is complete which will be reflected in the next paper to ARAC in February 2024. • 1 new Independent Review on Savings Governance Review – 3 recommendations, 1 of which is overdue without a revised timescale (N/K). • 1 IA report on Financial Management – 1 overdue recommendation without a revised timescale (N/K). • 1 IA report on Regional Integration Fund – 1 overdue recommendation without a revised timescale (N/K). • 1 IA report on Strategic Change Programme Governance - all recommendations have now been completed. Awaiting confirmation from IA to close report.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
Governance	3 ➔	0 ➔	3 ➔	0 ➔	0 ➔	• 1 new IA report Board Oversight Final Internal Audit Report- recommendations noted as complete and awaiting formal approval for closure. • 1 AW report on Structured Assessment 2022 - 2 recommendations on schedule for completion by December 2023 and March 2024. • 1 IA report on Escalation Status Actions – 4 recommendations noted as complete and awaiting formal approval for closure. • 1 Independent Review on Governance and Decision Making in relation to Bluestone Field Hospital closed since the previous report.
Long Term Care[2] *New service for reporting purposes*	1 N/A	1 N/A	7 N/A	5 N/A	5 N/A	• 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 underway, and will include following up on all recommendations in the Discharge Processes report, which is due to be presented to ARAC in February 2024. • The increase to the Long Term Care figures is due to the separation from the Primary Care service and the revising of the reporting structure to better align with DITS.
Medical	7 ➔	4 ➔	26 ➔	11 ➔	4 ➔	• 1 new IA report on NICE guidelines – 2 recommendations on schedule for completion by December 2023. • 1 new IA report on Board Revalidation Quality Review – 1 overdue recommendation with a revised completion date of December 2023. • 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). • 1 IA report on Job Planning – 4 recommendations are overdue with revised timescales of December 2023. • 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 without a revised timescale (N/K). • 1 IA report on Individual Patient Funding Requests – 7 recommendations, 1 of which is overdue by more than 6 months with a revised timescale of November 2023. • 1 HEIW report on Surgical Specialties, Glangwili General Hospital (GGH) – 2 recommendations, of which 1 has a revised timescale of December 2023 and 1 which is noted as 'external'. • HEIW reports on General Internal Medicine Bronglais Hospital and Obstetrics and Gynaecology Glangwili Hospital have been closed since the previous report.
Medicines Management	1 ➔	1 ➔	1 ➔	0 ➔	0 ➔	• 1 AW report on Medicines Management in Acute Hospitals - 1 'external' recommendation.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
MH&LD	11 →	3 ↓	55 ↓	29 ↑	6 ↓	• 1 new IA report on Timely Access - 7 recommendations on schedule with varying timescales to March 2024. • 1 AW report on Review of Mental Health and Learning Disabilities Directorate Governance Arrangements – 2 recommendations on schedule with completion dates of December 2023 and March 2024, and 1 overdue with a revised timescale of December 2023. • 1 CHC report on S-CAMHS – All recommendations implemented, formal approval to close to be requested from the Director of Mental Health & Learning Disabilities. • 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 December 2023. • 1 DU report on All Wales Review of Primary & Secondary Mental Health Services for Children & Young People – 1 recommendation on schedule with completion date December 2023 and 1 recommendation overdue without a revised timescale (N/K), awaiting confirmation from service that this recommendation can be closed. • 1 DU report on Review of Psychological Therapies in Wales - 2 recommendations with timescales to December 2023. • 1 HIW report on Mental Health Discharge Review – 12 recommendations on schedule with varying timescales to March 2024. 20 recommendations overdue, 19 of which have varying revised timescales to March 2024 and 1 without a revised timescale (N/K). • 1 HIW National Review of Mental Health Crisis Prevention in the Community - 2 recommendations overdue by more than 6 months, with revised completion dates of December 2023. • 1 HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months with revised dates of December 2023. • 1 HIW Bryngofal Ward – Prince Phillip Hospital, issued October 2022 - 2 recommendations overdue by over 6 months, 1 with a revised date of December 2023 and 1 without a revised timescale (N/K). • IA on Prevention of Self Harm (Follow up report) closed since the previous meeting.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
NQPE	7 ↓	3 ↓	11 ↓	5 ↓	2 ↓	• 1 new PSOW Annual letter 22/23 - 4 recommendations completed with evidence to be sent to PSOW to officially close the report. • The number of overdue recommendations has decreased from 11 to 5. The details of recommendations that have passed their original completion dates are below: ○ 1 CHC report on Accident & Emergency Departments – 2 overdue recommendations (1 overdue by more than 6 months), with revised timescales of December 2023 and January 2024. ○ 1 IA report on Falls Management – 1 overdue recommendations by more than 6 months, with revised completion date of March 2024. 1 'External' recommendation. ○ 1 IA Safety Indicators – Pressure Damage and Medication Errors – 2 overdue recommendations, 1 with a revised timescale of December 2023 and 1 without a revised timescale (N/K). • 1 PSOW report 202101889 - 3 recommendations on schedule with timescales of February 2024. • 1 PSOW report 202102692 - 2 recommendations on schedule with timescales of January 2024. • 1 IA Patient Experience – all recommendations completed, awaiting approval from Internal Audit to close report. • 2 PSOW reports 202002558 and 202203628 – closed since previous meeting.
Primary Care[2]	2 →	1 ↓	5 ↑	3 ↑	0 ↓	• 1 WLC report – 1 'external' recommendation. • 1 new IA Deprivation of Liberty Safeguards (DoLS) report – 4 recommendations, 3 of which have recently become overdue without revised timescales (N/K).
Public Health	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	• 1 PSOW report 202003536 transferred to USC PPH Directorate since the previous ARAC meeting.
Radiology	3 ↑	1 ↑	14 ↑	2 ↓	0 ↓	• 1 new Natural Resources Wales report on Radioactive Substance Regulation (RSR) Compliance Assessment Report (Sealed Radioactive Sources) – 2 recommendations on schedule. • 1 new Natural Resources Wales report on RSR Compliance Assessment Report (Unsealed Radioactive Sources) – 10 recommendations on schedule. • 1 HIW IRMER report GGH – 2 overdue recommendations without revised timescales (N/K), 1 of which has recently lapsed.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
Scheduled Care	8 →	6 ↑	84 ↑	24 ↓	9 ↓	• 1 new report on Getting It Right First Time (GIRFT) Ophthalmology Review with 55 recommendations due for completion by April 2024. • 1 IA report on Theatre Loan Trays and Consumables – 3 recommendations, 1 overdue without a revised timescale, 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 being undertaken imminently. • 1 Peer Review on Getting It Right First Time (GIRFT) General Surgery – 13 overdue recommendations with revised timescales between December 2023 and March 2024. • 1 Peer Review on Getting It Right First Time (GIRFT) Orthopaedic Review – 1 recommendation overdue by more than 6 months with a revised timescale of December 2023. • 1 CHC report on Eye Care Services in Wales (March 2022) – 2 recommendations which are 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 with revised completion dates between December 2023 and March 2024. • 1 HIW report – 1 recommendation overdue by more than 6 months, with a revised completion date of December 2023. • 1 PSOW report 202104390 closed since the previous meeting.
Strategic Development & Operational Planning	4 ↓	2 →	18 ↓	9 →	3 ↑	• 1 AW report on Structured Assessment 2021: Phase 1 Operational Planning Arrangements – 2 recommendations overdue by more than 6 months, with revised completion dates of March 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 on schedule for completion by December 2023 • 1 IA report on Glangwili Hospital Women & Children's Development (issued April 2021) closed since the previous report.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
USC BGH	1 ↑	0 ↓	4 ↑	2 ↑	0 →	• 1 new IA report on Quality & Safety Governance - Bronglais General Hospital – 4 recommendations, 1 which is overdue without a revised timescale (N/K), 1 overdue with a revised completion date of December 2023 and 2 on schedule for completion by their original completion dates.
USC GGH	1 →	1 →	4 ↓	4 →	0 →	• 1 HIW report on the Emergency Unit at GGH – 4 recommendations overdue without revised completion dates N/K.
USC PPH	4 ↑	2 →	6 ↓	5 ↓	2 →	• 1 new HIW report on Prince Philip Hospital Minor Injuries Unit- 3 recommendations overdue without revised timescales (N/K). • 1 Peer Review Lung Report, issued January 2020 - 1 recommendation overdue by more than 6 months without a revised timescale (N/K). • 1 Peer Review on Respiratory Cancer – 1 recommendation overdue by more than 6 months, with the revised timescale currently N/K. Risk 1655 (Fragility of Lung Cancer Service, current risk score 8) has been added to Datix which reflects the challenges in implementing the recommendations. • 1 PSOW report 202003536 (transferred from Public Health Directorate) - 1 recommendation due for completion by February 2024.
USC WGH	2 ↑	0 →	37 ↑	6 ↑	0 →	• 1 new HIW report on National Review of Patient Flow – a journey through the stroke pathway – 32 recommendations, of which 1 is overdue without a revised timescale (N/K). • 1 new HIW report on Emergency Department Withybush General Hospital – 5 recommendations overdue which have recently lapsed.
Women & Children	5 ↑	1 →	12 ↑	4 ↓	4 ↓	• 1 new PSOW report 202206868 – 6 recommendations on schedule for completion by December 2023. • 1 HIW report on National Review of Maternity Services - Phase 1, issued November 2020 reopened since previous meeting – all recommendations are complete, and awaiting confirmation from QAST to close report. • 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, 4 of which are overdue by more than 6 months with no revised timescales (N/K), and 1 'external' recommendation. • 1 HIW report on Bronglais Hospital Maternity Unit – all recommendations are complete and awaiting confirmation from QAST team to close report. • 1 IA report on Glangwili Hospital Women & Children's Development, (April 2022) closed since the previous meeting.

Service	Open reports as at November 23	Overdue reports As at November 23	Total number open recs November 23*	Total overdue (red) recs November 23	Of which overdue by more than 6 months	Comments
Workforce & OD	2 →	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 - all recommendations complete. Awaiting confirmation from Internal Audit to close report.
Total	**124**	**45**	**503**	**164**	**47**	

**Total number of recs now includes 'external' recommendations for completeness.*
1 *Since the last ARAC meeting the Digital service has been separated from the Performance service.*
2 *Since the last ARAC meeting the Long Term Care service has been separated from the Primary Care service.*

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	Director of Governance/Board Secretary

Parties / Committees consulted prior to Audit and Risk Assurance Committee:	

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, Green- complete)	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.
Jun-21	2021/22	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	High	R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked.	As part of Targeted Intervention, the Health Board is undertaking an assessment of its planning maturity, incorporating the alignment of plans. In addition, an Independent Review is being conducted by Sally Attwood on behalf of Welsh Government. Once complete the Health Board will develop action plans to respond to both of these pieces of work. The capacity and role of the planning function will be important considerations within this, see below for an update on capacity.	Sep-21	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - Update to ARAC -The review has now been complete. However, only a draft version has been sent to date with the recommendations omitted. The Health Board has responded to the factual accuracy and overall content relating to the body of the report. Unfortunately, at this stage (31 May 2023), the final report is yet to be received.
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.
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. 10/07/23 – 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.
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	~~Jul-22~~ Nov-23	External	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 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.
Oct-21	2021/22	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 23/03/2023 - Directorate Improving Together Sessions commenced in January 2023, which now supersede the operational risk review meetings, of which the generated TOAs are monitored via DITS, as we as via Senior Operational Business Meetings. To confirm with Director of Operations in April 2023 that the recommendation can now be closed. 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.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	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	Amber	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.
Dec-22	2022/23	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	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 ward/team based audits and wider Health Board requirements.	Dec-23	Dec-23	Amber	31/08/2023 - Medical Staffing Committee audit lead identified, and a meeting scheduled for September 2023 to develop the audit framework and plan and to discuss its implementation. MHLD directorate themed audits have also been identified and have been accepted as part of the Health Board's Clinical Audit Plan. 03/10/2023- Associate Medical Director requesting update by 20/10/2023. 12/10/2023- The Associate Medical Director confirmed that a Medical lead has been assigned to support this work, however they are on leave returning beginning of November 2023. Associate Medical Director to meet with Medical lead on their return to pick up the progress of this work. A multi professional group is to be arranged to oversee this work.
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.	Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed.	Dec-23	Dec-23	Amber	31/08/2023 - training sessions have been delivered on AMAT in terms of NICE guidance and HIW tracking, however still to be delivered in terms of clinical audit. 12/10/2023- linked to first action above. A number of leads have been trained with further AMAT training for other, including clinical staff, is being arranged.

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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 plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	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.
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.
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.	The Health Board routinely conducts staff surveys. The Directorate to undertake Directorate-specific surveys in order to inform future staff engagement plans, and to highlight any concerns which staff may have requiring the attention of Directorate senior management.	Dec-23	Dec-23	Amber	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- Director of MHLD is focusing on this action in the coming weeks and the work required will be split within the senior team.
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.
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	Dec-23	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.
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.
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	Dec-23	Amber	31/08/2023 - work is currently being undertaken by the service as part of wider Health Board ask in terms of vacancies, and has allowed the opportunity to better understand the vacancy position, with an ongoing reconciliation process in place, overseen by the Directorate Workforce Group. The Directorate has also engaged with the Health Board's retention team, with focus on staff feedback in terms of new starters and leavers, providing rich information which will inform the development of the Directorate Recruitment and Retention Plan. Conversations have also commenced regarding overseas recruitment, and linking with the future workforce team. Noted that there are several service-level risks on the MHLD risk register int terms of concerns on recruitment and retention, with a view to drafting a Directorate-wide risk. However it is noted that there may be constraints given the current financial climate of the Health Board. 11/10/2023- Meeting is up and running to progress this, including engagement with Corporate teams on recruitment (e.g. NQPE directorate on nursing retention and workforce colleagues on targeted recruitment.
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-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	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	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	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 (ODRM's); our operational workforce colleagues who facilitate change (OCP processes) and the workforce planning team. We are working collaboratively across WOD and with service leads to test our approaches to supporting services in the short, medium and long term. An evaluation will be undertaken and a paper on value of approaches in March 2024.	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	Medium	R4. We found that the Health Board is strengthening workforce planning capability through a range of training initiatives, some of which are still in development. Training is central to ensuring staff have the capability to support good workforce planning, as such the Health Board should develop an evaluation framework to measure the success of its training programme.	The approach to evaluation is in progress and a report reflecting the approach and outcomes will be undertaken in line with recommendation and actions under R3 above	Apr-24	Apr-24	Amber	

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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 Board is refreshing its workforce strategy. But in the interim it should update the People Organisational Development and Culture Committee twice a year on: A. progress against the key outcomes for success outlined in the workforce strategy; and B. how actions are having an impact on reducing workforce risks, specifically by developing a set of measurable impact measures for the Workforce Strategy.	Please note commentary in relation to R1 above and references to gauging progress and impact. In the interim, specifically in relation to A: we will be appraising the PODCC committee and introducing SPPEG to the requirements of the workforce plans in progress and developing, which align to our current and evolving strategic approach and implementation plans. Specifically in relation to B, again this is in progress through a number of pieces of work on Workforce Risk Assessment & Intervention Framework; Development of Intelligence and Metrics linked to Workforce Performance and further organisational alignment to the HB's Benefit's Realisation Tool will be sought to ensure an integrated strategic & operational approach to workforce planning and measurement of impact.	Apr-24	Apr-24	Amber	
Jul-23	2023/24	Audit Wales	Review of Workforce Planning Arrangements	Open	N/A	Workforce & OD	Workforce & OD	Head of Strategic Workforce Planning and Transformation	Director of Workforce & OD	High	R6. The Health Board benchmarks its workforce performance metrics with other health bodies in Wales, but there is potential to benchmark with similar bodies outside of Wales. The Health Board should look to other health organisations with similar demographics, geography, and challenges, both to benchmark performance and seek good practice.	The Health Board has undertaken scoping to assess relevant health organisations on a local and international scale, this is referenced in a number of HB documents. Further work is ongoing as part of continuous improvement to our approach to workforce planning.	Apr-24	Apr-24	Amber	
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	2022/23	Audit Wales	Audit Wales ISA 260 and Letter of Representation 2022/23	Open	N/A	Finance	Workforce & OD	TBC	Director of Workforce & OD	Medium	R2. The Health Board should ensure that a more robust system is installed, and used, to readily, and accurately, monitor leave balances across the organisation at any one time. It is recommended that this is remedied before next year's audit.	We will put plans in place to ensure we have a robust mechanism for capturing and recording annual leave in time for the preparation of the 2023-24 accounts. The range of annual leave systems in use across the Health Board will be minimised. The recording of annual leave on the rostering system interfaces with ESR, further areas will move to using the rostering system to record annual leave to provide a robust mechanism for capturing annual leave and to improve management information.	TBC	TBC	Red	18/10/2023 - Rec assigned to Workforce
Jan-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul-20~~ ~~Apr-21~~ ~~Apr-22~~ ~~Jun-22~~ N/K	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 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 Eye Care 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.
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- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Positive progress being achieved in the delivery of Ministerial measures for the 52/104 week waiters. Further work underway to deliver additional weekend clinics to reduce the backlog of people awaiting appointments. This will continue until approximately June 2023 at present. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Template and job plan redesign has been completed to ensure outpatient activity is protected whilst allowing emergency eye services to continue. Positive progress being achieved in delivery of Ministerial Measures requirements for the 52/104-week pathway measures. Balancing the Ministerial Measures with the Eye Care Measures due to the backlog continues to be a challenge, however, through close micro-management of all available clinics and capacity we anticipate further improvement into 2023. 12/09/2023 - Current focus on 2 high risk areas: Intravitreal Therapy service - additional lists undertaken and whole pathway being reviewed (15 week breach has been reduced to 6 week breach) and an SBAR for this service is currently in draft. Glaucoma - Recent ARCH meeting with Swansea Bay UHB identified areas for improvement. Alongside GIRFT review, several additional actions identified. Several actions identified - Eye Care steering group due to meet November 2023.

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Mar-20	2019/20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ ~~Jun-23~~ Mar-24	Red	08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 18/04/2023 - Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Investment into Amman Valley has supported the repurpose of OPD for wAMD to allow the DSU to undertake high volume Cataract lists. Sustainable monies have been invested in the Glaucoma and Cataract Plans, however, there still remains other areas of the service (AMD, Paediatrics, VR, plastics) that require investment. On Demand Training Centre (ODTC) Contracts have been awarded to two providers Carmarthenshire and Pembrokeshire. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. Pan-Wales clinical view that central investment in estate, infrastructure and workforce is required to develop a sustainable long- term Ophthalmology Service model. 12/09/2023 - wAMD workshop identified several areas of improvement. Ophthalmology team has reviewed demand and capacity for this service. We have also reviewed the biologic and biosimilar pathways with a view to the introduction of a virtual process to reduce pressure on this service. Regional 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.
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	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.
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	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 testing before handing over to the service.
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.
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.
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	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
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	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.

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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	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.
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	Dec-23	Amber	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.
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.	S-CAMHS will contribute to the update ensuring all the new service developments are aligned to the Measure, including the new SiR Service.	Dec-23	Dec-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for implementation by December 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. 26/10/2023-A team of peers is being co-ordinated to assist with steering group.
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	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Workforce capacity will be reviewed to address demand imbalance in each locality team and increase recruitment into vacant posts.	Oct-23	~~Oct-23~~ N/K	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Links with Child and Adolescent Psychiatric Assessment (CAPA) deep dive. 02/11/2023- Update has been provided by services, Assurance and Risk Officer clarifying with service if recommendation has been fully implemented.
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	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A workforce training analysis will be completed and training plan including CAPA Core competencies developed to ensure all staff have the core competencies required to meet service need.	Oct-23	~~Oct-23~~ N/K	Red	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Ongoing training, clear about choice appts, exit strategies and goals. 02/11/2023- Robust training plan now in place.
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	Dec-23	Red	16/03/2023- To be submitted for QS&EG Meeting 21/08/23 at the latest. 11/07/2023- Head of Service (Older Adult MH) confirmed on track for end of August. 28/09/2023- Head of Service (Older Adult MH) confirmed the review has been completed (a review of 23 case-studies - inclusive of recent near-miss and serious incidents - for people experiencing functional mental ill health [including some people with mild-cognitive impairment but capacitated and able bodied] using Older Adult Mental Health Services). Additionally, the OAMH Clinical Risk Lead held case and practice discussions CR[H]T Team Leads and a range of CR[H]T clinicians within this assessment process. The report is drafted nearing completion and there needs to be more time to consult within stakeholders before the report can be finalised and submitted to BPPAG. The reason for the delay in implementing the recommendation is in part due to underestimating the scope of the work involved combined with competing high clinical risk priorities consuming the reviewers time to complete the consultation and report. Revised date of December 2023 agreed.
Feb-23	2022/23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	N/A	R4. The Health Board should review accommodation within the Emergency Department to provide an environment where a mental health assessment can be provided to ensure privacy, low stimuli and safety for patients and staff.	Review undertaken. Appropriate areas in place Bronglais, Withybush and Prince Phillip. Layout change in Glangwill 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.
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	Dec-23	Amber	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.
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	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	The HB will ensure that the Patient Access Policy for Psychological Therapies Services outlines the accessibility across the age range with assurances regarding accessibility for different psychological needs across the adult life-cycle.	Dec-23	Dec-23	Amber	23/06/2023- policy prepared and required formal sign off. Taken to MH&LD documentation working group. Taken to clinical working documentation group – advised not appropriate. Advised requires corporate review group.
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	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	Links will be made with the older adult mental health team to project equity of access targets by reviewing the proportion of referrals received over 65 years old, how this reflects our local population demographic against estimated prevalence of mental health disorders in later life to inform what % referrals for over 65 years there should be locally.	Dec-23	Dec-23	Amber	23/06/2023- Work ongoing.
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	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	3.2 The service will link with the older adult team and aim to identify if access could be improved through: • Reviewing how the service attracts referrals for people in later life (review of how services recognise common mental disorders in later life, are aware of and refer older people for psychological therapy); • Reviewing the effectiveness of referral pathways between the service and primary and secondary mental health services for older people; • Undertaking a review of the evidence base and assure evidence based therapy modalities with any necessary reasonable adjustments are available for this population cohort; • Reviewing any modified 'engagement' procedures for supporting referrals for people in later life / access into the service; • Reviewing any training or support needs for staff in applying therapeutic skills to older people/people in later life.	Dec-23	Dec-23	Amber	23/06/2023- On track with discussions and collation of data. Looking at training across all services
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 Integration of the LMPHSS and IPTS will be progressed following the implementation of the OCP.	Dec-23	Dec-23	Amber	23/06/2023- Work ongoing, recent Wellbeing posts ongoing which will change and reshape the service slightly. Rebrand of service name and amalgamation of service spec. 09/08/2023-Integration on track and likely to be achieved before December 2023. Rebrand of service name and amalgamation of service spec ongoing. SUI has provoked consideration around some changes – client leaflet, assessment process etc ongoing
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	Dec-23	Amber	23/06/2023- Work ongoing, recent Wellbeing posts ongoing which will change and reshape the service slightly. Rebrand of service name and amalgamation of service spec. 09/08/2023-Integration on track and likely to be achieved before December 2023. Rebrand of service name and amalgamation of service spec ongoing. SUI has provoked consideration around some changes – client leaflet, assessment process etc ongoing
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 undertake a Service User Survey to obtain the views and suggestions of a new name.	Dec-23	Dec-23	Amber	23/06/2023- Work is underway regarding co production and survey for rename. Plan to send leaflets out to people with letters, put posters in waiting rooms, Social media, etc. 09/08/2023-Co-production processes with service users continue to be developed at pace and leaflets and posters have been circulated awaiting service user feedback.
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.

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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	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. •Bross 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.
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.
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	Amber	
Jul-23	2023/24	Health Education and Improvement Wales (HEIW)	Revalidation Quality Review Report	Open	N/A	Medical	Medical	Head of Medical Education & Professional Standards	Medical Director	N/A	R2, Identify a new Independent Member	Awaiting new IP to be announced.	Sep-23	~~Sep-23~~ Dec-23	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	
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	
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	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.	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	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.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	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.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R2: The process for identification of savings needs to commence much earlier in the financial year which would remove the concerns regarding these being based on the month 10 position and provider greater assurance to the Board when considering the Annual Plan.	1) Scope current workforce. 2) Scope current workforce competencies. 3) Develop a training pathway and competency assessment framework.	Apr-24	Nov-24	Amber	27/09/23 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3a: An agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	1) Establish demand and capacity tool for cataract service. 2) Increase capacity through HVCL and inreased delivery of cataract lists. 2) Develop trajectory for recovery.	Apr-24	Apr-24	Amber	27/09/23 Workforce planning in line with the RCOphth will be undertaken alongside the workforce development plan discussed with Swansea Bay.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3b: An agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	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	Trial of pre-loaded lenses currently being scoped with procurement and clinical team.. 27/09/23 Three companies identified for trial and 4 doctors who are going to participate.

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Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3c: An agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3d: An agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3e: n agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R3f: An agreed process for developing and agreeing savings plans/targets with standardised reporting and clear governance on how changes to plans are agreed and reported needs to be put in place including guidance on the maintenance of a robust evidence bank and audit trail of documentation to be reintroduced.	1) Review current audit data and identify gaps. 2) Establish audit timetable. 3) Feedback audits at QSE.	Apr-24	Apr-24	Amber	To discuss at upcoming QSE meeting.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R4a: Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	1) Review current audit data and identify gaps. 2) Establish audit timetable. 3) Feedback audits at QSE.	Apr-24	Apr-24	Amber	To discuss at upcoming QSE 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.	1) Review theatre lists and udertake initial audit. 2) Present report at QSE. 3) Repeat audit 6 monthly and report back to QSE.	Apr-24	Apr-24	Amber	27/09/23 Senior Nurse Manager for Ophthalmology has observational dates booked to review all theatre processes.
Aug-23	2023/24	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.	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	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.	1) Discuss self dilation with ophthamology team around logistics. 2) Meet with Pharmacy to explore possibility and risks of self dilation.	Apr-24	Apr-24	Amber	27/09/23 Preliminary discussion held with ward Sister, next steps, to be explored with pharmacy.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	There needs to be a clear and consistent reporting into Executive Team, ensuring any concerns are escalated promptly with mitigation plans, and all schemes are reviewed in full as opposed to focusing on one element of one scheme this will however be dependent of the value of the scheme.	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.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R7a: Developing 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.	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	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	R7:b Developing 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.	1) Develop a rolling programme of staff to go through OCT training. 2) Identify a training lead for the HB.	Apr-24	Apr-24	Amber	27/09/23 The OPT competency framework is being utilised in the development of the nurse practitioners and one of the middle grade doctors is atteding the OCT training to support as training lead.
Aug-23	2023/24	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	N/A	The Board should have clear and detailed saving plans presented within the Annual Plan, which can then be monitored throughout the financial year by SRC and to Board. Any changes to saving schemes should be included within these reports with clear narrative if there any changes to the level of savings identified, changes in leadership and any other changes.	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.
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	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.
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	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.

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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	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.
Feb-19	2018/19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	Medium	R7: Management should establish refresher sessions to ensure existing staff receive records management training.	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.	Feb-19	~~Jun-21~~ ~~Nov-22~~ ~~Mar-23~~ ~~Apr-23~~ ~~May-23~~ N/K	Red	19/04/2022 - update provided to ARAC with the following work remaining to be undertaken in order to close the recommendation 1) Identify shortfalls in records management processes and non-compliance with appropriate standards, within relevant services (November 2022). 2) Following on from (1) develop a plan for records management training within those areas (November 2022). 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile. 17/11/2022 – Health Records training remains part of the agenda for the Welsh Health Records Management Group, however no further progress has been made to date due to a prioritisation of work to the development and implementation of eth Records Management Code of Practice, Transgender procedures and adoption protocols. 28/03/2023 - the health records service has agreed a plan to develop a competence evaluation questionnaire, for all staff members to complete and be assessed against. This will be rolled out across the service over the next 6 months. 15/05/2023 - confirmation obtained at the Central Operations Improving Together session in May 2023 that questionnaires will be sent by the end of May 2023, and for the revised completion date to be noted as such. 10/07/2023- The questionnaire has been completed by the deputy health records manager and circulated to the health records supervisors in readiness for rolling out the process at the start of July 2023. Awaiting confirmation of revised date. 16/08/2023 - Training sessions have been provided to Health Records staff. The recommendation will stay red until the follow up Records Management audit takes place later this year.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	N/A	R1a. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	~~Mar-22~~ ~~Mar-23~~ N/K	External	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 31/10/2022- agreed by Director of Primary Care, Community and Long Term Care that this recommendation is changed to 'external'. Discharge requirements are being reviewed at an All Wales basis, in light of developments following Covid-19.Once these are reissued (the All Wales review is expecting to be completed imminently), the UHB discharge policy will be refreshed. The current discharge policy will be requested to be extended for three months, whilst the UHB awaits guidance from WG following the All Wales review, as well as awaiting ministerial advice on the Delayed Transfer of Care (DTOC), which will also feed into the amended policy. Revised date of March 2023 timescale provided, and the recommendation changed from red (overdue) to external (outside the gift of the UHB to implement) whilst the outcome of All Wales review is awaited. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 10/7/2023- USC lead has spoken to the WG Lead who confirmed that the Discharge requirements is still under review and would be published shortly. Work is ongoing locally to review the discharge policy in readiness.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	N/A	R2a. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. The importance across the Region is that the key principles and standards within the discharge policy are met and considered within the partnership boards. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	Sep-22	~~Sep-22~~ ~~Aug-23~~ N/K	Red	31/10/2022- Discharge to Recover then Assess (D2RA) pathways are being reviewed as part of the All Wales level work which feeds into the Policy Goal 6 work. Local Authority representatives are advising this national work. The Policy Goal 6 work is reviewing the processes and looking at a consistent approach. This is linked to the Programme delivery group structure now in place, as noted in the recommendation above. We recognise there is more work to do and therefore the work of this recommendation will be added into the relevant workstreams. Work is continuing however the UHB is mindful of the All Wales guidance which is expected imminently. Assurance and Risk Officer awaiting confirmation this recommendation has been added to the relevant workstream. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss these recommendations and if it has been added to the relevant UEC workstream. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 10/07/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach.
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.
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,

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Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	N/A	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. 10/7/23- 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.
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. 10/7/23- 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
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	N/A	R6. Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	~~Jun-22~~ ~~Aug-23~~ N/K	Red	31/10/2022- There are processes in place through the weekly panels, where process issues are identified, however as a UHB we are aware the learning is not routinely fed back. As part of the Policy Goal 5 Delivery Group work Safer review, learning will be considered and processes identified to support embedding this learning. As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by Improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the PG5 workplan, approximate timescale August 2023 for this process to be embedded. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach.
Dec-21	2021/22	Internal Audit	Discharge Processes	Open	N/A	Long Term Care	Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-22~~ ~~Mar-23~~ N/K	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 10/7/2023- USC lead confirmed Head of Quality Improvement & Practice & Professional Development is leading a piece of work looking at ensuring a consistent approach for Discharge Liaison Nurses within the UHB. As part of Policy Goal 6, a regional delivery plan has been developed and is being overseen by the Integrated Home First Group, chaired by the Director of Operations with co-chair from LA and representation from across the system. This group was established in July 2023 and will meet monthly to monitor actions, review the impact and benefit across the system and ensure a consistent approach.
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.
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,
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.

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Oct-22	2022/23	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement/ Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	~~Apr-23~~ ~~Jun-23~~ ~~Aug-23~~ Mar-24	Red	18/05/23 - Actions considered by the TUEC programme Director, further discussion taking place to determine timescales for implementation and congruence with priorities as determined by NHS Executive and delivery of Ministerial Objectives (Urgent Primary Care, SDEC, Discharge Planning Coordination, D2RA and DPOC). Update to be provided in June 2023 07/07/2023 - Falls strategy work in progress - meeting of the next falls strategy group to be held in July/August 2023 to review strategy progress to date. Draft strategy circulated to members of the work group. 13/09/2023- falls strategy meeting held 05/09/2023cand strategy reviewed to date. Task and Finish/working group established to fine tune the details of the strategy - next meeting due to be held in October. It is anticipated that this group will need to meet on a number of occasions to add more detail to the strategy. UHB anticipate a realistic timescale of March 2024 for a completed strategy. 12/10/2023-the strategy group met in September and reviewed the draft strategy. As a result a working group has now been established to fine tune the detail, before returning back to the main strategy group with actions. The first meeting of the working group is scheduled for 19/10/2023.
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.
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.
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.
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.
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.
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)
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.
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.
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.
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.
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.
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	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-22~~ ~~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.

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, Green- complete)	Progress update/Reason overdue
Dec-22	2022/23	Internal Audit	Individual Patient Funding Requests	Open	Reasonable	Medical	Medical	Head of Effective Clinical Practice & QI	Medical Director	High	R1. The IPFR Team, Finance and Pharmacy should collectively agree and establish a suitable mechanism for capturing and monitoring IPFR spend to ensure that approved costs and treatment duration are not exceeded. Noting that the IPFR budget sits outside of the IPFR Team, responsibility and arrangements for monitoring cumulative IPFR spend should be agreed. If this is outside of Finance (as budget holder), sufficient information needs to be provided Clarify ownership and accountability for the IPFR budget, including responsibility for monitoring spend.	To agree a mechanism with Finance (budget holder) and pharmacy to ensure spend is monitored and not exceeding the approved treatment duration. Agree a reporting process for monitoring cumulative IPFR spend against defined budgets and within standing budgetary control requirements.	Mar-23	~~Mar-23~~ N/K Nov-23	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.
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.
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.
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.
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.
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.
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.
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.
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.

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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	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 for 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	Red	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
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.
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	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.
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	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~~
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	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.
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	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.
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	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.
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	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.
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	Amber	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.
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	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.
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.	Jul-23	~~Jul-23~~ N/K	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.
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	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.

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, Green- complete)	Progress update/Reason overdue
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, (kpi/automation as appropriate) should be agreed. • Expected benefit delivery schedule should be agreed.	To fulfil Recommendation 1, the current digital benefits realisation framework will be retrospectively applied to the new overarching programme, and it will detail a full benefits plan with associated metrics for tracking said benefits.	Sep-23	~~Sep-23~~ N/K	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.
May-23	2022/23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	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	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.
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~~ N/K	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.
Jun-23	2022/23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	Medium	R10. Undertake an exercise to identify and capture all costs associated with the administration of the loan tray service to ensure that the service is not provided at a loss to the Health Board. This should include (but is not limited to): • staff resource for all aspects of the end-to-end process including administration, equipment preparation and decontamination • reasonable costs for use of the equipment, to cover wear and tear/replacement • consumables and utilities required for the decontamination process (Matters Arising 6)	A meeting was held between HSDU management and finance on 20.04.23 to discuss a refresh of prices. HSDU are currently collating data to support the updated reprocessing charges, which is due to be submitted by the 07.06.23 for the finance team to work on the initial costing.	Oct-23	~~Oct-23~~ N/K	Red	07/09/2023 - Update from IA: a follow up review of this audit report will be undertaken during Quarter 3/4 19/09/2023 - This recommendation is no longer applicable due to the suspension of Health Board loaned instrument sets being loaned to Werndale. However the HSDU service is currently working with finance colleagues to review costs associated with the reprocessing of Werndale owned instrument sets, which is currently supported from the HSDU based at Glangwili Hospital. 25/09/2023 - (Response to Board TOA): Physical folders are now located in every theatre location across the Health Board, with clear instructions noted therein outlining the process to be followed should a request from the private sector for an emergent emergency piece of equipment or consumable be made. Items of equipment loaned requires to be returned to Hospital Sterilisation and Decontamination Unit (HSDU), and to be tracked via Healthedge. Consumables are not required to be returned, and invoices are sent for these items. The HSDU service is currently working with finance colleagues to review costs associated with the reprocessing of private sector owned instrument sets
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.
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.
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Primary 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.	Digital Project Support request was submitted to the IT team on 8 the August 2023, awaiting feedback on acceptance of the project request and timescales for completion. Update on project to be provided by target date.	Oct-23	~~Oct-23~~ N/K	Red	
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Primary 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	Mar-24	Mar-24	Amber	
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Primary 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.	These steps will be added to the Risk Register within four weeks. DoLS Coordinator awaiting access to the Risk Register on Datix to enable these updates to be provided.	Oct-23	~~Oct-23~~ N/K	Red	
Aug-23	2023/24	Internal Audit	Deprivation of Liberty Safeguards (DoLS)	Open	Reasonable	Primary 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.
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	Amber	
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) - CGGC (7th November 2023)	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Quality & Safety Governance- Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matt 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	Amber	
Oct-23	2023/24	Internal Audit	Quality & Safety Governance- Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matt 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	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.
Oct-23	2023/24	Internal Audit	Quality & Safety Governance- Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matt Willis	Director of Nursing, Quality and Patient Experience	High	R5. 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	Amber	

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Oct-23	2023/24	Internal Audit	Quality & Safety Governance- Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matt Willis	Director of Nursing, Quality and Patient Experience	High	R5. 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	
Oct-23	2023/24	Internal Audit	Quality & Safety Governance- Bronglais General Hospital	Open	Limited	Unscheduled Care (BGH)	Unscheduled Care (BGH)	Matt Willis	Director of Nursing, Quality and Patient Experience	High	R6. Thematic reviews to identify trends and hotspots across wards and services within the directorate should be reported to the Quality Forum in order to target areas based on high risk. Matters Arising 5: Incidents Management	Thematic reviews are undertaken, but note that the administration support to ensure these are appropriately reported reduce their visibility. The recent creation of the Lead Nurse for Quality and Safety will take this forward and the additional administration resource identified above will support this (see 2.1 above)	Oct-23	~~Oct-23~~ N/K	Red	30/10/2023 - (Taken from DITS response pack): Thematic reviews are undertaken. The Lead Nurse for Q&S (2days a week) is in place and supporting the improvement in complaints response and will be focussing on incident backlog in the coming months. There is no agreement yet to the additional Band 3 (Junior Secretary) post to take forward the required improvements in facilitation of the site's governance processes. This post will also provide support for the forthcoming maternity leave of the Management Team's PA.
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	
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	R2. Management should review their current progress made against the identified gaps in controls and further actions identified, in order to assess the further work required to ensure actions as completed have been fully implemented.	• To ensure 'Keeping in touch' letters are routinely sent to those on the Learning Disability Psychology waiting list. • Following the audit of 1032, it is agreed the impact assessment is no longer required.	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	R3. Revisiting, reviewing and revising of the key controls, gaps in controls, actions and progress identified and reported within risk 1032, in order to provide an accurate account of the current status of risk 1032.	A review of Risk 1032 on the Risk Register will be started on the 17th October 2023.	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	R3. Revisiting, reviewing and revising of the key controls, gaps in controls, actions and progress identified and reported within risk 1032, in order to provide an accurate account of the current status of risk 1032.	Gaps in control and actions will be reviewed in line with the review of meetings, as this will reduce duplication and overlap of documentation.	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Low	R4, Revisiting and revising of the set trajectory, in order to reflect the progress of the implementation of new ways of working within the therapies service.	To review trajectory's quarterly in line with performance trends and adjust accordingly.	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	R5. A review is undertaken to identify the root cause of the decrease in the performance measure for July, with appropriate next steps and action taken to address the issue. Where a gap in control has been identified, consideration should be given to the inclusion of the action within risk 1032.	ASD Services will undertake a service review of demand and capacity to compare 2023 data against 2022 to ascertain cause of decline in performance.	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Internal Audit	Mental Health & Learning Disability Services - Timely Access	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Operations	Medium	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	
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	Low	R7. Potential consolidating or amalgamating the discussion elements of the performance measures in order to prevent duplication of work and to reduce the amount of time spent in meetings.	Undertake a review of both service level and Health Board level scrutiny meetings to identify most efficient use of resource and avoid duplication.	Dec-23	Dec-23	Amber	
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/KBJ/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-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ Nov-23	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.
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/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ Nov-23	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 M 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. WWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit 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.

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, Green- complete)	Progress update/Reason overdue
Jan-20	2019/20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/ 00175421/00175428/ 00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ Nov-23	Red	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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.
Jan-20	2019/20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/ 00175421/00175428/ 00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ Nov-23	Red	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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.
Feb-20	2019/20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ ~~Oct-23~~ Nov-23	Red	This work is part of the phase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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- MWWFRS letter confirms extension to October 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.
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.
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.

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, Green- complete)	Progress update/Reason overdue
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.
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/001062 19	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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.
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/001062 19	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. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/001062 19	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.
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/001062 19	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. Overarching delivery plan for the site is to March 2025. Recommendation moved back from red to amber.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/001062 19	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.
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/001062 19	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.

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, Green- complete)	Progress update/Reason overdue
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A fire door survey is required at the Tenby cottage hospital site due to a number of defects found at the time of inspection. The findings of this survey must be completed within the mentioned timescale. Fire resisting doors need to be fitted with: • A self-closing devices including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ ~~Mar-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. WHTM 05-02 Chapter 5 and paragraph 5.12. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ ~~Mar-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position of completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
Apr-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Revised date of March 2024 provided and agreed by MWWFRS. Recommendation moved back from red to amber.
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	~~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.
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 AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
May-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
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Jun-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	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.
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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.
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.
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.
Sep-22	2022/23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed 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.
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.
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	R6. Emergency escape routes must be indicated by adequate escape signage. Signage should be provided at; • All external escape routes Signs should be designed and installed in accordance BS 5499-4:20	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.
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.
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	R8. Locate the solar PV isolator in a position away from the roof area or add a device that would allow isolation away from an area of risk.	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.

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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	
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	
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	
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	
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	
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	R9. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •D001 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.	Nov-23	Nov-23	Amber	
Apr-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, Prince Phillip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •Id 1164a & 1164b •Id 1170a & 1170b Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 1.4)	Full action plan held by Estates.	Sep-23	Mar-24	Red	20/10/2023- More work is needed to address defect. Doors are not repairable. Revised date March 2024.

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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.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
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	
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.
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. •GF55 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	
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; •GF 06 •GF 01 •GF 15 •GF 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	
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	
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. •2241 Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 3.7)	Full action plan held by Estates.	Mar-24	Mar-24	Amber	

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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.
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	
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	
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	
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	R8. Ceiling tiles in the following areas were found to be missing: •File Store (R12) they should be repaired or replaced to provide or reinstated a 30 minutes standard of fire resistance. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1 A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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: • R45 and R51 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.	Full action plan held by Estates.	Sep-23	Nov-23	Red	05/10/2023- Estates action plan confirms more work required to address defect following investigations. Revised completion date November 2023.

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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.
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	R2. The following rooms are to be cleared of all storage. •R15 - Switch room	Full action plan held by Estates.	Nov-23	Nov-23	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	R3. The opening in the ceiling located in: •R15 – 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. •D09 – 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 26, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	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. •D014 •D024 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.	Nov-23	Nov-23	Amber	
Jul-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Block 27, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. Ceiling tiles in the following areas were found to be damaged or missing: •Server Room they should be repaired or replaced. 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.	Nov-23	Nov-23	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	R3. 'Fire Door - Keep locked shut' signs should be provided on the outside face of each fire door located: •Cleaners' storeroom	Full action plan held by Estates.	Dec-23	Dec-23	Amber	

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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	Dec-23	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	R8. In the case of public access buildings, or premises where the occupants may be unfamiliar with the layout and exits, panic exits devices should be operated by the horizontal bar, either "push bar" or "touch bar" type. Devices operated by a lever handle or push pad are unacceptable. Panic exit devices operated by a horizontal bar should comply with a relevant standard. Where variations are sought to this standard these must first be discussed with the Fire and Rescue Authority (and other enforcing Authorities where appropriate). For a relevant standard please refer to BS EN 1125:2005 Building hardware – panic exit devices operated by horizontal bar – requirements and test methods. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Dec-23	Dec-23	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	R9. The routes to emergency exits from premises and the exits themselves must be kept clear and free of obstruction at all times to allow persons to evacuate the premises as quickly and safely as possible. The photocopier, boxes of paper and spent toner cartridges need to be removed from the corridor.	Full action plan held by Estates.	Nov-23	Nov-23	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	R10. The gap around the door and frame was found to be excessive. The door should be repaired in order to prevent the passage of smoke and flame. •Id 0008 •Id 0009 •Id 1157 The 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.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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 selfclosing.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	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	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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	

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Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. During the inspection breaches in compartmentation were identified within the endoscopy storeroom which houses the photocopier and a large air conditioning unit. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. Compliance with this or an equivalent standard will normally satisfy the requirement. I am happy for this to item to be address in the Phase 2 enforcement works Scheme.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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	
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	
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	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	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	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST,	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. Reduce the risk within this area to as low as practicable by: Either reconfigure the area by moving the kitchen into the staff room or make up the corridor so it provides adequate fire resistance to allow the relevant person to effect a safe exit.	Full action plan held by Estates.	Feb-24	Feb-24	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA UNIVERSITY HEALTH BOARD, WITHYBUSH HOSPITAL, WITHYBUSH, FISHGUARD ROAD, HAVERFORDWEST, SA61 2PZ	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R11. Confirm that the ward approach to ward 3 will be made up to mirror the other ward approach areas within the hospital, to allow for progressive horizontal evacuation of the relevant person. 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	

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Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The inspection hatch in the wall of the following room: • R51 Switchgear room Requires to be re inserted. (Estates ref 5.4)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The opening in the ceiling located in • R31 Store 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 5.5)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. 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. • Photocopier / Printer The means of escape must not be used for storage or charging of electrical items. (Estates ref 5.6)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. 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. If the following door is required to be kept open: • R131 It should be fitted with an automatic hold open device. Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors. (Estates ref 5.7)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R7. It should be ensured that The fire alarm actuation points are not obscured. (Estates ref 5.9)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R8. The following 30-minute fire resisting door was found to be damaged/defective. These doors must be repaired/replaced. • R104 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. Timeframe for completion: 3 Months. (Estates ref 6.0)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R9. During the inspection the self-closing doors located at; • Cross corridor door by R48 Were found to be ineffective due to binding on floor 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. (Estates ref 6.1)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
Aug-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF 1012/BFS/EH/003459 62	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R10. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. • R136 A/B The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement. (Estates ref 6.2)	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
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	

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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 •Darkroom R30 •Storeroom R98 •Staff Room R17 should be in filled to achieve the same fire resistance as the rest of the floor/ceiling. The fire separation should conform to a relevant standard e.g. WHTM – 05-02 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
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	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.	Dec-23	Dec-23	Amber	
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	
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	R6. 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. •Photocopier / Printer The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	
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	R8.During the inspection the self-closing devices on the doors located at; •1006A/B 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.	Dec-23	Dec-23	Amber	
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	R9. 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. •1015 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.	Dec-23	Dec-23	Amber	
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	R10. Further Recommendations: The following doors need to be added to the PPM: •Cross corridor doors opposite R32 The following room requires to be highlighted as a High-Risk room due to the use of a fridge: •Cleaners Cupboard R18 The Microwave oven is to be removed from the following room: •Office R03	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	R2. Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	

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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	Dec-23	Amber	
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	Dec-23	Amber	
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	R5. Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors Fire doors should conform to a relevant standard e.g., Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	R6. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •1006 A 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.	Dec-23	Dec-23	Amber	
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	R7. During the inspection the self-closing devices on the doors located at; •1020 A •1019 A Were found to be ineffective due to binding on floor 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.	Dec-23	Dec-23	Amber	
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	R8. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •1001 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.	Dec-23	Dec-23	Amber	
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	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	R2. Wedges, hooks and any other devices in use at the present time as a means of holding the self-closing doors in the open position shall be removed to ensure that the doors are effectively self-closing.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	

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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	R3. Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors Fire doors should conform to a relevant standard e.g., Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	R4. Fire doors fitted with automatic hold open devices should conform to a relevant standard e.g. BS 7273-4:2015 - Actuation of release mechanisms for doors Fire doors should conform to a relevant standard e.g., Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	Dec-23	Amber	
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	R6. During the inspection the self-closing devices on the doors located at; • B016 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.	Dec-23	Dec-23	Amber	
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	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. • B007 • B008 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.	Dec-23	Dec-23	Amber	
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	R8. The Responsible Person must ensure that his employees are provided with adequate safety training, and that the training is repeated periodically at appropriate intervals. The % for Level 1 & 2 was low for staff on Padarn Ward.	Full action plan held by Estates.	Dec-23	Dec-23	Amber	
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	
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	

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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	R4. During the inspection the self-closing devices on the doors located at; •D0001746 •D0002158 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.	Dec-23	Dec-23	Amber	
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	R5. During the inspection the Door selector device on the door set located at •D0002157/2158 Were found to be missing and should therefore be replaced 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.	Dec-23	Dec-23	Amber	
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	R6. 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. •D0005583 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.	Dec-23	Dec-23	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	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R2. The storage and use of electrical equipment/devices within the means of escape is not permitted, remove all electrical devices into a suitable room with a fire door. •Bridge (Cadog Ward) The means of escape must not be used for storage or charging of electrical items.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R3. The following 30 minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •3037 •Store R30 Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R4. During the inspection the self-closing devices on the doors located at; •R08a •Stairwell (R40) to Corridor (R61) Were found to be missing/ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	

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Sep-23	2023/24	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	High	R5. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •3028 •To R55 The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
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	R6. Screws in the hinges fitted to the fire resisting doors leading to the following locations: •Stem corridor from stair well •Waste Room (R39) •Lobby (R38 were found to be missing and are required to be replaced.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
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 undertake 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	R3. Adequate Facilities- Practice of using the dispensing bench/ drainage board as a desk to cease as it introduces unnecessary risk of contamination transfer	A suitable shelf arrangement under consideration.	Nov-23	Nov-23	Amber	02/11/2023: There is no room in the small injection room for a desk. A suitable folding shelf has been identified. Awaiting Minor Works.
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- Operator remove soap dispenser from above the disposal sink (to reduce risk of accidental use as a hygiene sink by staff)	Estates to relocate.	Nov-23	Nov-23	Amber	02/11/2023: Awaiting Estates.
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- Splash shield of suitable material that can be decontaminated easily, to be installed on the side of the disposal sink.	Discussed at RPA Audit on 31/10/23.	Nov-23	Nov-23	Amber	02/11/2023: An alternative measure of decommissioning designated radioactive disposal sink is under consideration. RPA to advise. Estates/Minor works input may be needed.
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- Operator to stop the practice of placing solid wastes in sharps containers (1-123 waste procedure)	Instead of segregating I-123 waste we may opt to re-word the Local Rules instead; options are being explored.	Apr-24	Apr-24	Amber	02/11/2023: Discussed in RPA review on 30/10/2023. To be followed up.
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	R5. Radiopharmaceuticals Receipt Procedure- There must be clear and robust procedures in place to specify how ALL radiopharmaceuticals are received and secured on site, with clear specification for the record keeping requirements to provide a means of tracking materials at all times. For example: Records must include unique identifiers (e.g. batch numbers) to allow clear trackability between the radiopharmacy Swansea, the courier and receipt at Withybush NM suite.	Protocol and master documentation requires a few small amendments.	Nov-23	Nov-23	Amber	02/11/2023: A batch number column has been added to the Radioactive Vial Receipt and Waste Disposal record. Discussion is needed with MPE regarding a minor change to the Receipt of Radiopharmaceuticals (TP19) protocol. A new hand-over sheet for I-123 and Se-75 delivery driver needs developing.
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	R6. Procedure for Monitoring Contamination in Patient's toilet- Update procedures to include reference to the requirement for staff to undertake visual checks for signs of spillages around the toilet after each occasion that it's been used.	Local Rules to specify this.	Nov-23	Nov-23	Amber	02/11/2023: Local Rules currently under review.
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	R7. Review- Area Contamination Monitoring Forms- Form need to be improved to expand the description of the areas and/or equipment requiring monitoring.	Contamination Monitoring Forms require additional columns of information.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R7. Review- Area Contamination Monitoring Forms- Staff to print their names and ensure they are legible on all records.	Contamination Monitoring Forms require additional columns of information.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R8. Decontamination Procedures- Ensure documented decontamination procedures are accurate and adhered to	Procedures are adhered to. RPA to provide additional staff training and guidance to be put in local Rules.	Nov-23	Nov-23	Amber	02/11/2023: Local Rules currently under review.
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.

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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	R10. Review "Transport Log"- The template to be revised to require printed names of both consignor and consignee.	Minor change to documentation required.	Nov-23	Nov-23	Amber	02/11/2023: To be discussed with MPE.
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	R11. Local Rules & BAT Assessment revision- Please review local rules and ensure decontamination procedures are clearly defined and a clear definition of Major Spill included.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- The NRW out of hours contact number has changed to 0300 065 2000, please update	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- There is no mention of se-75 administration in section 4.6 of the local rules, for completeness this should be included	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- The local rules (section 4.11) refers to a record called "Accumulation and Radioactive Waste Record" the assessor has queried whether this is an error as they were not shown these records	This record has been renamed following change of radiopharmaceutical provider. Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- The section covering wate management should be reviewed and expanded to better describe the process for each waste stream, clearly identifying the different storage locations (this section will need to be reviewed in any event to reflect the improvements identified in this report)	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- Appendix 4 of the local rules sets out the protocol for accumulation of tc99m wastes it makes reference to a solid waste store- however it was confirmed on site that there is no store presently available on site.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- The excretion factors listed in the local rules differ from the BAT documents. The local rules also omits mention of se-75 excretion factor. Please revise and ensure both documents align.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- In the section detailing action following Major Spill the local rules indicates that the notification of NRW "may" be required. In the event of a Major Spill NRW must be notified (to the timescales specified in the permit). Please revise.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- In the section detailing the actions to be taken following a permit breach this indicates that the RWA will confirm the breach before notifying NRW. Please note that the notification should occur as soon as the suspected breach is detected and there is a risk that a delay (whilst awaiting to discuss it with the RPA) could result in permit breach. The notification requirements of the EPR permit are tight.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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	R11. Local Rules & BAT Assessment revision- Please also ensure version control for all documents that form part of the site's written management system.	Local rules and BAT revision needed.	Nov-23	Nov-23	Amber	02/11/2023: Under review.
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 (Sealed Radioactive Sources)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	N/A	R4. Operator to undertake a review and justification for the continued use of a sealed source beyond its RWL. If the operator can justify the continued use, a more frequent (annual) leak test will need to be specified in the procedures.	RPA to try and write a justification. Source is from the decommissioned radiopharmacy unit. Disposal of the old radioactive source was previously quoted at £3000, so we have incorporated into QA programme, therefore not classified as 'waste'.	Nov-23	Nov-23	Amber	A suitable response is under consideration. An annual leak audit will be introduced.
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.

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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. 27/10/2023- Assurance and Risk Officer to discuss with Head of Pathology Service if this recommendation can be closed.
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	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. 26/09/2023 - 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-22~~ ~~Aug-22~~ ~~Oct-22~~ N/K	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.
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-22~~ ~~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 UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact. 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	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	~~Nov-22~~ ~~Oct-23~~ 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 UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact. 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-22~~ ~~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 UHB review. 04/04/2023 - Given patient/service user cohort sits within maternity services, request made to Head of Midwifery for an update on current provision. 26/09/2023 - A CYP working group has been established which is chaired by Dir of Ops and psychology provision is being assessed by that group. The health board is currently undergoing a Psychological Therapies Review being undertaken by the NHS Executive. The outcomes of that a review are not yet available. There is an ambition to deliver psychology services from a local service perspective. Despite successful recruitment of 1 x WTE Health Psychologist in 2022 the psychology team is very small, and further reduced due to maternity leave. The capacity of the Health Psychology Team remains constrained in terms of ability to manage additional conditions. From a network perspective, regional provision will improve when new posts in place however some constraints will remain due to maternity leave within the service. Referrals can be made to Bristol for patients requiring tertiary (surgical) intervention- and that service will also increase capacity with new appointments.
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 2024work 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.
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.
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	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. 09/06/2023 - The 2023/24 Orthopaedic Delivery Plan has been endorsed by the Board within the Annual Plan. Capacity remains below pre-pandemic levels. Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7). The Orthoapedic Portfolio Management team and CL are fully supportive of such expansions. 25/09/2023 - Orthopaedics has a clear understanding about the demand within the service currently and data reports have been developed in conjunction with Informatics and Performance teams to assist with the management of patient referral to Treatment pathways and improve efficiencies across the stages. The service monitors and reports on RTT data, KPI's and governance in order to reduce duplication and avoid pathway variation, with the aim of improving standardisation of care. Work to increase activity across the Health Board continues with scrutiny around addressing inefficiencies and maximising the use of resources. Weekly Health Board wide theatre scheduling meetings have been established and are used to review and challenge utilisation of lists. A focussed Trauma & Orthopaedic specific theatre utilisation meeting is also held to discuss and review the ability to increase sessions across sites on an ongoing basis. BGH currently has an allocation of 5 main theatre sessions per week which is in line with pre-covid capacity. WGH currently has an allocation of 7 main theatre and 3 day case theatre sessions per week which is 4 main theatre sessions below the pre-covid allocation. PPH currently has an allocation of 12 main theatre sessions per week which is 8 sessions below the pre-covid allocation. However we also have 7 day case sessions available to us through the Demountable Day Unit which we did not have pre-covid. Delivery is directly impacted by the Health Board's current financial position and the lack of recovery money that has been made available. Andrew Carruthers, Director of Operations, is the lead for the Health Board on the South West Wales Regional Orthopaedics work between HDUHB and SBUHB. Some progress has been achieved in recruitment of theatre staffing and Consultant Anaesthetists but levels have not increased enough to allow an increase in elective theatre sessions. Scheduled Care Risk 1657 highlights the risk around non-delivery of ministerial priority expectations of planned care recovery ambitions due to uncertain resource, availability of workforce and UEC pressures which continue to impact on available capacity. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand.

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, Green- complete)	Progress update/Reason overdue
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	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7) 09/06/2023 - Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services. 25/09/2023 - A number of actions are replicated within recommentation 12. An EQuIP project is currently being run by Pre-assesment and focusses on streamlining processes Health Board wide due to a lack of consistency. There continues to be discharge delays for medically fit patients due to delays in social services assessments. Work is being undertaken through NHFD groups around early mobilisation and is captured through NHFD reported KPI's. This work also advises on the reasons for being unable to mobilise patients. Updates to be obtained from NHFD groups and Pre-assessment EQuIP project. 20/11/2023 - Currently in same position, but regional work being considered to further increase capacity. An options appraisal was presented at Orthopaedic Deep Dive meeting on 30th October 2023 to GM and Director of Secondary Care to consider. amongst other options, the transfer of day case theatre staffing and anaesthetists to main theatre to address the in-patient demand. A Task and Finish Group has been established to standardise the Pre-assessment process across the Health Board - increasing efficiency and the flow of patients across the HB to where theatre and surgical staff capacity exist, thereby utilising resources more effectively. An all Wales group is also being established to assist facilitation of Regional work
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	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.
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	R12k. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	June 2022 -Recommendation was accepted by HDUHB - Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	Jun-22	~~Oct-23~~ Dec-23	Red	30/06/2022 - Service delivery planned in accordance with HVLC programme principles. 09/06/2023 - Service delivery planned in accordance with HVLC programme principles. Clinicians from HB fully involved and integrated with Welsh Orthopaedic Network CRG's to deliver changes to pathways and ensure improved efficiency and productivity Theatre staffing and anaesthetist shortfalls (which would provide dedicated and consistent workforce to support flow in theatre environment), treat in turn and the clinical urgency of patients all currently contribute to not routinely achieving 2 joints per theatre session across BGH and PPH (only sites where joints are carried out). This situation is being monitored so compliance is achieved whenever possible. List loading for GA and LA theatre sessions has been standardised across all sites/consultants and to maximise throughput and efficiency adopting HVLC programme and GIRFT principles. Maintaining thses standards is assured via the weekly Theatre User Groups and Theatre Scheduling meetings 25/09/2023 - Theatre User Groups and Theatre Scheduling meetings are ongoing and represented by the service management team. Our current delivery model reflects GIRFT and NCSOS principles with high volume, low complexity work being undertaken at WGH, DSU PPH and GGH. Low volume, high complexity work is undertaken at PPH Main Theatre and BGH. There is a high volume of available day case surgery however this can create in the long waiter management, treat out of turn due to availability of main theatre sessions. The service is monitoring the ability to perform 2 joint sessions (in line with GIRFT Best Practice Guidelines) and the reasons for not undertaking through discussions with Consultants. The Clinical Director and Clinical Lead are aware of the ambition to increase productivity however discussions with Consultants have not been fruitful. There has been a recent resolution around previously allocated half day lists in PPH on Wednesdays which will now provide an opportunity to increase productivity and efficiency - first all day list to commence 11/10/23. 20/11/2023 - Day cases - we are listing in line with GIRFT recomnedations around HVLC cases. The service continues to monitor ability to perform 2 join sessions. Regional orthopaedic meetings will feed into this work.
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.	Dec-23	Dec-23	Amber	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.
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.	Dec-23	Dec-23	Amber	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.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R1. Clinical leadership within the OOH service requires expansion to include leadership at system wide level and on- shift. Action: Review leadership roles and recruit to expand both at system level and operational level.	This is accepted as an area requiring attention. Exploration of the capacity of leadership is now the subject of discussion within the senior team along with at the Improving Together sessions recently instituted by executives. Limited numbers of GPs with an interest in OOHs remains a challenge so longer term development opportunity may be needed. The operating relationship with leads in TUEC and UPC opens up further reconciliation needs.	Jun-23	~~Jun-23~~ ~~Aug-23~~ Mar-24	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.
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.
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.
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	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 .
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts. Action: Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST.	Jun-23	~~Jun-23~~ ~~Sep-23~~ Mar-24	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
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. 16/08/2023 - conversations ongoing and impacted by current financial position. Revised completion date noted.

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, Green- complete)	Progress update/Reason overdue
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.
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	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.
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	Amber	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.
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	Amber	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.
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.
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.
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	Amber	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.
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.
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.
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.
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.
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	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.
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.
Apr-23	2022/23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	N/A	R17. Clinicians were concerned about calls being held on the 111 advice queue from early afternoon and then being passed to OOH at 6:30pm on weekdays. Action: Gather data to determine the extent of this issue and raise via Joint Operational group.	Similar data profile noted above to be gathered to assess validity of claim	Sep-23	~~Sep-23~~ N/K	Red	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.

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May-23	2022/23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	N/A	R2. HDUHB to establish a robust mechanism for capturing procedure level data of impatient day case and outpatient procedures.	Awaiting management response.	Jul-23	~~Jul-23~~ ~~Nov-23~~ Jan-24	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 is 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	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
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	Jan-24	Jan-24	Amber	16/11/2023 - GIRFT review in regular Opthalmology Business meeting. First meeting undertaken 20th October 2023. Executive oversight GIRFT meeting for all specialites in discussion.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack /Marta Barreiro Martins	Director of Operations	N/A	R3. Review the line management structure and explore whether a MDT cataract or whole ophthalmology surgical team across all areas (OP, day case, theatres, preop, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care	1) Workforce review to be undertaken by head of nursing and Senioer Nurse Manager 2) Workforce development plan to be written and implemetnted.	Apr-24	Nov-24	Amber	16/11/2023 - New Ophthalmology management structure inclusive of Nursing representation will work closely with Clinical teams to review theatre delivery. Workforce development plan to be developed with Swansea Bay HB.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R4. Appoint a formal clinical lead who has enough time in their job plan, and appropriate stable, senior service manager support to deliver.	1) Clinical lead JD to be reviewed and updated 2) Clinical lead role to be advertised for recruitment	Apr-24	Apr-24	Amber	16/11/2023 - JD for Clinical lead to be circulated to all elegible staff within the service as an expression of interest for this role.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R5. Review the reasons with local optometrists as to why conversion rates lower than should be and take action to improve. Use a formal shared decision making tool, such as the NHS England one, in primary care	1) Review data for conversion rates 2) develop decision making tool for use in primary care	Jan-24	Jan-24	Amber	27/09/23 Preliminary meeting held with Optometrists.
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.
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 undertakenby head of Nursing and Senior Nurse Manager 2) Workforce development plan to be written.	Apr-24	Nov-24	Amber	27/09/23 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R9.Consent patients for both eyes at the first eye preop visit. Consent by phone for second eye or very long waiters already assessed and on list and post consent form out to read +/- sign at home	1) Review of current consent process for bilateral cataracts 2) Review of current consent forms to align with above process.	Apr-24	Apr-24	Amber	27/09/23 Review of consent process currently being explored with HB consent lead.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	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. Staffing constraints currently.
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.

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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 maily GA however LA patients added to fill the lists rather than lists go under utilised
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	R20. Do not mop the theatre floors routinely between cataract cases.	1) Check that mopping of theatre floor has stopped in between cases. AVH-only if body fluid id spilled. BGH- GGH-	Dec-23	Dec-23	Amber	16/11/2023 - Floor only mopped inbetween cases where there is a visible spillage or bodily fluids in AVH. GGH to be discussed.
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	Amber	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 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R27. The unit should undertake a whole MDT workforce review, pushing everyone to the top of their licence and assessing numbers and training requirements for cataract and HVLC.	1) Scope current workforce. 2) Scope current workforce competencies. 3) Develop a training pathway and competency assessment framework.	Apr-24	Nov-24	Amber	27/09/23 HDUHB to devise a Workforce development plan which has been discussed with Swansea Bay for support to undertake staff training days.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R28. RNOH/GIRFT recommends use of the Modelling software available RCOphth cataract workforce calculator.	1) Establish demand and capacity tool for cataract service. 2) Increase capacity through HVCL and inreased delivery of cataract lists. 2) Develop trajectory for recovery.	Apr-24	Apr-24	Amber	27/09/23 Workforce planning in line with the RCOphth will be undertaken alongside the workforce development plan discussed with Swansea Bay.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R29. Use both efficiency/finance aspects and patient safety issue to agree to source and start using pre-loaded lenses .	1) Establish which lenses the clinicians want to trial. 2) Scope with procurement. 3) Undertake trial and feedback to procurement. 4) Procure preferred lenses across site.	Mar-24	Mar-24	Amber	Trial of pre-loaded lenses currently being scoped with procurement and clinical team.. 27/09/23 Three companies identified for trial and 4 doctors who are going to participate.
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	To discuss at upcoming QSE meeting.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R34. Undertake regular observational audits to measure and monitor the flow in cataract lists - Consultants and managers to go and observe the timings and flow of other consultant lists.	1) Review theatre lists and udertake initial audit. 2) Present report at QSE. 3) Repeat audit 6 monthly and report back to QSE.	Apr-24	Apr-24	Amber	27/09/23 Senior Nurse Manager for Ophthalmology has observational dates booked to review all theatre processes.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R35. Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Apr-24	Nov-24	Amber	27/09/23 Preliminary discussion held with ward Sister.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R36. Undertake a pilot of patient self dilating and, if successful, roll out to all suitable patients.	1) Discuss self dilation with ophthamology team around logistics. 2) Meet with Pharmacy to explore possibility and risks of self dilation.	Apr-24	Apr-24	Amber	27/09/23 Preliminary discussion held with ward Sister, next steps, to be explored with pharmacy.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R37. Consent must be taken before the day of surgery. Consider supporting the primary care optometrists to do more and share the consent form. Consider posting the consent form out to patients in advice, nurses and optometrists in clinic to be trained to consent and all consents done within the one stop clinic.	1) Explore consenting patient at pre-assessment. 2) Review consent form format and update as necessary. 3) Explore nurse led consent.	Apr-24	Nov-24	Amber	27/09/23 Review of consent process started with Head of Consent for the HB.

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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	R38. Use an appropriate cataract specific consent form similar to the RCOphth consent form, which is approved by the major patient charities as accessible.	1) Review current consent form in line with RCOphth consent form. 2) Make necessary changes to consent form as agreed by team and consent lead.	Apr-24	Apr-24	Amber	16/11/2023 - Cataract specific consent form currently in place, aligned to whole HB consent forms which has been overseen and implemented by Head of Consent and Mental Capacity
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R39. Review methodology for ophthalmology/glaucoma activity and waiting times data collection, validation and sense checking and ensure all of the relevant team have sight of this and can discuss any actions required.	1) Review of Demand and Capacity. 2) Review of outpatient delivery. 3) Increase primary care delivery to Glaucoma A and B patients.	Feb-24	Feb-24	Amber	16/11/2023 - Work has been commenced on coding and data analysis.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	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 vitual platforms
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	Currenlty 8 Optomotrists hold a higher certificate with another 15 Optomotrists currently being developed in the HB.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R42. Ensure accurate data is regularly reported on the performance of referral filtering as well as ODTC's to drive improvements – as well as the % of first hospital glaucoma attendance discharge, what % of patients are kept out of new hospital visits by the repeat measures and ODTC refinement separately?	1) Discuss referral refinement delivery and delivery with primary care colleagues. 2) Undertake agreed audit of referral pathway. 3) Feedback data at QSE.	Apr-24	May-24	Amber	27/09/23 Review of data collection and referral management has commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R43. Ensure consistent risk stratification is used for all patients at every glaucoma visit. This needs to be done at all sites and at all types of visit, including, as the pathway develops, in community optometry. Use this data to create a view of the whole glaucoma patient population who are at high, medium & low risk - this is critical to ensure they are managed appropriately and that resources can be deployed appropriately. This needs to be delivered as a matter of urgency.	1) Review of current waiting list and risk startification. 2) Optometrists to support with completing risk startification. 3) Glaucoma Consultants to assist with completing risk staratification process.	Apr-24	Apr-24	Amber	Risk stratification has been applied with E and F category almost eliminated from the New pathway. Plan to validate whole FU waiting list with plans to eliminate uncoded patients and the E and F catgories in the the FU cohort.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R44. Rationalise where ophthalmic outpatients are delivered to fewer better sites with dedicated ophthalmic spaces.	1) Undertake review of current delivery for Glaucoma clinics. 2) Plan increase in delivery of Glaucoma clinics including review of infrastructure. 3) Commence delivery of increased Glaucoma clinics	Apr-24	Apr-24	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	R45. Re-explore the use of remote consultations after diagnostic data collection, to reduce the burden on outpatient space. Virtual reviews have to be carried out on a hospital site, but ensure they and remote consultations are not being done in clinical consulting rooms, as long as the clinicians can see the diagnostics data and records.	1) Introduce further virtual Glaucoma sessions for Consultants. 2) Scope delivery of virtual Glaucoma sessions for SAS doctors.	Apr-24	Apr-24	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	R52. Urgently link up regionally to use resources to their best availability including medical and MDT manpower for cataract, glaucoma and other areas.	1) Continue to develop open eyes project as a regional development. 2) Scope possibility of cataract delivery through SBUHB.	Jan-24	Nov-24	Amber	27/09/23 Regional Glaucoma Consultants secured. Regional EPR system being scoped and workforce development plan to include regional support from 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	R53. Fund more ophthalmic (optometrist, orthoptic and nurse) practitioners and develop them. Fund more technicians and health care support workers and train them to deliver a wider scope of practice.	1) Scope the recruitment of 1.9 WTE Glaucoma practitioner. 2) Plan development of Glaucoma practitioners. This action may be restricted by costs to implement.	Apr-24	Nov-24	Amber	27/09/23 Funding available for further Glaucoma Practitioners, Regional workforce development plan will need to be implemented to support the development of these nurses.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R54. Consider adapting UKOA Guidelines across all 3 professions including training SLT practitioners using UKOA guidance. Utilise the OPT framework for training MDT staff.	1) Develop a rolling programme of staff to go through OCT training. 2) Identify a training lead for the HB.	Apr-24	Apr-24	Amber	27/09/23 The OPT competency framework is being utilised in the development of the nurse practitioners and one of the middle grade doctors is atteding the OCT training to support as training lead.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R55. Undertake a comprehensive review of the roles, job plans, numbers and professional development of the MDT, in glaucoma services in hospital and the ODTCs. Utilise the capabilities of non-medical staff to maximum so that the consultants can concentrate on the complex cases, training and service improvement.	1) Undertake review of current roles in delivery of Glaucoma pathway by Head of Nursing and Senior Nurse manager. 2) Map development of workforce within pathway to align with service plan.	Apr-24	Nov-24	Amber	27/09/23 Review of workforce commenced.
Aug-23	2023/24	Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	N/A	R57. 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	R58. Undertake proper demand and capacity work and explore realistic options for change, and how much and how quickly they will deliver. Accelerate business cases to 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	R59. The very long waiters need to be assessed now (e.g. by virtual assessments) regardless of the original risk rating to avoid cases of serious harm.	1) Utilise demand and capacity work recently undertaken to build a robust model of service delivery. 2) map recovery plan in line with the above.	Apr-24	Apr-24	Amber	27/09/23 100% delayed patients in high risk categories being reviewed with plans to increase virtual sessions to review these patients.
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.

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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 modeland contingency plans for resourcing any future outbreak	Jul-23	~~Jul-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A 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 dated 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 in terms 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.
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	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

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, Green- complete)	Progress update/Reason overdue
Sep-19	2019/20	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Matthew Willis	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-22~~ 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 (External rec)	N/A	Primary Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	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.
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
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	R4. Implement a requirement for all clinicians who take consent from patients to complete a recognised training programme. It is recommended that the frequency of this should be at least once per revalidation cycle for the relevant professional group, it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.	Discuss this recommendation with the Medical Director, Director of Nursing, Quality and Patient Experience, and the Director of Therapies and Health Science to determine the most appropriate approach. Implement agreed approach.	Sep-23	Mar-24	Red	15/06/2023- Lead officer provided implementation date of September 2023. Discussions taking place with Deputy Medical Director (Acute Services). 07/09/2023- This is on track to be agreed by the end of September (although this depends on the pace of decision making by others). Positive discussions have taken place with key people in the Medical, Nursing and Therapies & Health Science Directorates and have meetings in the diary s to make final decisions regarding whether the new National Consent e-learning course developed by Welsh Risk Pool course should be mandatory, and if so, for which particular groups of staff. Agreement regarding frequency of completion will also need to be reached. In the interim, the course (which is available via ESR) has been advertised via Global email (10/08/23) and will be readvertised every few weeks to encourage registered professionals to complete it. Also, the Medical Directorate have circulated details of the course to all doctors. 28/09/2023-Following discussions across Medicine, Nursing and Therapies & Health Science, and the MCA & Consent Group, it has been agreed that the e-learning should be mandatory for:•All doctors and physicians associates. •All registered nurses and Health Care Support Workers. •Most therapists and some health scientists (details currently being finalised). Welsh Risk Pool have specified the training should be undertaken every 3 years. A request to add it to the mandatory training requirements for relevant staff will now be submitted to Learning and Development. In the interim, the course is being advertised via Global email every few weeks to encourage registered professionals to complete it. The Medical Directorate have circulated details of the course to all doctors. Discussions are also being held with primary care (re General Medical Practices, Dental Practices, Optometrists) and Pharmacy to consider access to the training.MCA & Consent Group (25/09/23) recommended the timescale is updated from September 2023 to March 2024 to take account of Learning and Development approval and implementation 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	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	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.
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	Dec-23	Amber	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.

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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	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.
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	Red	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date. QAST Awaiting an update chased Dec 22, Jan 23, Feb 23. 09/05/2023 - Fire works expected to be completed by end of May 2023. 03/07/2023 - QAST chased for update June 23. QAST update 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. 03/10/2023- Estates work has been delayed due to prioritising the WGH RAAC work, revised date of December 2023 provided. QAST update 30/10/23 actions chased, fire works approaching completion, to be confirmed once finalised.
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.	the	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~Jan-23~~ ~~May-23~~ ~~Aug-23~~ Dec-23	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response. 20/12/2022- All IPC issues with furniture have been addressed as all communal dining and lounge furniture has been replaced. Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed. QAST update Feb 23 Advanced for works were delayed and currently underway and 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.
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	
Mar-22	2021/22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	N/A	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ Dec-23	Red	QAST update 07/09/22 no update on this recommendation to date. QAST update 01/11/22, meeting being arranged to progress the recommendation planning QAST update 09/05/2023 - GP and MH Leads meeting to progress. QAST update 27/06/2023 - all posts filled and undergoing recruitment checks. 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. QAST update 30/10/23 actions chased no update from service.
Mar-22	2021/22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	N/A	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	To complete the work that is already underway to outline the steps regarding the development and recruitment of the MH practitioner role.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ Dec-23	Red	18/05/2022 - PAS team to liaise with SDM of Psychological Therapies to develop a response and obtain updates QAST update 07/09/22 no update received on this recommendation to date. QAST update 01/11/22 no service update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 09/05/2023 - GP and MH Leads meeting to progress. QAST update 27/06/2023 - all posts filled and undergoing recruitment checks. 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion. QAST update 30/10/23 actions chased no update from service.

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Oct-22	2022/23	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Kay Isaacs	Director of Operations	N/A	Patients are assessed in a timely manner if they have physical health problems and for doctors on the ward to feel supported by their colleagues on the general wards	Senior medical staff from Mental Health Services and General Acute Services in Prince Philip Hospital to liaise and discuss how communication to support timely assessments and support can be improved upon for doctors.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ N/K	Red	QAST update 01/11/22 chased action Oct 2022. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 09/05/2023 chased 21/04/2023, no update received. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 Clinical Director of MH has asked if this remains an issue for service, response seems to indicate this is no longer an issue, requested service if they are content to close the action on that basis. Awaiting response. QAST update 30/10/2023 - chased service for consideration of closure of action.
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	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.
Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital O5, 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	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To arrange provision of new information screens for the department.	May-23	~~May-23~~ ~~N/K~~ ~~Aug-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 expected completed by end Aug 23, all actions chased 10/08/23, no update or new target date provided. QAST update 30/10/23 Regular notifications of waiting times etc provided by Staff . E-mail sent to all A&E staff, both Medical and Nursing as well as to Specialties reminding of the need to update patients/carers regarding their care and treatment. At times of extreme demand, PALS colleagues do support with information giving and sharing.
Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital O5, 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	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To facilitate working with '2 Wish' charity regarding the refurbishment of relatives/viewing room	Sep-23	~~Sep-23~~ 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.
Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital O5, 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.
Mar-23	2022/23	HIW	Emergency Unit, Glangwili General Hospital O5, 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.
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.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level e.g. Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions a) 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.
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.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level e.g. Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions b) 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	Nov-23	Amber	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	R2. The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	WARRN is used as a standardised approach to formulation based risk assessments across the MH/LD Directorate. A cohort of WARRN trainers deliver monthly training sessions for initial and refresher training. The presence of a WARRN is verified through Care and Treatment Planning audits undertaken monthly by team leaders. The MH/LD Directorate is linked into All Wales work surrounding development of a national approach to safety planning. Further Action c) Review of WARRN training provision and monitoring of uptake to inform longer term, sustainable approach and ability to provide targeted practice development in response to lessons learnt from SI's. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Dec-23	Red	10/10/2023- Roles identified to extend local training pool and funding/train the trainer dates being sought to support. Work to develop a process for reporting essential training in MH/LD being undertaken with Learning and Development (to include WARRN training). National leads approached to explore consideration of a national pool for trainers and blended learning options for delivery. Revised timescale for completion 31/12/23. QAST update 30/10/23 no update received from service on action.

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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.	Routine offer of Carers Assessment is built into the Comprehensive Assessment Tool referenced in recommendation 1 and is explicitly referenced in its accompanying guidance. Documentation of routine offer of Carers Assessment is incorporated into CAT forms on the Electronic Patient Record. WARRN and Care and Treatment Planning Reviews also prompt staff to offer Carer Assessment and document outcomes to this. The Health Board is signed up to the Investors in Carers scheme and all teams across the MH/LD Directorate are actively benchmarking services against the schemes standards. There are Carer Leads on all Inpatient Wards and specific support for dementia carers can be accessed through Admiral Nurses and Dementia Wellbeing Teams. Further Action d) 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	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.
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.	Daily Board Rounds plus scheduled Ward Rounds take place across Inpatient areas. The structure, format and approaches to quality assurance of Ward Rounds vary across services. There is feedback to indicate that short notice for Ward Rounds impacts on Service User and Carer involvement. Further Action e) 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.
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.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- - MDT attendance by Ward & CMHT (Care Coordinators) - Pre-discharge Care and Treatment Planning Meetings - Directorate wide access to Electronic Patient Records - Current pilot of Medicines Transcribing and e-Discharge (MTeD) system - Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow - Sector Approach within OA Mental Health Services promoting continuity of care Further Actions f) Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53). Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	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.
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.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- - MDT attendance by Ward & CMHT (Care Coordinators) - Pre-discharge Care and Treatment Planning Meetings - Directorate wide access to Electronic Patient Records - Current pilot of Medicines Transcribing and e-Discharge (MTeD) system - Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow - Sector Approach within OA Mental Health Services promoting continuity of care Further Actions g) And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	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.
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.	There are a range of mechanisms that support embedding practice for timely and effective communication and information sharing relating to patient discharge process however no single specific training to outline expected standards in place that is monitored. Further Action h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Oct-23	~~Oct 23~~ 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	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.	All Inpatient Wards are supported by Ward Clerk roles. A recent Quality Improvement project was undertaken by the MH/LD Directorate to focus on releasing Ward Management time spend on admin tasks. This led to a pilot of a new band 4 admin role to complement existing band 2 Ward Clerk roles. Further Action i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	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.
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.	Mechanisms to prompt patient, family, carer and/or advocate views to inform inpatient care and discharge plans are incorporated within Care and Treatment Planning process and within the Comprehensive Assessment Tool and guidance. The Electronic Patient Record has functionality to enable sensitive information (potentially provided by patients, family, carers) to be recorded separately. All inpatients are offered advocates on admission which is documented in the Electronic Patient Record and routinely monitored by the MH/LD Directorate. Quarterly reports to provide assurance on practice surrounding the offer of advocates are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures. Advocates regularly visit wards and participate in Ward Review/MDT Meetings. Inpatient services operate a 'named nurse' model which promotes engagement with patients, family, carers and / or advocates to inform person-centred care planning. Inpatients are allocated a community Care Co Ordinator prior to discharge to support discharge planning. We will develop an auditing mechanism to routinely audit records to be assured that family carers and advocates are able to provide their views to inform inpatient care and discharge planning. Further Actions as per Recommendation 7.	Sep-23	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.

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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.	Crisis plans are jointly developed between ward/community staff (CMHT/CRHT), patients, families / carers and /or advocates through discharge planning and cover plans for the next 7/14 days including 72 hours follow up (by who and when), medication /crisis numbers and details of any other actions agreed. A Service User information leaflet to support person centred crisis planning has been developed and is currently being piloted. Comprehensive Assessment Tool (CAT) and Care and Treatment Plans (CTP) are reviewed and updated at transfers of care (including discharge from inpatients). An updated Care and Treatment Planning review tool has been developed and is in the process of being implemented. The tool is incorporated within the Electronic Patient Record and is covered within CAT Training and guidance. Older Adult Mental Health Services have a Clinical Risk Management Lead monitoring high-risk presentations and transitions (admissions/discharges) to support & upskill Care Coordinators. Further Actions as per recommendation 7.	Sep-23	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	R13. The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	A discharge checklist is in place across MH/LD inpatient services. This is completed during the discharge process to record information associated with the completion of discharge tasks and notifications. Once complete this is scanned and uploaded to the Electronic Patient Record. Further work to strengthen assurances around consistency and effectiveness of this process will be undertaken through the below actions. Please see overarching Clinical Audit Action (Recommendation 34) Further Actions as per Recommendation 7.	Sep-23	Dec-23	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.
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.	Please see response to recommendation 13. The health board has a daily bed conference (twice daily Monday – Friday), originally established in the pandemic and now an embedded process, to review and proactively manage bed utilisation, availability, access and discharge which has MH/LD directorate wide multi-disciplinary input from services across admission and discharge pathways, MH/LD commissioning roles and multi-agency representation (including Police and Local Authority reps). Action notes are made and shared following bed conferences to ensure communication of key outcomes. Electronic Patient Records are updated with patient specific information. Older Adult mental health services also participate in additional discussions about regional admission needs across daily Acute Pathway Meetings (Multi Agency and Health Board wide). MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator provide additional support with coordination of discharges in more unusual circumstances. Further Action as per Recommendation 6 and 7.	Sep-23	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	R15. The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	Please see response to recommendation 14 in relation to bed conferences and daily Acute Pathways Meetings. MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator lead on coordination of risk based MDT decisions in the event of contingency plans needed for patients that require return to hospital from leave. Escalation processes are in place to support out of area bed / placement requests. Use of out of area placements by the MH/LD directorate are low. Further Action j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	Dec-23	Amber	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	R16. The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.	Please see response to recommendation 15.	Dec-23	Dec-23	Amber	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.	The health boards policy on Discharge and Transfer of Care incorporates definitions and guidance on delayed discharges. Delayed discharges in MH/LD directorate are operationally reviewed at a service level through the daily bed conference process referenced in the response provided to recommendation 15. Delays are identified and actions to address delays are agreed and reviewed with escalation as needed. Monthly reports of delayed transfers of care are produced and reported to the MH/LD Business Planning and Performance Assurance Group. Further Action as per Recommendation 15.	Dec-23	Dec-23	Amber	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	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions k) Develop procedural guidance and standards for uploading paper records to the Electronic Patient Record across the MH/LD Directorate	Aug-23	Jan-24	Red	QAST update 07/09/23 all actions chased 10/08/23, no update from service or new target date received. 10/10/2023- Mapping of existing processes underway, to include a review of access to equipment across teams that enables digitisation of clinical records. Mapping work will be used to inform development of guidance and standards to improve consistency. Due to volume of work required to inform this action, and operational pressures, timescales revised to 31/01/24 for completion. QAST update 07/09/23 all actions chased 10/08/23, no update from service or new target date received.
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.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions l) Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Sep-23	Jan-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.
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.	The MH/LD Directorate operates a consistent Electronic Patient Record (Care Partner) across all of its services. The system allows access to contemporaneous records across inpatient and community services and has business continuity plans to guide staff in the event of system outage. Further Action m) Development of process to enable timely access of clinical records for temporary staff e.g. temporary staff log ins that are issued locally.	Nov-23	Nov-23	Amber	

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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	Nov-23	Amber	
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.	Details of discharge plans, including 72 hour follow up are included in discharge Care and Treatment Plans. The inpatient Discharge Checklist includes the need to check and record that discharge notifications have been completed and shared with relevant people. METeD, a system that digitally transfers discharge notifications and details of medication on discharge to GPs is currently being piloted for full roll out across the MH/LD directorate. Standard templates for discharge letters are in place. These require review to ensure they are reflective of NICE guideline standards for Transition between inpatient mental health settings and community or care home settings (NG 53). Work to strengthen assurance of consistency in quality and timeliness of discharge letters and discharge summaries being shared is required. Feedback indicates a regular theme of these not being shared in a timely way. Patient information leaflets outlining rights to re-refer are in use. Scrutiny of trends in cases that re-refer to services and referrals from GPs that could have re-referred themselves under the Mental Health (Wales) Measure 2010 is undertaken through the MH/LD Legislation Scrutiny Group. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	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	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions o)**R**eview application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Sep-23	Nov-23	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.
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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions p)**P**ilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Nov-23	Nov-23	Amber	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.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions q)**D**evelopment of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Dec-23	Dec-23	Amber	QAST update 30/10/23 no update received from service on action.

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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.	The MH/LD Directorate has an established Accommodation Strategy Group that meets monthly. Its remit is: •To ensure that services experiencing the greatest demand and growth are able to access suitable estate. •Govern and oversee the repurposing of current MH&LD estate to minimise impact on service delivery. •Improve access to accommodation to enable sustainable service provision in order to increase efficiency and maximising clinical time. •Ensure MH&LD accommodation is safe and appropriate in which to delivery therapeutic/clinical interventions. •Act as the point of escalation for risks, issues and actions to the MH/LD Business Planning and Performance Assurance Group. •Progress appropriate Capital bids in collaboration with partner agencies and ensure MH&LD Estate is included in Health Board maintenance and refurbishment schedules. •Report formally, regularly and on a timely basis to the MH&LD BP&PAG on options, plans and progress relating to the Group's activities. •Ensure appropriate escalation arrangements are in place to alert the Hywel Dda University Health Board (HDUHB) Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of HDUHB. •To monitor the completion of Point of Ligature Audits, ensuring they are reviewed and completed in a timely manner. •To receive the requests for environmental improvements required and agree a prioritisation process for completion of essential works. CRHT services have identified a current risk in relation to being able to access space within emergency departments which is held on the service risk register. Progress has been made with now just one locality to be resolved. Further Action t)Resolve CRHT access to space within all emergency departments.	Jul-23	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.
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.	Actions to ensure sufficient medical capacity across all mental health teams are ongoing within the directorate and active approaches to recruitment and retention are underway through active and frequent review of medical vacancies at the MH/LD Directorate Business Planning and Performance Assurance Group (BPPAG) and Workforce Group, targeted, refreshed, national recruitment campaigns, provision of relocation packages, implementation of a Clinical Fellowship Model, post graduate development support. The MH/LD Directorate holds a risk on its risk register in relation to sustainability of the medical workforce across the MH/LD Directorate (Ref 1525) in response to difficulties and challenges experienced in recruiting doctors and retention risks associated with the age profile of the existing Consultant workforce. The risk is currently mitigated through service awareness and plans to manage impacts through service level risk registers, recruitment, and development of complimentary workforce (for example Advanced Practitioners and introduction of Physicians Associate roles), implementation of an escalation process in the event of medical deficits and through attendance at HEIW Workforce Meetings. The risk is reviewed and updated regularly. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	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	R31. The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Capacity and demand work across mental health therapy services is underway to strengthen capacity where needed and develop flexibility in use of skills. Therapy workforce plans are in place across each MH/LD service speciality. Current deficits as a result of being unable to recruit to specialist psychology roles is held as a service level risk (Risk 138). Mitigations and actions include: -Cross Directorate cover to ensure that there is no inequity in the availability of services across both specialities and localities. -Upskilling the wider multi-disciplinary workforce to deliver interventions under the supervision of psychology and psychotherapy and use of CBT Therapy roles. -Continued efforts to recruit to psychology roles and plans for a 'grow your own' scheme coming into place during 23/24 for 3 funded places on the Clinical Psychologist programme. Waiting lists are frequently reviewed to identify and reassess individuals and 'Keeping in Touch' processes are in place. A continued focus on recruitment and retention to include therapy roles across MH/LD directorate will be undertaken through the MH/LD Workforce Group. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	
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.	A range of developments to ensure that MH/LD directorate inpatient and community mental health staff have the appropriate knowledge and skills to effectively undertake their role are being undertaken including delivery of training to support risk assessment and suicide prevention through WARRN and STORM training. Further work is needed to provide a systematic approach to this to ensure needs are fully assessed and gaps identified, sustainable methods of provision planned and mechanisms for monitoring applied. Further Action u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Nov-23	Nov-23	Amber	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	R33. The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	The Psychological Wellbeing Service is widely promoted by team leaders via Workforce Advisers monthly sickness absence catch up meetings with Team Leaders and during sickness absence meetings and through completion of All Wales Sickness Absence Training. Regular 1:1 meetings are held with managers and the workforce operational team advisers, ensuring appropriate wellbeing advice is given on a case by case basis so they can cascade this information to their staff members. Managers are supported to actively engage and refer staff to Occupational Health for appropriate support. Further Action v)Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	Mar-24	Mar-24	Amber	

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, Green- complete)	Progress update/Reason overdue
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.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of compliance with 72 hour follow up	Dec-23	Dec-23	Amber	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	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	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	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions y) Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed	Dec-23	Dec-23	Amber	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	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Mar-24	Mar-24	Amber	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	R36. The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. Further Actions bb) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	Amber	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	R38. The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Social Worker identified incidents are currently reported on Datix via health board managers as direct system access is not currently in place. Further Action dd) 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	Nov-23	Red	QAST update 07/09/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. A written protocol is to be developed to capture and share the process for consistent implementation. No new target date provided by service. 10/10/2023-Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. Overdue due to the volume of work involved in completing, alongside capacity pressures across the directorate. Revised timescale for completion 31/11/23.
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.	Improvement planning meetings are facilitated by the Quality Assurance and Practice Development Team as standard following completion of all Level 4 and 5 incidents which include senior stakeholders and services involved. Where needed, follow on review meetings are also booked to review and ensure implementation. Further cascade of learning and consistent embedding of actions are delegated to service managers for operational implementation. Forums including Ward Manager, Community Manager, Professional Nurse Forums are used to discuss themes from learning and communication methods such as 7 minute briefings are used where wide cascade is needed. Further Action ff) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	Amber	QAST update 30/10/23 no update received from service on action.
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	Dec-23	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.
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	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
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	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
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 HDD UHB stroke leads collaborative working with the National Stroke Programme Board and the NHS Executive. HDD UHB has representatives attending all national stoke groups.	Dec-24	Dec-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	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	
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	

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Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	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	
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/K	N/K	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	
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 Hub Escalation Policy will be amended once this is complete.	Dec-23	Dec-23	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	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/K	N/K	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 HDD UHB 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	
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 HDD UHB	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	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	
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/K	N/K	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/K	N/K	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/K	N/K	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	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	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	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	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	
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	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	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	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	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	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	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	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.	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	

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Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	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	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	R23. Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	At present the HB uses the NIHS assessment and FAST as the assessment tool. However due to the HIW recommendation the HB will now introduce the ROSIER assessment tool to the ED team. This assessment tool will be part of the stroke proforma.	Oct-23	~~Oct-23~~ N/K	Red	
Sep-23	2023/24	HIW	National Review of Patient Flow – a journey through the stroke pathway	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (WGH)	Senior Nurse Manager	Director of Operations	N/A	R23. Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	The stroke team will provide updated training on the ROSIER tool to the ED team	Mar-24	Mar-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	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	
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	
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 thrombolysis 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 thrombolysis 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	
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/K	N/K	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/K	N/K	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	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	
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	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	
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	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	
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	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	
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	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	
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	R39. Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Majority of stroke rehabilitation environments across the Health Board are appropriate and adequate to meet the patients' needs. There are currently significant short to medium term operational challenges in : 2) Stroke rehab on the BGH site is considered as part of BGH strategy. Interim arrangements include ward& bed based rehab, with longer term inpatient rehabilitation provision being scoped as part of CDU / Leri Day business case, due to be developed by December 2024.	Dec-24	Dec-24	Amber	
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/K	N/K	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	
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	
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	
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	

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Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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 undertaken by reception staff to review waiting room environment	Nightly reception spot check to be undertaken by reception staff to review waiting room environment	Aug-23	~~Aug-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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 undertaken by reception staff to review waiting room environment	Repeat Quality Improvement Assurance audits.	Sep-23	~~Sep-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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.	Observational weekly spot checks audits commenced to be undertaken by ED Senior Sister for six weeks to ensure compliance.	Aug-23	~~Aug-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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.	Establish refresher IPC training within the department for medical, nursing and AHPs.	Oct-23	~~Oct-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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.	IP&C training to be prioritised with ED staff to achieve over 85%	Sep-23	~~Sep-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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	Amber	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	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	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R3. Provide HIW with details of the action taken to demonstrate suitable daily checks of emergency equipment and the recording of this.	Emergency equipment checklist updated to meet standard.	Oct-23	~~Oct-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R3. Provide HIW with details of the action taken to demonstrate suitable daily checks of emergency equipment and the recording of this.	Observational weekly spot checks to be undertaken for six weeks to ensure daily compliance by Senior Sisters with feedback through Health & Care Standards meeting.	Oct-23	~~Oct-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R5. increase the frequency of audits / spot check activity related to emergency trolley checks to ensure that improvements are implemented and sustained.	Checks to be undertaken on service dates for suction equipment across site.	Sep-23	~~Sep-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R5. increase the frequency of audits / spot check activity related to emergency trolley checks to ensure that improvements are implemented and sustained.	Observational daily spot checks commenced to be undertaken for six weeks, with reducing frequency thereafter according to compliance. Feedback on findings through bi-monthly directorate Quality & Governance meetings.	Oct-23	~~Oct-23~~ N/K	Red	
Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R6. Formalise its approach to the risk assessment / mitigation, governance and escalation processes for the management of patients in surge areas. This should include environmental and equipment risk assessments, how specific clinical / surge situations are responded to, when situations are escalated and any mitigation, where and how staffing is allocated, and the numbers of and clinical criteria for the placement of patients in specific surge areas	Linked with Fire Officer, H&S officer, resus training, Moving and handling, IP&C leads to support environmental assessment for escalation areas to support mitigation of risk related to demand and acuity.	Sep-23	~~Sep-23~~ N/K	Red	

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Nov-23	2023/24	HIW	Emergency Department, Withybush General Hospital, Hywel Dda Health board. Inspection date: 21, 22, 23 August 2023	Open	N/A	Unscheduled Care (WGH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	N/A	R6. Formalise its approach to the risk assessment / mitigation, governance and escalation processes for the management of patients in surge areas. This should include environmental and equipment risk assessments, how specific clinical / surge situations are responded to, when situations are escalated and any mitigation, where and how staffing is allocated, and the numbers of and clinical criteria for the placement of patients in specific surge areas	Plan to be presented to bi-monthly directorate Quality & Governance meeting.	N/K	N/K	Red	
Feb-23	2022/23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Open	N/A	Radiology	Radiology	Head of Radiology	Director of Operations	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These competencies will be added to matrix.	May-23	~~May-23~~ ~~Jun-23~~ ~~N/K~~ ~~Aug-23~~ N/K	Red	QAST update 09/05/2023 chased, awaiting progress. 13/06/2023 - (Update taken from DITS response pack June 2023): 11/14 of the actions which were behind schedule have now been completed the remaining 3 are on target to be completed by the end of the month. HIW have recently confirmed the extension to the original timelines. The carers and comforters' policy has been updated – awaiting sign off at the end of June. This includes review of dose constraints and justification arrangements as recommended by Medical physics. The EP has been updated to included operator roles in surgical theatres. 03/07/2023 - QAST chased for update June 23 no update received. QAST update 07/09/23 all actions chased 10/08/23, o update or target date suggested. QAST update 30/10/23 service chased for an update, no update received.
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	R17. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Sep-23	~~Sep-23~~ 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.

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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.
Aug-23	2023/24	Public Service Ombudsman (Wales)	202003536	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Megan Harris	Director of Operations	N/A	R2. Update the Ombudsman on what action it has taken to comply with the recommendations set out in the Review and if there are any outstanding actions, provide the timetable and plans for their completion.	Action plans held with Ombudsman Liaison Manager	Feb-24	Feb-24	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R1. (a) Apologises for the failings identified in this report.	To reflect on the Ombudsman's report and draft an appropriate apology Letter	Nov-23	Nov-23	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R2. (b) Make a redress payment of £500 for the discomfort and distress caused by the failings identified in this report including delay in provision of pain relief, independently transferring between hospitals and the difficulties in arranging a scan when she experienced ongoing symptoms.	To include offer in the apology letter and ask for bank details. Finance to provide confirmation once paid.	Nov-23	Nov-23	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R3. (c) Shares this report with relevant staff and asks them to reflect on its findings.	Action plans held with Ombudsman Liaison Manager	Nov-23	Nov-23	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R4. (d) Reminds relevant staff in the Emergency Department (ED) of the importance of pain assessment and timely administration of pain relief.	Action plans held with Ombudsman Liaison Manager	Nov-23	Nov-23	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R5. (e) Considers the development of local guidelines for independent inter-hospital transfer.	Action plans held with Ombudsman Liaison Manager	Dec-23	Dec-23	Amber	
Oct-23	2023/24	Public Service Ombudsman (Wales)	202206868	Open	N/A	Women and Children's Services	Unscheduled Care (WGH)	Lisa Humphries	Director of Operations	N/A	R6. (f) Review the appropriateness of pathways for patients undergoing termination of pregnancy and early pregnancy problems so that patients are not asked to arrange referrals and bookings at times when struggling with their health problems.	Action plans held with Ombudsman Liaison Manager	Dec-23	Dec-23	Amber	

Reports closed on the Audit Tracker since ARAC October 2023

Report name	Lead Executive/Director
HEIW: General Internal Medicine Bronglais Hospital	Medical Director
HEIW: Obstetrics and Gynaecology Glangwili Hospital	Medical Director
Independent Review: Governance and decision making in relation to Bluestone Field Hospital	Director of Corporate Governance
Internal Audit: WGH Fire Precautions Works: Phase 1	Director of Estates, Facilities and Capital Management
Internal Audit: Follow-up: Prevention of Self Harm	Director of Nursing, Quality and Patient Experience
Internal Audit: Glangwili Hospital Women & Children's Development, issued April 2021	Director of Operations
Internal Audit: Glangwili Hospital Women & Children's Development, issued April 2022	Director of Operations
Internal Audit: Service Reset and Recovery	Director of Operations
Internal Audit: Lessons Learned	Director of Nursing, Quality and Patient Experience
PSOW: 202002558	Director of Operations
PSOW: 202104390	Director of Operations
PSOW: 202203628	Director of Nursing, Quality and Patient Experience

Reports opened on the Audit Tracker since ARAC October 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
HEIW: Revalidation Quality Review Report	Medical Director	8	Audit and Risk Assurance Committee
HIW: Emergency Department, Withybush General Hospital, Hywel Dda Health Board. Inspection date: 21, 22, 23 August 2023	Director of Operations	7	Quality, Safety and Experience Committee
HIW: National Review of Patient Flow – a journey through the stroke pathway	Director of Operations	50	Quality, Safety and Experience Committee
Internal Audit: Escalation Status Actions	Director of Corporate Governance	4	Audit and Risk Assurance Committee
Internal Audit: Board Oversight Final Internal Audit Report	Director of Corporate Governance	1	Audit and Risk Assurance Committee

Internal Audit: Deprivation of Liberty Safeguards (DoLS)	Director of Primary Care, Community and Long Term Care	4	Audit and Risk Assurance Committee
Internal Audit: Mental Health & Learning Disability Services - Timely Access	Director of Operations	7	Audit and Risk Assurance Committee
Internal Audit: NICE Guidelines	Medical Director	5	Audit and Risk Assurance Committee
Internal Audit: Quality & Safety Governance- Bronglais General Hospital	Director of Nursing, Quality and Patient Experience	7	Audit and Risk Assurance Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Block 26, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	7	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Block 22 - TY Cadell, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	8	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Block 24 - Diabetes Research Clinic, West Wales General Hospital, Dolgwili, Carmarthen. SA31 2AF	Director of Operations	9	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Block 27, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	3	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Block 28, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	10	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Cadog & Dewi wards, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	6	Health and Safety Committee

MWWFRS: Letter of Fire Safety Matters. Premises: Template 1, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Director of Operations	6	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters Premises: Hywel Dda University Health Board, Withybush Hospital, Withybush, Fishguard Road, Haverfordwest, SA61 2PZ	Director of Operations	11	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: Padarn, Gwenllian & Stem Corridor, Block 4, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF	Director of Operations	8	Health and Safety Committee
MWWFRS: Letter of Fire Safety Matters. Premises: CCU, Towy Ward & Stem Corridor, West Wales General Hospital, Dolgwili, Carmarthen, SA31 2AF.	Director of Operations	8	Health and Safety Committee
Natural Resources Wales: RSR Compliance Assessment Report (Unsealed Radioactive Sources)	Director of Operations	11	Quality, Safety and Experience Committee
Natural Resources Wales: RSR Compliance Assessment Report (Sealed Radioactive Sources)	Director of Operations	4	Quality, Safety and Experience Committee
Peer Review: Getting It Right First Time (GIRFT) Ophthalmology Review	Director of Operations	59	Quality, Safety and Experience Committee
PSOW: 202206868	Director of Operations	6	Quality, Safety and Experience Committee
PSOW: PSOW_1723 Annual Letter 2022/23	Director of Nursing, Quality and Patient Experience	4	Quality, Safety and Experience Committee
Total		**249**	

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

Report name	Lead Executive/Director	Number of recommendations	Final report received at
HIW: National Review of Maternity Services - Phase 1	Director of Operations	1	Quality, Safety and Experience Committee
Total		**1**	

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Audit Wales ISA 260 and Letter of Representation 2022/23	1	July 2023	1 - awaiting confirmation for closure	Finance	Recommendation relates to a requirement for a mechanism to capture and record annual leave for inclusion om the 2023-24 accounts. Confirmation from the Director of Workforce & OD has been obtained since the collation of data for this report noting the recommendation is complete, and will be reflected in the next paper to ARAC in February 2024.
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 are currently awaiting confirmation of funding. The Agile Digital Business Group are scrutinising the Electronic Prescribing and Medicines Administration (ePMA) business case prior submission to November 2023 public Board. 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 November 2023.
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board (October 2021)	1	December 2022	1 - awaiting confirmation for closure	Director of Operations	The Assurance and Risk team have requested confirmation if the recommendation can be closed in relation to Governance arrangements given the introduction previously of the Executive Risk Register Review process, which has now been superseded by Directorate Improving Together sessions, or if further work is required to evidence completion.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Review of Quality Governance Arrangements – Hywel Dda University Health Board (October 2021)	1	December 2022	1 - awaiting confirmation for closure	Director of Operations	The Assurance and Risk team have requested confirmation if the recommendation can be closed in relation to Governance arrangements given the introduction previously of the Executive Risk Register Review process, which has now been superseded by Directorate Improving Together sessions, or if further work is required to evidence completion.
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 awaiting a “go live” date from the national Eyecare project team following delays in the rollout of the Electronic Patient Record platform, with an update expected in Q3 of financial year 2023/24.
Delivery Unit- All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	1	October 2023	1 - Original completion dates lapsed since previous meeting	Mental Health & Learning Disabilities	The Assurance and Risk team are currently clarifying with service progress made against the recommendation, with updates to be reflected to ARAC in February 2024.
HIW - Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	1	July 2023	1 – QAST team awaiting update	Mental Health & Learning Disabilities	Awaiting clarification from the service via the Quality Assurance and Safety Team (QAST) if the recommendation can be closed as communication to support timely assessments has improved, and therefore addressing the requirement of the recommendation. Updates will be reflected to ARAC in February 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW- Emergency Department Withybush General Hospital, Hywel Dda Health Board, Inspection date: 21, 22, 23 August 2023	5	October 2023	5- Original completion dates lapsed since previous meeting	Unscheduled Care (WGH)	Timescales are currently being requested from the service via the Quality Assurance and Safety Team (QAST), with updates to be reflected to ARAC in February 2024.
HIW - Emergency Unit, GGH 05, 06 and 07 December 2022 (Publication date 17 March 2023)	4	June 2023	4 – QAST team awaiting update	Unscheduled Care (GGH)	Awaiting clarification from the service via the QAST Team if the recommendation has been implemented, or if a revised completion date is required, with updates to be reflected to ARAC in February 2024.
HIW - Mental Health Discharge Review	1	October 2023	1 – Original completion dates lapsed since previous meeting	Mental Health & Learning Disabilities	Timescales are currently being requested from the service via the QAST Team, with updates to be reflected to ARAC in February 2024.
HIW - National Review of Patient Flow – a journey through the stroke pathway	9 (8 External)	October 2023	8 - External 1 - Original completion dates lapsed since previous meeting	Unscheduled Care (WGH)	Timescales are currently being requested from the service via the QAST Team, with updates to be reflected to ARAC in February 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	2	August 2023	2 - revised completion dates lapsed since August and September 2023	Radiology	Timescales are currently being requested from the service via the QAST Team, or whether the recommendations have been implemented, with updates to be reflected to ARAC in February 2024.
Independent Review - Savings Governance Review	1	October 2023	1 – original completion date lapsed since previous meeting	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. An update on this recommendation with a timescale for implementation is being presented to ARAC and will be reflected in the next paper to ARAC in February 2024.
Internal Audit – Deprivation of Liberty Safeguards (DoLS)	3	September 2023	3 - Original completion dates lapsed since previous meeting	Primary Care	The recommendations in this report have recently lapsed, revised timescales will be requested and updates to be reflected to ARAC in February 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)	June 2022	2 – External 5 - revised completion dates lapsed	Long Term Care	WG Lead has confirmed that discharge requirements are still under review, and will be published shortly. Work is ongoing locally to review the Health Board's discharge policy in readiness, and work is being progressed through the 6 Policy Goals of the Regional Urgent & Emergency Care (UEC) Programme Delivery Group. An Internal Audit report on 'Transforming Urgent & Emergency Care (TUEC) Discharge management' is being undertaken and is due to be reported to ARAC February 2024. This report will include following up on all the recommendations in the Discharge Processes report.
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. 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 .
Internal Audit - Financial Management	1	October 2023	1 – completion date has lapsed since previous meeting	Finance	The Operational Delivery Framework was completed and reviewed during September 2023 and reviewed by the Director of Finance in October 2023. The engagement aspect of the recommendation will be implemented once structural changes have been communicated by the Director of Operations.

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	August 2023	1 – revised timescale has lapsed	Digital	A Strategic Options Appraisal is currently being reviewed and a business case for the Regional Data Repository is being prepared for the Regional Digital Group. An update will be reflected to ARAC in February 2024.
Internal Audit - Follow-up: Welsh Language Standards	1	September 2023	1 - revised timescale has lapsed since previous report	CEOs Office (Welsh Language)	Internal Audit are currently awaiting clarification from the service as to whether a steering group is still planned and have offered to assist in developing an alternative plan if this is not the case.
Internal Audit - IT Infrastructure	2	August 2023	1 – revised completion date lapsed 1 - external	Digital	The Assurance and Risk Team are liaising with relevant service leads to obtain a revised completion date, and will be reflected to ARAC in February 2024. The 'external' recommendation relates to the supply chain security workstream of the cyber programme and is currently stalled due to the lack of an All Wales Cyber assurance process from NHS Wales Shared Services Partnership (NWSSP).
Internal Audit - Quality & Safety Governance- Bronglais General Hospital	1	October 2023	1 – original completion date lapsed since previous meeting	Unscheduled Care (BGH)	The recommendation relates to carrying out thematic reviews and highlighting target areas for discussion at governance meetings. A revised completion date will be provided by the service once administrative support has been recruited.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit – Records Digitisation	3	July 2023	3 - original completion dates lapsed	Central Operations	Report re-assigned to Central Operations from the Digital Directorate agreed by the Digital Director and the Health Records Manager in September 2023. Revised timescales will be requested and updates will be reflected to ARAC in February 2024.
Internal Audit - Records Management	1	May 2023	1 - revised completion date lapsed	Central Operations	The Assurance and Risk Team are requesting clarification from IA to establish if this recommendation can be noted as implemented. IA will be undertaking a follow up Records Management audit in Q3/4 of 2023/24.
Internal Audit - Regional Integration Fund (RIF)	1	September 2023	1 – revised completion date lapsed since previous meeting	Finance	Finance are awaiting responses from the Regional Partnership Board (RPB) lead who will be finalising and signing the Memorandum of Understanding outlining the arrangements for Regional Integration Funding for the next financial year, upon which the recommendation will be completed.
Internal Audit - Safety Indicators – Pressure Damage & Medication Errors	1	June 2023	1 – original completion dates lapsed	Nursing	Deputy Director of Nursing, Quality & Patient Experience is clarifying with Heads of Nursing if this recommendation has been implemented across all sites, or if revised completion dates are required, and updates will be reflected to ARAC in February 2024.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Theatre Loan Trays & Consumables	1	October 2023	1 – Original completion date lapsed since previous meeting	Scheduled Care	This recommendation is assigned to the Hospital Sterilisation and Decontamination Unit (HSDU) service who are working with finance colleagues to review costs associated with the reprocessing of private sector owned instrument sets. The Assurance and Risk Team are currently awaiting a revised timescale for completion of this recommendation from the Head of Decontamination.
NHS Wales Cyber Resilience Unit - Cyber Assessment Framework Report	4 (2 External)	August 2023	1 External – revised timescale lapsed since previous meeting 1 External – Original completion date lapsed since previous meeting 2 – Original completion date lapsed since previous meeting	Digital	The 'external' recommendations relate to policies, procurement processes, supply chain agreements, contracts, and communication security requirements in Service Level Agreements with external suppliers and contractors. These have stalled due to the delays in receiving the guidance documents, assurance process and framework from NHS Wales Shared Service Partnership (NWSSP). 2 recommendations, which fall under the Asset Management and Business Continuity and Disaster Recovery Workstreams cannot be progressed due to the lack of funding for the tools required to progress.

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)	Recommendation to be discussed with Director of Operations for closure. The Strategic review has now taken place and the service have recruited a locum consultant to support the previous lone working consultant.
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 lung cancer 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.
Peer Review - Congenital Heart Defect Provider (October 2021)	5 (1 external)	October 2022	1 external– awaiting national roll out 3 – revised timescale lapsed since previous meeting 1 – revised timescale lapsed in October 2022	Women and Children's Services	The external recommendation is unable to be progressed due to delays with the roll-out of national templates and guidance. The Congenital Heart Defect Network have confirmed there is no further action required by the Health Board at this time. 3 recommendations relating to the availability of a Practitioner Psychologist have not progressed due to lack of funding. 1 recommendation, relating to Local Children's Cardiology Centres having cardiac physiologists trained in congenital echocardiography has not progressed due to a lack of capacity within the Health Board.

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	4 (1 External)	September 2023	1 - External 3 - Original 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 original completion dates for 3 recommendations have lapsed since the previous meeting. The Assurance and Risk Team will be seeking updates on this recommendation in preparation for the next ARAC meeting in February 2024.
Public Health Wales - Llwynhendy Tuberculosis Outbreak External Review	7 (6 External)	June 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 in place. The service has also discussed additional support from the Health Board's Sampling and Vaccination team if needed for screening. Awaiting confirmation if the recommendation can be closed.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
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 will be seeking updates on these recommendations which will be reflected to ARAC in February 2024.
Welsh Risk Pool - A National Review of Consent to Examination & Treatment Standards in NHS Wales	1	October 2023	1 – revised completion date lapsed since previous meeting	Mental Health & Learning Disabilities	The latest review of the Transfusion policy is in progress by the task and finish group. The Blood transfusion manager is leading on this review and will be progressing things over the next few weeks.
Total number of N/K Recs	**77**				