Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 October 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Since the previous report, 8 reports have been closed or superseded on the Audit Tracker, and 14 new reports have been received by the Health Board, as detailed in Appendix 2.

As of 14 September 2023, the number of open reports has increased from 105 to 111. 40 of these reports have recommendations that have exceeded their original completion date, an increase from the 33 reports previously reported in August 2023. This detail can be found in the 'Audit Tracker Summary Per Service / Directorate' table later in the SBAR.

There is an increase in the number of recommendations where the original implementation date has passed since the previous meeting, from 151 to 164. However, the number of recommendations that have gone beyond six months of their original completion date has reduced from 57 to 54, as reported in August 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.

It is noted that since the previous ARAC report, services have been impacted by the remedial works at Withybush General Hospital (WGH) relating to reinforced aerated autoclaved concrete (RAAC), and ongoing financial recovery work. However good engagement has continued with services despite these pressures.

	Open reports at ARAC August 23	New reports since August 23	Closed reports since August 23	Open reports at ARAC October 23	Open reports which are overdue[1]	Red recommendations[2]	Red recommendations overdue by more than 6 months
AW	5	2	0	7	3	5	3
Llais[3]	3	0	0	3	2	4	2
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	5	1	0	6	2	6	5
HEIW	3	0	0	3	3	15	1
HSE	0	0	0	0	0	0	0
HIW	10	3	3	10	5	29	7
HTA	0	0	0	0	0	0	0
Independent Review	1	0	0	1	1	3	0
IA	29	2	1	30	14	45	17
Internal Review	0	0	0	0	0	0	0
MHRA	1	0	0	0	0	0	0
MWWFRS	29	2	0	31	0	1	0
NHS Wales Cyber Resilience Unit[4]	1	0	0	1	0	9	0
Peer Reviews	8	0	0	8	5	37	15
PSOW - S23 (Public interest)	0	0	0	0	0	0	0
PSOW - S21	6	4	4	6	2	2	1
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	0	4	0
TOTAL	**105**	**14**	**8**	**111**	**40**	**164**	**54**

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 **409 open recommendations** (a decrease from the 438 reported in August 2023) on the audit tracker, and detailed in Appendix 1 (which includes the 30 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 (previously CHC) reports relating to inspections of independent contractors (i.e. GP and dental practices not managed by the Health Board). The practices remain directly accountable for implementing these recommendations.

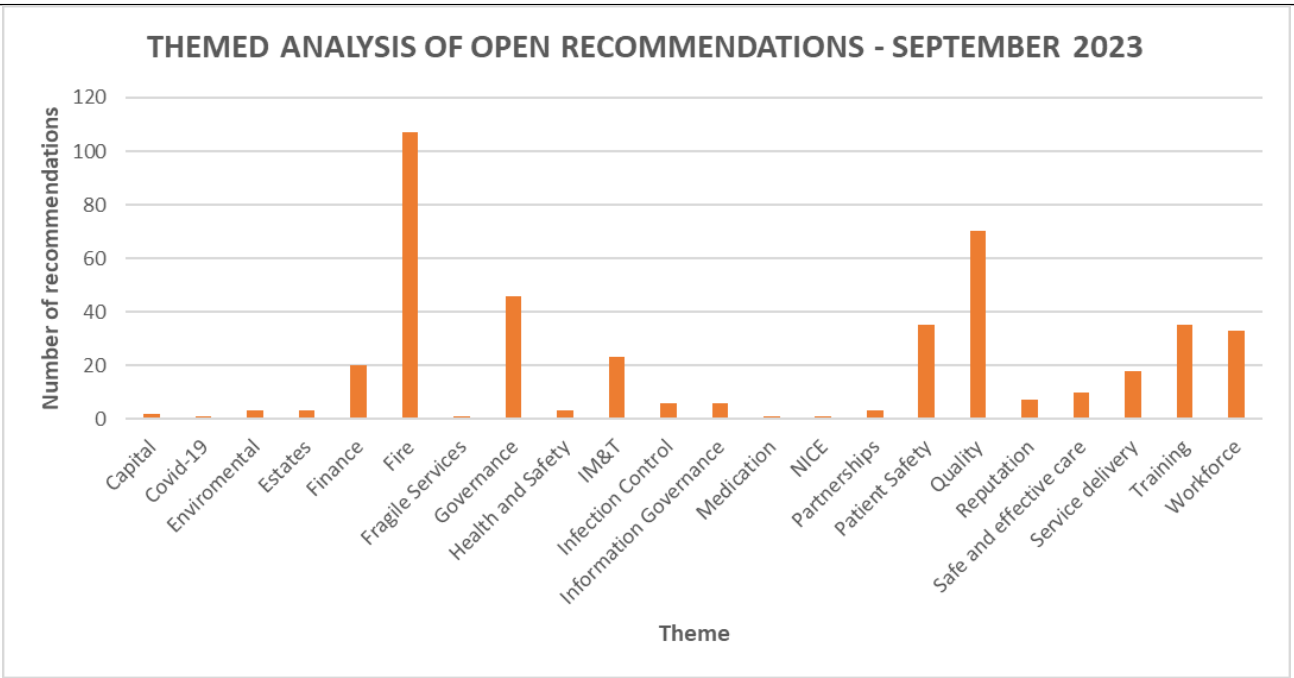
Appendix 2 details reports which have been added to the Audit tracker since August 2023.

There are 89 recommendations that do not have revised timescales (where the original date has passed and not known (N/K) is reported), a slight decrease from the 91 previously reported. Individual recommendations are included in Appendix 3, which details the date at which recommendations became N/K, and the reason why they are N/K.

The 89 recommendations are comprised of:

- 4 recommendations which have recently lapsed to N/K status since August 2023;
- 18 recommendations from 3 HEIW reports, and a Royal College of Physicians report all reassigned to the Medical Directorate between July and August 2023;
- 4 recommendations from the Getting It Right First Time (GIRFT) General Surgery peer review aligned to Scheduled Care;
- 14 recommendations noted as 'external', which are considered to be outside the gift of the Health Board to currently implement; and
- 49 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 September 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 14 September 2023 is included on page 7, including trends since the last report to ARAC in August 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 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 August 2023 (detail for each service can be found in the table on page 7):

Services of Improving Trend

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

Acute Services

4 recommendations which were within the gift of the Health Board to implement, as raised in the HIW 'National Review of WAST' report issued in September 2021, have been confirmed as implemented by the Director of Secondary Care in September 2023. Progress updates have been forwarded to the Quality Assurance and Safety Team (QAST) in line with governance processes on HIW activity, and awaiting formal approval to close this report from the Director of Nursing, Quality and Patient Experience. In addition, a further recommendation

raised in the IA report 'Service Reset and Recovery' has been confirmed as completed by the Director of Secondary Care in September 2023, with IA satisfied to close the report.

Cancer Services

A concerning trend was noted in the previous Audit Tracker paper due to lack of progress updates received resulting from operational pressures. A full progress update has been received since the previous ARAC meeting on the outstanding recommendations from the Peer Review on Colorectal Cancer, and whilst there has been no change in the number of outstanding recommendations, revised timescales have been obtained ranging between March 2024 and January 2025, reflecting the ongoing work with ARCH.

MH&LD

A concerning trend was noted in the previous Audit Tracker paper due to the number of outstanding recommendations assigned to the service. Since the previous report, the total number of open recommendations has decreased from 69 to 58. While the number of overdue recommendations remains at 15, 5 of these have only recently lapsed into this category. The number of recommendations overdue by 6 months has decreased from 10 to 7 since August 2023. 4 recommendations currently do not have revised timescales, however these are being actively sought by the QAST team via the AMAT system. The Assurance and Risk Team continue to have good engagement with the service, and the Audit tracker is discussed monthly via Directorate governance meetings which is attended by senior management ensuring ongoing scrutiny of recommendations.

NQPE

A concerning trend was noted in the previous Audit Tracker paper due to an increase in the number of overdue recommendations. Since the previous report, the number of overdue recommendations has slightly decreased from 12 to 11, with two of these only recently lapsing into this category. Revised completion dates have been obtained for 3 recommendations since the previous report, resulting in the service having 5 recommendations for which timescales are currently N/K as at September 2023 (two which had completion dates previously noted of July and August 2023). The number of recommendations overdue by more than 6 months has remained at 3, with two of these relating to the Internal Audit on Falls Prevention with revised completion dates ranging to October 2023. The remaining recommendation relates to a PSOW recommendation whereby the Health Board has been requested to submit further evidence by September 2023. Progress against these will be reflected in the next Audit Tracker paper. The Assurance and Risk team continue to work closely with the service, with continued engagement with the Deputy Director of Nursing, Quality & Patient Experience.

Scheduled Care

A concerning trend was noted in the previous Audit Tracker paper due to the high number of overdue recommendations with unknown timescales (N/K). Since the previous report, a comprehensive review of the Audit Tracker by senior management within the Directorate has been undertaken, resulting in the number of open recommendations decreasing from 49 to 35, and the number of N/Ks decreasing from 22 to 6. While there has been an increase in the number of total overdue recommendations from 26 to 28, it is noted that this is due to the completion dates for recommendations within the Getting It Right First Time (GIRFT) report for General Surgery have lapsed since the previous ARAC meeting in August. 4 of the outstanding N/K recommendations require input from clinical leads to ascertain revised completion dates or confirmation of their implementation, and this will be reflected in the next Audit Tracker paper in December 2023.

Since the preparation of the Audit Tracker report, a Getting It Right First Time (GIRFT) report has been received by the Directorate in relation to Ophthalmology, and contains 59

recommendations, some of which may supersede the existing recommendations from the historic reports currently assigned to the service. A review of all recommendations will be undertaken by the Directorate to determine if any historic recommendations can be closed due to them being superseded, and these will be presented to the Executive Director of Operations for approval to close, if required. Updates will be reflected in the Audit Tracker paper due to the December 2023 ARAC meeting.

The Assurance and Risk team continue to work closely with the service, including continuous engagement with the General Manager for Scheduled Care.

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 September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Acute Services	1 ↓	1 →	6 ↓	0 ↓	0 ↓	• 1 HIW National Review on WAST - 4 recommendations closed since the previous meeting, and 6 recommendations remain with an 'External' status • 1 IA report on Service Reset and Recovery – awaiting confirmation from IA to close report.
Cancer Services	1 →	1 →	2 →	2 →	2 →	• 1 Peer Review on Colorectal Cancer – 2 outstanding recommendations overdue by more than 6 months, with revised completion dates of March 2024 and January 2025.
Cardiology	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
CEO Office (Welsh Language)	1 →	1 →	2 →	2 →	2 →	• 1 follow-up IA report on Welsh Language Standards - 2 recommendations overdue by more than 6 months, 1 recommendation with a revised timescale which is 'not known' (N/K) and 1 recommendation with revised completion date of September 2023.
Community – Carmarthen-shire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Community – Ceredigion (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Community - Pembrokeshire (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*
Central Operations	3 ↑	1 →	19 ↑	11 →	3 →	• 1 Peer Review on Out of Hours – 12 recommendations, 7 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. 1 recommendation with a revised timescale which is 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, 1 with a revised timescale which is N/K. The Record Digitisation report has been reassigned from Digital and revised timescales are being requested from the service.

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Digital and Performance	4 ↓	1 →	23 ↓	15 →	3 →	• 1 IA report on Fitness for Digital – Use of Digital Technology - 2 recommendations, 1 of which is overdue by more than 6 months without a revised timescale (N/K) and the other overdue with a revised completion date of December 2023. • 1 NHS Wales Cyber Resilience Unit report on Cyber Assessment Framework – 14 recommendations (consisting of 31 sub-recommendations), 9 of which are overdue with revised completion dates ranging between November 2023 and July 2024. 1 recommendation noted as 'external'. Progress of these recommendations are monitored via Sustainable Resources Committee (SRC) In-Committee bi-monthly. • 1 IA report on IT Infrastructure - 6 recommendations, 1 of which is overdue by more than 6 months without a revised timescale (N/K), 1 which is overdue without a revised timescale (N/K), 1 which is overdue and has a revised completion date of September 2023 and 1 recommendation noted as 'external'. • 1 IA report on Cyber Security - 1 recommendation reopened by IA who have requested additional work be undertaken to fully complete. Recommendation overdue by more than 6 months with a revised timescale of December 2023. • 1 IA report on Records Digitisation reassigned to Central Operations Directorate.
Director of Operations	2 →	1 →	9 →	5 →	1 →	• 1 WRP report A National Review of Consent to Examination & Treatment Standards in NHS Wales – 7 recommendations of which 4 are overdue, with revised timescales varying from September to 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.
Estates	35 →	1 ↓	110 →	2 →	0 →	• The number of recommendations has increased from 100 to 110 (5 of these recommendations are from 4 IA reports, with the remainder from the 4 MWWFRS Enforcement Notices (ENs) and 18 Letters of Fire Safety Matters (LOFSMs)). • The number of overdue recommendations has increased from 0 to 2, however since the audit tracker was run off for this report confirmation has been received from the service that the recommendations have been implemented and will be reflected in the next Audit Tracker report to ARAC in December 2023. • 2 new LOFSMs for PPH have been received since the previous report. • 1 EN and 8 LOFSMs have all recommendations completed. Assurance and Risk Team to confirm if MMWFRS approve the closure of the reports on the audit tracker. • All MWWFRS recommendations are overseen by Health and Safety Committee (HSC) via the Fire Safety Update Report provided to every meeting.

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Finance	5 ↑	3 ↑	12 ↑	7 ↑	0 →	• 1 new Audit Wales report on Audit Wales ISA 260 and Letter of Representation 2022/23 – 1 recommendation awaiting a progress update and timescale. • 1 new Independent Review on Savings Governance Review – 6 recommendations, 1 of which is overdue with a revised timescale of October 2023. • 1 IA report on Financial Management – 1 overdue recommendation without a revised timescale (N/K). • 1 IA report on Strategic Change Programme Governance - 3 recommendations, 2 without revised timescales (N/K) and 1 with a revised completion date of September 2023. • 1 IA report on Regional Integration Fund – 1 overdue recommendation without a revised timescale (N/K).
Governance	3 ↑	1 →	4 →	2 →	0 →	• 1 Independent Review on Governance and Decision Making in relation to Bluestone Field Hospital – 2 overdue recommendations, with revised completion dates of September and November 2023. • 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 since previous ARAC, and awaiting formal approval for closure.
Medical	7 ↑	6 ↑	33 ↑	24 ↑	4 ↑	• 1 RCP report on Visit to Ysbyty Bronglais, reassigned from Bronglais General Hospital (BGH) to Medical Directorate since previous report - 3 recommendations overdue by more than 6 months without revised timescales (N/K). • 1 HEIW report on Surgical Specialties, Glangwili General Hospital (GGH) – 7 recommendations, of which 6 recommendations are overdue without revised timescales (N/K) and 1 which is noted as 'external'. • 1 HEIW report on General Internal Medicine (BGH) – 6 recommendations, of which 4 recommendations are overdue without revised timescales (N/K) and 2 which are noted as 'external'. • 1 HEIW report on Obstetrics and Gynaecology Glangwili Hospital – 5 recommendations are overdue without revised timescales (N/K) of which 1 by more than 6 months • 1 IA report on Job Planning – 4 recommendations are overdue without revised timescales (N/K). • 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 – 1 recommendation overdue without a revised timescale (N/K). IA are awaiting further evidence to close this recommendation.

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Medicines Management	1 →	1 →	1 →	0 →	0 →	• 1 AW report on Medicines Management in Acute Hospitals - 1 'external' recommendation.
MH&LD	11 ↑	4 ↓	58 ↓	15 →	7 ↓	• 1 new DU report on Review of Memory Assessment Services - 1 recommendation with completion date of March 2024. • 1 AW report on Review of Mental Health and Learning Disabilities Directorate Governance Arrangements – 5 recommendations, 1 of which is 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 All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults – 1 recommendation on track for March 2024, and 1 recommendation overdue which has a revised date that is not known (N/K). • 1 DU report on All Wales Review of Primary & Secondary Mental Health Services for Children & Young People – 2 recommendations with completion dates ranging from October to December 2023. • 1 DU report on Review of Psychological Therapies in Wales - 3 recommendations with timescales to December 2023. • 1 HIW report on Mental Health Discharge Review – 32 recommendations on track with varying timescales to March 2024, 4 recommendations overdue, 2 of which have revised timescales which are not known (N/K). • 1 HIW National Review of Mental Health Crisis Prevention in the Community - 3 recommendations overdue, of which 1 by more than 6 months, with revised completion dates not known (N/K). • 1 HIW St Caradog Ward (2021) - 2 recommendations overdue by more than 6 months with revised dates not known (N/K). • 1 HIW Bryngofal Ward – Prince Phillip Hospital, issued October 2022 - 2 recommendations overdue by over 6 months, both of which have revised timescales not known (N/K). • 1 IA on Prevention of Self Harm (Follow up report) - 2 recommendations overdue by more than 6 months, with revised completion dates of October 2023.

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
NQPE	9 ↑	6 ↑	24 ↑	11 ↓	3 →	• 1 new PSOW report 202101889 - 8 recommendations with timescales of September 2023. • 1 new PSOW report 202102692 - 2 recommendations with timescales of January 2024. • The number of overdue recommendations has decreased from 12 to 11. The details of recommendations that have passed their original completion dates are below: ○ 1 new PSOW report 202203628 - 1 recommendation overdue with a revised timescale N/K. ○ 1 CHC report on Accident & Emergency Departments – 2 overdue recommendations, 1 of which have timescales currently N/K. Deputy Director of Nursing, Quality & Patient Experience is in the process of clarifying with Heads of Nursing at the acute sites if these recommendations have been implemented, or if revised completion dates are required. ○ 1 IA report on Falls Management – 3 overdue recommendations, 2 which are overdue by more than 6 months, with revised completion dates ranging from September 2023 to March 2024. 1 'External' recommendation. ○ 1 IA Patient Experience – 1 overdue recommendation with revised completion date of October 2023. ○ 1 IA Safety Indicators – Pressure Damage and Medication Errors – 3 overdue recommendations with revised timescales that are N/K. Deputy Director of Nursing, Quality & Patient Experience is in the process of clarifying with Heads of Nursing at the acute sites if these recommendations have been implemented, or if revised completion dates are required. ○ 1 PSOW report 202002558 – 1 overdue recommendation by over 6 months with revised date of September 2023. 1 IA report on Lessons Learned- 2 recommendations with completion dates of September and December 2023. • PSOW reports 202101488 and 202003189 closed since the previous meeting.
Pathology	0 ↓	0 ↓	0 ↓	0 ↓	0 ↓	• 1 MHRA report for WGH closed since the previous meeting.
Service	**Open reports as at September 23**	**Overdue reports As at September 23**	**Total number open recs September 23***	**Total overdue (red) recs September 23**	**Of which overdue by more than 6 months**	**Comments**

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Primary Care, Community and Long Term Care	2 ↓	2 →	8 ↓	5 →	5 →	• 1 IA Discharge Processes report – 2 'external' recommendations and 5 overdue by more than 6 months without revised timescales (N/K). The planned Transforming Urgent & Emergency Care Programme Internal Audit scheduled for Quarter 3 2023/24, has been delayed due to awaiting national guidance with regards to Discharge Processes. • 1 WLC report – 1 'external' recommendation. • 1 PSOW report 202200545 closed since the previous meeting.
Public Health	1 ↑	0 →	2 ↑	0 →	0 →	• 1 New PSOW report 202003536 – 2 recommendations due for completion by September 2023 and February 2024.
Radiology	1 →	0 →	8 ↓	7 ↓	1 ↑	• 1 HIW IRMER report GGH – 8 recommendations, 7 of which are overdue, 2 with revised timescales of November 2023 and 5 without revised timescales (N/K).
Scheduled Care	8 →	5 →	35 ↓	28 ↑	13 →	• 1 IA report on Theatre Loan Trays and Consumables – 4 recommendations with completion dates between October 2023 and December 2024. A follow-up review of this audit report is being undertaken during Quarter 3/4. • 1 PSOW report 202104390 – 1 recommendation due for completion by September 2023. • 1 Peer Review on Getting It Right First Time (GIRFT) General Surgery – 16 recommendations, 1 of which is on track for completion by November 2023, 11 which are overdue with revised timescales ranging between October 2023 and March 2024, and 4 which are overdue without revised timescales (N/K). • 1 Peer Review on Getting It Right First Time (GIRFT) Orthopaedic Review – 5 recommendations which are overdue by more than 6 months, with revised timescales between October and December 2023. • 1 CHC report on Eye Care Services in Wales (March 2022) – 3 recommendations overdue by more than 6 months, 2 with revised timescales of March 2024, and 1 'external' recommendation with an unknown timescale (N/K). • 2 DU reports – 5 recommendations overdue by more than 6 months with revised completion dates between September 2023 and March 2024. • 1 HIW report – 1 recommendation overdue by more than 6 months, with a revised completion date of December 2023.

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Strategic Development & Operational Planning	5 →	2 →	19 ↓	9 ↑	2 →	• 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 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 IA report on Glangwili Hospital Women & Children's Development – 1 recommendation with completion date of October 2023. • 1 Peer Review – Planning Arrangements in Hywel Dda University Health Board – 2 recommendations on schedule for completion by December 2023
Therapies (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A – No open reports at present.*
USC BGH	0 ↓	0 ↓	0 ↓	0 ↓	0 ↓	• 1 RCP report re-assigned from BGH to the Medical Directorate since the previous meeting.
USC GGH	1 →	0 →	5 ↓	4 ↓	0 →	• 1 HIW report on the Emergency Unit at GGH – 1 recommendation on schedule for completion by September 2023. 4 recommendations overdue with revised completion dates N/K.
USC PPH	3 ↑	2 →	8 ↑	7 ↑	2 →	• 1 new HIW report on Prince Philip Hospital Minor Injuries Unit- 13 recommendations, 8 implemented, 1 which is on track for completion by December 2023, and 5 recommendations overdue with revised timescales (N/K). • 1 Peer Review Lung Report, issued January 2020, has been added to the audit tracker - 1 recommendation overdue by more than 6 months without a revised timescale (N/K). • 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.
USC WGH (*N/A*)	0 N/A	0 N/A	0 N/A	0 N/A	0 N/A	*N/A - No open reports at present.*

Service	Open reports as at September 23	Overdue reports As at September 23	Total number open recs September 23*	Total overdue (red) recs September 23	Of which overdue by more than 6 months	Comments
Women & Children	4 ↓	1 ↓	10 ↓	7 ↓	6 →	• 1 new HIW report on Bronglais Hospital Maternity Unit – 2 recommendations due for completion by September 2023. • 1 IA report on Glangwili Hospital - Women & Children's Development, issued February 2023 – 1 recommendation on track for completion by December 2024. • 1 Peer Review – 7 recommendations, 6 of which are overdue by more than 6 months with revised completion dates of October 2023, and 1 'external' recommendation. • 1 IA report on Glangwili Hospital Women & Children's Development, (April 2022) - 5 recommendations noted as complete, and awaiting confirmation from IA to close the report. • 1 HIW report on Glangwili – Maternity Services closed since the previous meeting. • 1 HIW report on Angharad Ward, Bronglais Hospital closed since the previous meeting.
Workforce & OD	2 ↑	0 →	11 ↑	0 →	0 →	• 1 new AW report Review of Workforce Planning Arrangements- 6 recommendations with varying timescales to April 2025. • 1 IA report Agency & Rostering - 5 recommendations on track for completion with timescales to September 2023.
Total	**111**	**40**	**409**	**164**	**54**	

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

Argymhelliad / Recommendation

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

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

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

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

	UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance/Board Secretary

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

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
AW_295A2015	Jun-15	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	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Jun-16	N/K	External	15/03/2022- recommendation placed back on the audit tracker from the Strategic Log. A funding request is currently being consider by Digital Health and Care Wales (DHCW) to support the establishment of a small clinical & technical project team to progress this work within the HB. This forms one of WG priorities and has a timescale of 3-5 years for full implementation across Wales. 13/04/2022- agreed with Director of Primary Care, Community and Long Term Care that this recommendation will be noted as 'external' as this is being consider by DHCW and is being implemented across Wales. 30/12/2022- WG have provided some funding for a small pre-implementation team that is now in place to develop local business case to secure funding for Electronic Prescribing and Medicines Administration (ePMA). Nationally there are currently 3 systems that have been approved on the framework and once funding approved then a mini-procurement process will be undertaken to secure most appropriate system for the UHB. 28/06/2023- ePMA business case to be submitted to WG.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	AW_2360A2021-22_001	High	R1. Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked.	As part of Targeted Intervention, the Health Board is undertaking an assessment of its planning maturity, incorporating the alignment of plans. In addition, an Independent Review is being conducted by Sally Attwood on behalf of Welsh Government. Once complete the Health Board will develop action plans to respond to both of these pieces of work. The capacity and role of the planning function will be important considerations within this, see below for an update on capacity.	Sep-21	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - 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.
AW_2360A2021-22	Jun-21	Audit Wales	Structured Assessment 2021: Phase 1 Operational Planning Arrangements	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Director of Strategy and Planning	Director of Strategy and Planning	AW_2360A2021-22_002	High	R2. The planning team have adopted a 'business partnering' approach to support the development of the quarterly operational plans which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process is developed across all team members.	The Health Board has recently (January 2023) transferred the commissioning function in to the Planning Directorate. The alignment and amalgamation of the Planning and Commissioning team has provided additional resilience within the Directorate. However, it is worth noting the commissioning team only consisted of 2.0 WTEs (with 1.0 WTE split between Planning and Commissioning) and are responsible for a budget of circa £170m. As part of Targeted Intervention, there is an Independent Review being conducted by Sally Attwood on behalf of Welsh Government. It is anticipated this will consider the capacity and capabilities within the team, which the Health Board will then consider how best to respond.	Mar-22	Mar-24	Red	22/02/2023 - The WG Review is underway and will report back to the Health Board in March 2023, at which point the Health Board will develop a further action plan. 22/02/2023 - This recommendation supersedes the original recommendations. These refreshed recommendations were reported to ARAC in February 2023. Recommendation to remain red RAG status as as the original completion dates are based on the timescales provided in the original report. 01/06/2023 - 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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b3	High	R3b.3. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales).	Dec-21	~~Dec-23~~ 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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_003b4	High	R3b.4. Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some risks are recorded more than once, are not co-ordinated across service areas and there is also potential that the impact of a combination of separate risks could lead to critical consequences for services. Specific risks for the General Surgery Team are also not included in the Scheduled Planned Care Directorate risk register. The Health Board needs to strengthen its management of risks at an operational level by: b) putting arrangements in place to ensure that the management of risks are coordinated across operational teams and that mechanisms are in place to identify when the combination of a number of risks across service areas could lead to an increased severity of risk.	During the ongoing pandemic, risks continue to be managed on a daily basis however, they have not always been captured on the Datix Risk system due to operational capacity. As outlined in R2, a review of capacity across the operational and Corporate functions will be undertaken teams to ensure a consistent approach to managing assurance, risk and safety. In addition to this: iv) Interim work to be undertaken on the current Datix Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.	Dec-21	~~Jul-22~~ 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.
AW_2583A2021-22	Oct-21	Audit Wales	Review of Quality Governance Arrangements – Hywel Dda University Health Board	Open	N/A	Director of Operations	Governance	Cathie Steele	Director of Operations	AW_2583A2021-22_004	High	R4. The approach taken by operational managers to risk management is inconsistent and there is a lack of ownership and accountability of some risks at an operational level. The Health Board should provide support to enable senior managers across the operational structure to take ownership and be accountable for their risk management responsibilities including the need to address the issues set out by the recommendations in this report.	This will be addressed as part of the review outlined in R2 and R3.	Dec-22	~~Dec-22~~ N/K	Red	21/11/2021- the audit tracker will be updated following the reviewed/revised management response reported to ARAC in December 2021. 17/01/2022- updates requested by 31/01/2022. 22/02/2022- original timescale corrected to December 2022 (originally noted in the tracker as December 2021 in error). 12/08/22- New process in place through operational risk review meetings to review operational level risks by Director of Operations and Director of Nursing, Quality and Patient Experience, and reporting of risks to committees. 01/09/2022- Discussed during recommendation Review Process with Director of Nursing, Quality and Patient Experience, who believes this recommendation may be able to be closed. Head of Assurance and Risk to obtain confirmation from Director of Operations. 20/09/2022- Director of Operations informed report will now be transferred to him, as all recommendations under the remit of the Director of Nursing, Quality and Patient Experience have been implemented. Lead Directorate amended from Nursing to Acute Services. Assistant Director of Assurance and Risk to discuss these recommendations in further detail with Director of Operations in early October. 23/03/2023 - Directorate Improving Together Sessions commenced in January 2023, which now supersede the operational risk review meetings, of which the generated TOAs are monitored via DITS, as we as via Senior Operational Business Meetings. To confirm with Director of Operations in April 2023 that the recommendation can now be closed. 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.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_002	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 associatedgovernance arrangements progresses as a matter of urgency.	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	Dec-23	Dec-23	Amber	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.
AW3273A2022	Dec-22	Audit Wales	Structured Assessment 2022	Open	N/A	Governance	Governance	TBC	TBC	AW3273A2022_006	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_001a2	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a) Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b) Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	To undertake annual reviews of the planned BPPAG agendas, ensuring that strategic and operational plans are discussed and monitored at the appropriate time.	Sep-23	Sep-23	Amber	31/08/2023 - BPPAG agenda and workplan reviewed annually, and next scheduled for March 2024. This requirement is to be reflected in the revised TORs as noted in the progress udpate above.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_001a3	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a) Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b) Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	To ensure that updates to the Table of Actions (TOAs) arising from previous BPPAG meetings are provided in writing in advance of the meeting to ensure appropriate time management of meetings.	Sep-23	Sep-23	Amber	31/08/2023 - verbal updates are currently provided at the meetings in a swift manner, with TOAs sent in advance of the meeting, however written responses to be implemented in advance of the September 2023 meeting, and included within the revised in the TORs.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_001b	N/A	R1. The Business Planning and Performance Group (BPPAG), although operating well, has a very full agenda. In addition, there is a lack of clarity around how information from this group is escalated to the Board. The Health Board and Directorate should: a) Critically review the contents of the BPPAG agenda to ensure it is manageable within the time; and b) Clarify the route of escalation of information from the BPPAG to the Board and its committees, ensuring that reporting requirements are streamlined and reduce duplication.	Matters of concern raised in BPPAG are escalated to the Director of Operations' Senior Operational Business (SOB) meetings, which are held monthly. Matters requiring the attention of Board or its committees can be discussed in this forum, and advised on the appropriate escalation route required. Matters of concern are also discussed via the recently implemented Improving Together sessions, which are attended by Executives and Directorate Senior Management.	Sep-23	Sep-23	Amber	31/08/2023 - matters are escalated to the monthly SOB meetings, which is attended by the Director of Mental Health. Revised TORs to reflect the escalation process and corresponding reporting requirements.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_002b	N/A	R2. There is uncertainty within the Directorate of the thresholds for escalation of risks and issues, which could affect the ability of the Board to be assured. The Health Board should work with the Directorate to improve its understanding of the escalation and deescalation of risks.	Directorate to implement the defined thresholds and/or performance metrics in order to assist in the escalation and de-escalation of risks, with training to be provided to relevant staff, supported by the Assurance and Risk Team.	Dec-23	Dec-23	Amber	31/08/2023 - deep dive of service risks at BPPAG and QSE, and individual serivce risk review meetings to commence, which will promote discussion on the escalation of risks and defining thresholds. This is on course to be embedded by December 2023.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_004a	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements.	Dec-23	Dec-23	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_004b	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed.	Dec-23	Dec-23	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_004c	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_004d	N/A	R4. The clinical audit programme has been impacted by the pandemic and changes in leadership. The Directorate should ensure that a full clinical audit programme is reinstated and operational.	Update reports on progress of the clinical audit programme to be provided to MHLD QSE in order to provide oversight on outcomes.	Mar-24	Mar-24	Amber	31/08/2023 - Medical Staffing Ccommittee 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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_005a1	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	The Health Board routinely conducts staff surveys. The Directorate to undertake Directorate-specific surveys in order to inform future staff engagement plans, and to highlight any concerns which staff may have requiring the attention of Directorate senior management.	Dec-23	Dec-23	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_005a2	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms.	Mar-24	Mar-24	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_005b	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Continue to promote on a regular basis a regular approach to leadership visibility and engagement visits across clinical areas as early as possible	Jun-23	~~Jun-23~~ 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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_005c	N/A	R5. Staff feel that there are poor relationships with senior management (both within the Directorate and at an Executive level), with a perception that mental health and learning disabilities are not a priority, and a sense of staff not being listened to or valued. The Health Board should work with the Directorate to: a) Ensure mechanisms to listen to staff and encourage dialogue are strengthened, and having the desired effect on improving staff engagement; b) Increase senior management visibility across the Directorate; and c) Include engagement and culture change as part of the Directorate's organisational development work.	Engagement and culture change to be included while developing the Directorate Staff Engagement and Organisational and Development Plan	Mar-24	Mar-24	Amber	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.
AW_3507A2023	Feb-23	Audit Wales	Review of Mental Health and Learning Disabilities Directorate Governance Arrangements	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Director of Mental Health and Learning Disabilities	Director of Operations	AW_3507A2023_006	N/A	R6. There are significant vacancies within the Directorate which are affecting the ability of the service to meet demand in a timely fashion. Although the Directorate has developed an embryonic workforce management group, there needs to be a more formal approach. The Directorate should develop a formal and targeted approach to address recruitment hotspots and ensure sustainability.	Work has been undertaken by each service within the Directorate to identify significant vacancies. These findings are to inform the development of an overarching Directorate Recruitment and Retention Plan, which will be aligned to wider Health Board strategic objectives and wider national priorities. The development of the Recruitment and Retention Plan will be completed and overseen by the MHLD Workforce Group, which is attended by Heads of Service and Professional Leads monthly.	Dec-23	Dec-23	Amber	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 regsiter int erms 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.
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_001	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	
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_002	Medium	R2. We found that there are several regional transformation projects at various stages, which have workforce implications and will need regional workforce modelling and plans. The Health Board should ensure these are adequately reflected in workforce plans to ensure it has the resources needed to support their development.	We are alert to ensuring that the needs of the Regional Workforce Planning activity is met, and are reflecting on how best we can approach this. At present, this is being absorbed through ARCH, Mid & West Wales Group and the Regional Board for Workforce. Resources for a) modelling and planning the workforce and b) associated workforce pipeline developed to ensure resource for delivery of the programmes themselves will be explored in partnership with other HB's and wider partners. A joint solution would be preferable however mitigations of risk may need to be introduced in the interim.	Apr-24	Apr-24	Amber	
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_003	Medium	R3. We found that service leads generally understood their role in workforce planning but operational pressures did not allow them sufficient time to 'think strategically' to develop solutions. The Workforce Planning Team should develop a process to ensure services Page 32 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health Boardroutinely receive support with workforce planning, for example through adopting a workforce planning business partnering model.	WOD does not have a Business Partnering Model we have 3 distinct teams which deliver on supporting cultural development (ODRM's); our operational workforce colleagues who facilitate change (OCP processes) and the workforce planning team. We are working collaboratively across WOD and with service leads to test our approaches to supporting services in the short, medium and long term. An evaluation will be undertaken and a paper on value of approaches in March 2024.	Apr-24	Apr-24	Amber	
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_004	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	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_005	High	R5. We found that in the absence of a clear implementation plan supporting the 10-year workforce strategy, it is difficult to gauge the progress and impact of its delivery. We recognise that the Health Page 33 of 36 - Review of Workforce Planning Arrangements – Hywel Dda University Health BoardBoard is refreshing its workforce strategy. But in the interim it shouldupdate 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	
AW_ 3462A2023	Jul-23	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	AW_ 3462A2023_006	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 referencedin 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	
AW_3682A2023	Jul-23	Audit Wales	Audit Wales ISA 260 and Letter of Representation 2022/23	Open	N/A	Finance	Workforce & OD	TBC	Director of Workforce & OD	AW_3682A2023_002	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	
CHC_ECSIW0320	Jan-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	CHC_ECSIW0320_005	N/A	R5. The Welsh Government and the NHS in Wales needs to make sure digital communication moves forward at pace in all areas.	EPR to be awarded to allow Health Board to progress	Apr-20	~~Jul 20~~ ~~Apr 21~~ ~~Apr 22~~ ~~Jun 22~~ N/K	External	WG have awarded the contract and implementation of EPR will be progressed on an All Wales basis with potential to use Cardiff & Vale UHB platform. This has a 6 to 8 week leading time to being rolled out. 16/07/2020 update- Full Business Case has been agreed by the Health Minister. Awaiting further updates from national EPR group. 26/11/2020- Update from SDM- there is a regional working group with Swansea Bay UHB to ensure both Health Boards are ready for phase 1 go live for Glaucoma by March 2021. Approximate timescale April 2021, subject to progress of national work stream. 25/05/2021-Interim Ophthalmology Service Manager update- The National EPR (Electronic Patient Record) work is progressing. We now have a dedicated Project Manager who is able to concentrate on developing the project. There are delays due to IT limitations (broadband) which has been escalated and a timescale for resolution being > 8 weeks. This will delay implementation. However a project group is established to prepare and embed the project. 01/02/2022- Update from service delivery manager -EPR due to be rolled out by April 2022. 13/05/2022- SDM unsure if this is being rolled out soon due to national IT issues. Approximate new date of June 2022. 07/07/22- Joao Martin, as Digital lead for the Health Board, is leading the roll out and needs to update. The roll out is still delayed due to nationwide technical issues. 30/09/2022- No further update at present. Technical issues and unsure of leadership of national team due to sickness and retirement. Joao Martin unable to give further updates on timescale for when OpenEyes will go live as there are too many unknowns - hoping to provide a more informative update when HDUHB is provided with the UAT V6.3 environment and pending no more critical issues found. 14/10/2022 - Update from Joao Martin: LHBs have not yet received the OpenEyes UAT for testing. Believed to be pending on CRNs duplicates issues and last Monday's test was unsuccessful. Unknown when this will be resolved nationally. We do meet with the National Team every Monday and I expect clarification on some of the issues next week. Further guidance may be provided at the National Programme Board at the end of month. 18/05/2023 - Update from Head of Digital Programmes: At national level the governance of the EyeCare project is transitioning from Cardiff and Vale to DHCW, this raises some uncertainty around the national plan during the transition, discussions are ongoing to clarify. At local level some concerns have been identified with the DPIA for version 6 of OpenEyes, but work continues with Information Governance, the national project team and Ophthalmology to address the concerns in readiness for when the transition at national level is complete, which is expected in Q3 this year 06/06/2023 - (Taken from DITS Response Pack June 2023) - This continues to be delayed and we are awaiting a "Go Live" date.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	CHC_ECSIW0320_001	N/A	R1. The Welsh Government and the NHS in Wales needs to do more to reduce the current backlog of people waiting for appointments	Continue re-design of optimum pathways and further utilisation of Community Optometrist Capacity. Identify sustainable funding.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Aug-22~~ ~~Mar-23~~ ~~Jun-23~~ Mar-24	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). 12/07/22- work is in progress for the establishment of a data capture service for diabetic retinopathy services. Ophthalmology services have appointed a Specialist Optometrist who will review the data with the support of a Consultant Ophthalmologist to inform the next steps for the patient pathway. This service will be operational by August 2022. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Positive progress being achieved in the delivery of Ministerial measures for the 52/104 week waiters. Further work underway to deliver additional weekend clinics to reduce the backlog of people awaiting appointments. This will continue until approximately June 2023 at present. 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) but a lot mroe work still be done. Glaucoma - Recent ARCH meeting with Swansea Bay UHB identified areas for improvement. Alongisde GIRFT review, several additional actions identified. GIRFT to be addressed in QSE meeting and working group to be established.
CHC_ECSIW0320	Mar-20	CHC	Eye Care Services in Wales, issued March 2020	Open	N/A	Scheduled Care	Scheduled Care (ophthalmology)	Victoria Coppack	Director of Operations	CHC_ECSIW0320_002	N/A	R2. The Welsh Government and the NHS in Wales needs to make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Development of 3-year plan for Ophthalmology. Further introduce community led services to provide care closer to home.	Mar-21	~~Mar-21~~ ~~Sep-21~~ ~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ ~~Jun-23~~ Mar-24	Red	25/05/2021- Update from SDM-The ARCH Programme is developing regional pathways for: Glaucoma, Medical Retina and Cataracts. These pathways are being developed in conjunction with the Optometric Advisors for both Health Boards & Lead Clinicians. Revised timescale September 2021. 08/10/2021- The Glaucoma Business Case has been approved by Hywel Dda Exec Team, awaiting outcome of Swansea Bay Exec Team decision and agreeing honorary contract with SB consultant. WG transformation funding for virtual diabetic retinopathy has been approved, work underway to commence this pathway. Additional WG funding of £697k has been identified for the UHB, plans are being developed in conjunction with Primary Care Optometric leads to focus on developing Ophthalmic diagnostic and treatment centres. Revised date of March 2022 provided, all monies must be spent by this date. 01/02/2022- Update from service delivery manager - Honorary contract for Consultant Ophthalmologist with a special interest in Glaucoma in place and clinics commenced mid-Jan 2022. Risk stratification of Glaucoma patients commenced to ensure they are seen in the pathway most appropriate for their condition. Virtual diabetic retinopathy clinics commenced end of Jan 2022 utilising money from OPD Transformational funds - progress update to be available by March 2022. OCTC funding and setup plans is being led by the Primary Care Optometric Leads who need to update on this action. 07/07/22- No feedback as yet on plans submitted to IMTP (awaiting clarity on IMTP response before timescales can be provided). Awaiting update on ODTC element from Mary Owens. 12/07/22- Updates for ODTC's and Diabetic Retinopathy as provided in R2.1 and R1. 30/09/2022- Data capture service for diabetic retinopathy service is now in place and the glaucoma service has now commenced. WG want eye care measures and MD to be implemented- service micro-managing capacity and booking to ensure both targets are prioritised. Increased cataract operating capacity at AVH will support with the reduction of the backlog. Timescale revised to March 2023 in alignment with that of Ministerial measures. 9/1/2023 - Progress to be reviewed in March 2023 02/03/2023 - Whilst sustainable money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. 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.
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_005a	N/A	R5. The Health Board should look to improve patient parking. Hospital car parks should be exclusively available for patients	GGH is working with Gwili railway to provide an additional 140 spaces for staff to release space in the hospital site.	Jun-23	~~Jun-23~~ ~~Aug-23~~ Oct-23	Red	28/11/2022 - Parking on all hospital sites remains a challenge. Alternative ways to support patients access is being continually considered by Director of estates and Facilities 31/05/2023- Business & Governance Manager (central ops) confirmed the Gwili Railway scheme is nearing completion. Confirmation still required from Carms Countil that they will support a change in planning permission prior to finalisation of the remaining enablement works. There will be a 6 week lead time from confirmation of planning consent to commencement of this scheme due to the need to finalise enablement works. Unfortunately no indication has been provided on how long this consent may take. We now estimate that the earliest date for commencement of this scheme will be August 2023. An additional 40 parking spaces are due for completion on the GGH site at the end of June 2023 associated with the W&C phase 2 development 11/09/2023- development have been delayed due to the development and signing of the legal agreements taking longer than anticipated. We expect the development to be completed within three weeks of the legal agreements being approved by both parties.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
CHC_AEDHDHBA1122	Nov-22	CHC	Accident & Emergency Departments in the Hywel Dda Health Board area	Open	N/A	Nursing	Acute Services	Louise O'Connor	Director of Nursing, Quality and Patient Experience	CHC_AEDHDHBA1122_007b	N/A	R7. The Health Board to have better communication by keeping patients regularly informed of waiting times.	Funding agreed via WG for digital communication screens in waiting area, once purchased will have information on waiting times.	Mar-23	~~Mar-23~~ N/K	Red	28/11/2022 - Funding agreed awaiting screens. 11/07/2023- to be checked with Heads of Nursing if this has been implemented.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Digital and Performance	Victoria Coppack	Director of Operations	DU_FOAR0116_007	N/A	R2.1. Lack of progress with Ophthalmic Diagnostic Treatment Centre (ODTC) in Ceredigion	No clear actions provided	N/K	~~Apr-22~~ ~~Oct-22~~ ~~Nov-22~~ 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.
DU_FOAR0116	Jan-16	Delivery Unit	Focus on Ophthalmology: Assurance Reviews	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	DU_FOAR0116_011	N/A	R2.6: Concern over the number of patients not reviewed within their target date.	No clear actions provided	N/K	~~Mar-23~~ ~~Apr-23~~ ~~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. 30/09/202- 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.
DU_AWRPTDECM0919	Sep-19	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	DU_AWRPTDECM0919_002	N/A	R2. The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures.	IMTP for Ophthalmology submitted to Director of Acute Services for review.	Nov-19	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~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 aranged as a priority around Opthalmology 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 coveredi n the Corporate risk). There needs to be consideration of the regional model including the mid-Wales collaborative model ad this needs to be assessed for not only clinical impact, but financial surety.
DU_AWRPTDECM0919	Sep-19	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	DU_AWRPTDECM0919_004	N/A	R4. Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.	Included as part of IMTP, awaiting Executive approval.	Mar-20	~~Jul-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~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 aranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There is currently a fiancial gap, in particular to deliver the required acitvity 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.
DU_AWRPTDECM0919	Sep-19	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	DU_AWRPTDECM0919_006	N/A	R6. Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently.	Recent recruitment campaign (ended December 2019) was unsuccessful in attracting permanent medical staff. Locum solutions are being explored to support with delivering required capacity. Recruitment Campaign to be re-launched February 2020.	Mar-20	~~Jun-20~~ ~~Aug-20~~ ~~Oct-20~~ ~~Mar-23~~ ~~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. 30/09/202- We have successfully recruited 2 speciality doctors and 2 locum consultants. A second honorary annual contract with Swansea Bay glaucoma consultants is in progress via ARCH. The midwales (Powys and Betsi) clinical lead was readvertised with no applicants. SDM to meet with the County Director Ceredigion for next course of action. 02/03/2023 - Regional clinical view is that without central prioritised investment, it would be difficult to attract appropriately qualified skilled individuals who are able to be recruited into centres of excellent elsewhere across the UK. 18/04/2023 - Update from SBAR presented at ARAC: Between September – November 2022 the service has successfully recruited two locum consultants and four speciality doctors. A second consultant with an interest in glaucoma has been awarded an honorary contract to continue to support this service. Specific action on risk 1664 in terms of holding regional discussion to be aranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services, with an action date noted of 30th September 2023. 27/09/2023 - There has been further successful recruitment at consultant level, however further recruitment needs to be considered at joint regional posts.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_001a	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	HDUHB will undertake a review of the Health Board Part 1 Scheme in collaboration with partner agencies (LA) and commissioned services to ensure the service is aligned to the MH Measure.	Dec-23	Dec-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for impementation by December 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_001b	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure. The service may also wish to use take the opportunity to consider the availability and equitability of LPMHSS support provided across the HB footprint through different local commissioning arrangements.	S-CAMHS will contribute to the update ensuring all the new service developments are aligned to the Measure, including the new SIR Service.	Dec-23	Dec-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for impementation by December 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004a	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	S-CAMHS will establish a Steering Group with specific terms of reference, to develop and monitor a recovery plan.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Monthly meetings in place for CAPA and Waiting lists monitoring within localities.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004b	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	An improvement trajectory will be developed to monitor the numbers of clients waiting for clinical interventions following assessment under Secondary CAMHS.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Develop forum to produce trajectory based on good analysis of the data. Steering group is being co-ordinated.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004c	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Workforce capacity will be reviewed to address demand imbalance in each locality team and increase recruitment into vacant posts.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Links with Child and Adolescent Psychiatric Assessment (CAPA) deep dive.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004d	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A review of clinicians' Job Plans overseen by locality team leads in conjunction with professional clinical leads will be undertaken.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Linking in with CAPA.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004e	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	Further monitoring of DNA's or was not brought (as lost capacity needs to be minimised) discharge and transfer information (to help ensure flow through services and avoid blockages e.g. access to specialist therapies) and actions to improve engagement and letting go if needed.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track. Linking in with CAPA.
DU_AWRPSMHS1122	Nov-22	Delivery Unit	All Wales Review of Primary & Secondary Mental Health Services for Children & Young People	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_AWRPSMHS1122_004f	N/A	R4. The HB must develop a recovery plan and improvement forecast to address SCAMHS intervention waits for children and young people with moderate to severe presentations alongside existing recovery plans for Part 1a, 1b. Whilst successful recruitment is likely to support recovery actions, the impact of capacity needed for workforce development of new staff without a CAMHS background should be reflected within the improvement trajectory.	A workforce training analysis will be completed and training plan including CAPA Core competencies developed to ensure all staff have the core competencies required to meet service need.	Oct-23	Oct-23	Amber	04/04/2023- Assistant Director, Mental Health & Learning Disabilities confirmed recommendation on track for October 2023. 09/08/2023- Assistant Director, Mental Health & Learning Disabilities confirmed on track.Ongoing training, clear about choice appts, exit strategies and goals.
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_001c	N/A	R1. The Health Board should review the pathways for all older adults who present in crisis to understand whether there is parity of the offer with those of working age adults to have care delivered in the community. This should be inclusive of those living with functional or organic illness.	Produce a report for QS&EG with any required pathway improvement/equality recommendations.	Aug-23	Aug-23	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.
DU_AWARCLPSOA0223	Feb-23	Delivery Unit	All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_AWARCLPSOA0223_004	N/A	R4. The Health Board should review accommodation within the Emergency Department to provide an environment where a mental health assessment can be provided to ensure privacy, low stimuli and safety for patients and staff.	Review undertaken. Appropriate areas in place Bronglais, Withybush and Prince Phillip. Layout change in Glangwili ED has led to identified area no longer available for mental health assessment. On-going discussions needed with ED management across HDUHB to resolve and ensure the provisions of appropriate assessment areas.	Mar-24	Mar-24	Amber	22/03/2023- ED departments currently under significant pressures and are unable to ring-fence identified rooms for mental health assessment only. Timescale for a full implementation for this recommendation is challenging for MH&LD service as this can only be fully implemented with the EDs support. The recommendation has been facilitated across 3 areas but remains a considerable issues in 1 area. Therefore a timescale of March 2024 is provided for full implementation for all areas.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_001a	N/A	R1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.	The service have commenced a Directorate wide review to update the Health Board Part 1 Scheme in collaboration with partner agencies (LA) and commissioned services to ensure the services are aligned with the MH Measure.	Dec-23	Dec-23	Amber	28/04/2023 - AH to lead on this, initial work done to gather internal pathways. SM to support. 23/06/2023- On track for December 2023 deadline.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003a	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	The HB will ensure that the Patient Access Policy for Psychological Therapies Services outlines the accessibility across the age range with assurances regarding accessibility for different psychological needs across the adult life-cycle.	Dec-23	Dec-23	Amber	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.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003b	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	Links will be made with the older adult mental health team to project equity of access targets by reviewing the proportion of referrals received over 65 years old, how this reflects our local population demographic against estimated prevalence of mental health disorders in later life to inform what % referrals for over 65 years there should be locally.	Dec-23	Dec-23	Amber	23/06/2023- Work ongoing.
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_003c	N/A	R3. The HB should consider ways to improve the access and referral rates to psychological therapies for older adults to ensure parity across the age range.	3.7The 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
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004a	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The Integration of the LMPHSS and IPTS will be progressed following the implementation of the OCP.	Dec-23	Dec-23	Amber	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
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004b	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The service will update all service documents and pathways.	Dec-23	Dec-23	Amber	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
DU_RPTW0323	Mar-23	Delivery Unit	Review of Psychological Therapies in Wales	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Angela Lodwick	Director of Operations	DU_RPTW0323_004c	N/A	R4. The HB should continue to align the services delivered by LPMHSS and IPTS to ensure the staff skills are used effectively across services and any gaps in service are eliminated.	The service will undertake a Service User Survey to obtain the views and suggestions of a new name.	Dec-23	Dec-23	Amber	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.
DU_RMAS_0723	Jul-23	Delivery Unit	Review of Memory Assessment Services	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Neil Mason	Director of Operations	DU_RMAS_0723_005	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.
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Medical	Women and Children's Services	Head of Medical Education & Professional Standards	Director of Operations	HEIW_OGGH_0123_001b	N/A	R1. The Health Board should develop a proactive rota management system to ensure training opportunities were adequately directed.	Introduce and implement proposed Medirota that provides live, dynamic rota information.	Jan-23	~~Jan-23~~ N/K	Red	15/06/2023 - The Women's and Children's directorate are in the initial stages of piloting a new electronic roster management system across the medical staffing for Obstetrics and Gynaecology. This will provide clinicians with easy access to a live roster and have details of any areas that require cover, volumes of leave and importantly training session opportunities. It will also allow them to update their own availability and provide a clear and actuate live update on the current staffing situation across the services. This is the early stages of introduction. 19/06/2023- Management response formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. This recommendation remains Red as no revised completion date was noted. 03/07/2023 - (Taken from DITS repsonse pack June 2023): Rota includes fixed days off for personal learning and protected time for learning. These rotas include personal requirements of training attainment for trainees to tailor opportunities to suit their needs. Clinical sessions are arranged to match training modules when the service allows. Service awaiting Health board wide decision around appropriate electronic rota management system adoption.
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Medical	Women and Children's Services	Head of Medical Education & Professional Standards	Director of Operations	HEIW_OGGH_0123_002b	N/A	R2. The Health Board should ensure trainees have opportunities to raise concerns about patient safety, support, and education.	Provide relevant information on how to raise concerns at induction.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - Work has been undertaken to incorporate relevant information into the induction programme. We have shared access to Health Board 'raising concerns' team and how to access this service and sign posted on how to access to external support and procedures if or when required. 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.
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Medical	Women and Children's Services	Head of Medical Education & Professional Standards	Director of Operations	HEIW_OGGH_0123_003	N/A	R3. The Health Board should ensure that a workforce behaviours group is created, which includes a senior midwife, a senior gynaecology nurse, trainee representation and a consultant.	Monthly Workforce Behaviours Group.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - As a service we are currently exploring the formulation of a workforce behaviours group which will meet on a monthly basis. This will include the service delivery lead, Senior nurse for Gynaecology, the head of Midwifery, Obstetrics and Gynaecology clinical lead and appointed trainee representation. A standard operating procedure document and terms of reference are being generated to guide the structure and effectiveness of the group. This will be fully implemented in the coming weeks. 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Medical	Women and Children's Services	Head of Medical Education & Professional Standards	Director of Operations	HEIW_OGGH_0123_006	N/A	R6. The Health Board should take steps to incorporate ultrasound training into the trainees' rota.	Include ultrasound in the Trainee rota.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - The incorporation of ultrasound training into the Trainee's schedule is underway. One of our Consultants has recently been appointed as the gynaecology scan lead for Wales and will be working with the clinical lead for Obstetrics and Gynaecology, College tutor and Service management team on a programme to develop trainees in ultrasound, which will be implemented in the coming months. 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.
HEIW_OGGH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	Obstetrics and Gynaecology Glangwili Hospital	Open	N/A	Medical	Women and Children's Services	Head of Medical Education & Professional Standards	Director of Operations	HEIW_OGGH_0123_007	N/A	R7. The Health Board should make consideration of how to improve the MTI doctors' experience to ensure training is optimised.	Improve MTI training experience.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - The Clinical director has identified a potential opportunity to work with one of the current MTI doctors in an attempt to gain an understanding of their perspective and experiences. This information will be fed into the work of the service management team and the clinical lead for Obstetrics and Gynaecology, to identify areas for improvement in the educational support and structure for the MTI Drs currently in the service and for those due to join. This will enable the development of a more robust training plan, which will be in place over the coming months. 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.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_002a	N/A	R2. The Health Board must ensure that the induction is effective both at the start of the trainees' posts and when they rotate into new departments.	General Health Board Induction, provided by Medical Education, with main one being in August. We will also ask that trainees sign so that we can ensure attendance.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - Induction completed for April changeover with more structured approach. Evaluation sheets disseminated to attendees for feedback and identification of potential improvements. 19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit. 10/07/2023-Head of Medical Education & Professional Standards confirmed- Induction completed for April changeover with more structured approach. Evaluation sheets disseminated to attendees for feedback and identification of potential improvements.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_003a	N/A	R3. The Health Board should consider improving support for new IMG trainees.	Extended period of shadowing for IMG trainees as suggested by HEIW during Team Appraisal.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - HEIW have yet to confirm financial support for extended shadowing however, we have offered this to the new FP1s as an option and have put an enhanced induction programme together for them. 19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit. 10/07/2023- HEIW have yet to confirm financial support for extended shadowing however, we have offered this to the new FP1s as an option and have put an enhanced induction programme together for them.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_003c	N/A	R3. The Health Board should consider improving support for new IMG trainees.	Scenario based workshops to be arranged during the period of extended shadowing and/or when the new IMG trainees start.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - The Health Board have started to introduce these sessions on the Withybush and Glangwili sites and a task and finish group has been set up to further develop this work. In Bronglais, we have appointed a Clinical Teaching PA who will support these workshops and a new Medical Education Teaching Fellow will be starting in August 2023 and will further support this provision. 19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit. 10/07/2023- The UHB have started to introduce these sessions on the WGH and GGH sites and a task and finish group has been set up to further develop this work. In BGH, a Clinical Teaching PA has been appointed who will support these workshops and a new Medical Education Teaching Fellow will be starting in August 2023 and will further support this provision.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_003e	N/A	R3. The Health Board should consider improving support for new IMG trainees.	Use recommendations from local research into experiences of IMG doctors employed by Hywel Dda to inform improvements to processes and systems.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - Report is now complete. PID and SBAR has been created detailing proposal for 2-week Enhanced Induction Programme for IMGs – could also be used for all other doctors. Awaiting exec sign off. 19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_004d	N/A	R4. The Health Board must ensure that all feedback is constructive, informative, and never undermining.	HEIW to consider including feedback training in annual CPD programme for trainers	Jan-24	Jan-24	External	19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_005d	N/A	R5. The Health Board should offer the consultants with training roles education and training around their role, with information about the curriculum, and the use of the e-portfolio and these opportunities should be accessed by the trainers as needed.	A programme of contact points between the FPD and ES/CS to be set up, possibly linking with the rolling programme (as above point).	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - Identify and confirm set dates and times when FPDs will be in the medical education centres so that trainers can access them. 19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit. 10/07/2023- Head of Medical Education & Professional Standards provided update-Identify and confirm set dates and times when FPDs will be in the medical education centres so that trainers can access them
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_009b	N/A	R9. The Health Board must ensure that F1 trainees are not given inappropriate tasks, including communication.	Standard operating procedures for physicians involved with the transfer of patients to be developed to ensure that the needs of the patient are balanced with the competence of the clinician.	Jun-23	~~Jun-23~~ N/K	Red	19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit. 10/07/2023- Head of Medical Education & Professional Standards update shows recommendation is outstanding, revised timescale to be provided.
HEIW_GIMBH_0123	Jan-23	Health Education and Improvement Wales (HEIW)	General Internal Medicine Bronglais Hospital	Open	N/A	Medical	Unscheduled Care (BGH)	TBC	Director of Operations	HEIW_GIMBH_0123_012	N/A	R12. HEIW will re-visit in six months' time.	Awaiting re-visit.	N/K	N/K	External	19/06/2023- Management response presented at People, Organisational Development & Culture Committee (PODCC) meeting. The audit tracker was updated following presentation of the report at PODCC, and the RAG status of the recommendation was changed back to amber. 07/07/2023 - Progress made; awaiting revisit.
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_001	N/A	R1. The Health Board must ensure that the trainees receive induction, (Hospital and departmental), before they undertake significant clinical duties, such as on-calls. The process should incorporate arrangements to release trainees from clinical duties to attend as well as a system to monitor attendance and respond if trainees appear to have missed their session. Arrangements should be made to accommodate those starting out of step with their peers.	To review the Induction Programme with full collaboration with current trainees, to ensure the relevance of topics and timing of sessions within the programme. To produce a PID/SBAR for an Enhanced Induction Programme for new Doctors who arrive out of sync to allow induction to the area, hospital and speciality, with an enhanced clinical skills element. Each clinical team to identify a named individual/deputy for departmental inductions and trainees to confirm receipt of this session.	Jul-23	~~Jul-23~~ N/K	Red	15/06/2023 - An enhanced Induction Programme has been produced and will be offered to new F1's prior to their shadowing period in August 2023. This includes orientation to the area/hospital, clinical skills teaching and wellbeing sessions. Format template for departmental induction has been shared with teams. Clinical teams are in the process of identifying induction lead. PID/SBAR for ongoing enhanced induction has been compiled, awaiting exec sign off. 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.
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_003	N/A	R3. There should be a named senior member of staff in each sub speciality who is responsible for leading the induction as well as arrangements to share responsibility to ensure induction is facilitated when the named lead is on leave.	Contact Clinical Leads/Service Delivery Manager for confirmation of named individual providing Induction.	Aug-23	~~Aug-23~~ N/K	Red	15/06/2023 - Medical Education Centre to identify lead in each clinical area/deputy to provide Departmental Induction. Registers/departments to be monitored to ensure 100% attendance. 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.
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_004	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~~ N/K	Red	15/06/2023 - Several meetings have been organised with Service Delivery Managers and Clinical Leads to develop the new handover system. Sessions held at induction and out of sync for new doctors to ensure they are aware of the system and obtain regular feedback. The following new processes have been developed:. •Night to Day Handover Night cross cover doctor will hand over to the night T&O doctor any issues with T&O outlying patients @ 7.30am. Night T&O SHO will then disseminate that to the morning Trauma Meeting. •Day to Night Handover ENT and Urology to handover to cross cover doctor @ 8pm in the Merlin doctor's office. Day Orthopaedic doctor to handover to night orthopaedics doctor @ 8pm in Orthopaedic handover room. •Cross cover night doctor and Orthopaedic night doctor meet at 8.30pm to handover Orthopaedic outliers (this could be in person/phone call/teams) •Hywel Dda Surgical Specialties Teams Channel Teams channel has been set up. Admin rights given to Medical Education staff members, Service Managers and Educational Supervisors 19/06/2023- Management response formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. Following presentation of the report at PODCC, the RAG status of this recommendation was changed back to amber.
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_007	N/A	R7. There needs to be a specific forum within the directorate that is a safe space for trainees and trainers to be able to raise and discuss concerns. This should be minuted and action points assigned and developed. It will be useful to involve the educational faculty team in this process.	To develop regular departmental meetings consisting of Consultants and Trainees to ensure discussion of issues or concerns. To improve attendance of Educational Supervisors at Junior Doctors Forums, run by the Medical Education Centres.	Jul-23	~~Jul-23~~ N/K	Red	15/06/2023 - Initial meeting with Trainers for 21st June 2023 to consider departmental meeting format. Educational Supervisors and their secretaries to be notified of future Junior Doctor Forums and dates to facilitate attendance.
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_008	N/A	R8. The Health Board should produce and share with HEIW, the previously requested document that covers the plans made to mitigate the effect of rota gaps on teaching, training, and curation of evidence for portfolios.	To develop a document to identify how Dr gaps are affecting the ability of Trainees attending educational events.	Jun-23	~~Jun-23~~ ~~Aug-23~~ N/K	Red	15/06/2023 - Percentages of Doctors attendance at Core Teaching prepared and shared with Surgical Departments to identify those specialities with low attendance. Departments have been asked to comment on how they plan to mitigate effect on trainee experience. 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. 10/07/2023-Percentages of Doctors attendance at Core Teaching prepared and shared with Surgical Departments to identify those specialities with low attendance. Departments have been asked to comment on how they plan to mitigate effect on trainee experience. Medical recruitment have been approached to provide some information about recruitment initiatives to help improve recruitment and support teaching and training.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HEIW_SSGGH_0423	Apr-23	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	HEIW_SSGGH_0423_009	N/A	R9. The Health Board should continue to build upon the work that is being undertaken to ensure clarification around which staff members may be expecting trainees to obtain consent for procedures inappropriately.	To continue to identify procedures where trainees are required to obtain consent to ensure they are acting within their capabilities.	Mar-23	~~Mar-23~~ ~~Aug-23~~ N/K	Red	15/06/2023 - Several meetings have gone ahead with various clinicians. Lists of procedures have been collated to identify those that the trainees feel less confident to obtain consent for. Alternative systems have been identified e.g. It has been agreed that the CNS nutrition nurses may be better placed to take consent for PEGs. 19/06/2023- Report was formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. No revised date was presented for this recommendation. 10/07/2023- Several meetings have gone ahead with various clinicians. Lists of procedures have been collated to identify those that the trainees feel less confident to obtain consent for. Alternative systems have been identified e.g. It has been agreed that the CNS nutrition nurses may be better placed to take consent for PEGs.
HEIW_SSGGH_0423	Apr-23	Health Education and Improvement Wales (HEIW)	Surgical Specialties Glangwili General Hospital	Open	N/A	Medical	Unscheduled Care (GGH)	Head of Medical Education & Professional Standards	Director of Operations	HEIW_SSGGH_0423_010	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	N/K	External	19/06/2023- Report was formally presented at People, Organisational Development & Culture Committee (PODCC) meeting. No formal management response presented for this recommendation. Date of HEIW visit has yet to be confirmed.
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_002	N/A	R2. To consider developing 'Decision Making whilst in emergency response' Guide for Health Board staff.	The importance of making safe decisions during emergency responses will be reiterated in the revised Board and Committee Standard Operating Procedure. This will indicate that any deviation from business-as-usual decision making processes must be communicated to and approved by the Executive Team.	Mar-23	~~Mar-23~~ Nov-23	Red	01/06/2023 - This will be included along with other amendments in the Board and Committee SOP which will be revised as planned by November 2023.
IR_GDMRBFH_1122	Nov-22	Independent Review	Governance and decision making in relation to Bluestone Field Hospital	Open	N/A	Governance	Governance	TBC	Director of Corporate Governance	IR_GDMRBFH_1122_003	N/A	R3. To review the governance processes in relation to decision making groups between the Health Board and Pembrokeshire County Council (PCC) to ensure that decisions are clearly recorded in the minutes.	A review will be undertaken of the joint groups established between the Health Board and PCC. Furthermore, a review will be undertaken of the governance and reporting arrangements of the Integrated Executive Group which reports into the West Wales Care Partnership.	May-23	~~May-23~~ Sep-23	Red	01/06/2023 - This will be incorporated into the review of our partnership governance arrangements which will be reported to September 2023 Board meeting.
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_001b	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.	An exercise to refresh the medium term financial outlook is underway and is reporting into Executive structure at regular points. This will include options for the Board on future trajectories, including financial breakeven. Having selected a trajectory an underlying annual and cumulative savings requirements, before further cost pressures, will be clearly spelt out.	Mar-24	Mar-24	Amber	31/07/2023 - In year the minimum savings requirement is £19.5m, as agreed via annual plan. Whilst progress made operational plans incomplete at this point and routinely communicated and escalated via Executive Team. Process outline shared with and approved by Executive Team June 2023. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_002	N/A	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.	The next management response, sets out a proposed timeline to remedy this recommendation.	Sep-23	Sep-23	Amber	An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003a	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 1.Initial Planning Considerations for Operational and Savings (September - October 2023): Action - Begin early discussions with operational, finance and workforce teams to identify potential opportunities. Action - Initiate the process of savings identification for the 2024/25 financial year and agree the quantum required.	Oct-23	Oct-23	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003b	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 2. Drafting Stage (November - December 2023) Action - Carry out a financial assessment to identify potential savings and the preliminary financial gap. Action - Produce the first draft of the savings plan, including the appropriate data sources and monitoring proposal.	Dec-23	Dec-23	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003c	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 3. Refinement Stage (January - February 2024) Action- Refine the financial and operational plans, based on feedback from the executive team, the board, and other key stakeholders. This should involve multiple rounds of review and revision. Action - Finalise the annual plan, incorporating the identified savings and operational plans to address the financial gap.	Feb-24	Feb-24	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003d	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 4. Final Review (Early to Mid-March 2024) Action - Conduct a final review and sign-off of the plan with the executive team and the board, making last-minute adjustments as required. Action - Secure the final approval from the board.	Mar-24	Mar-24	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003e	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 5. Submission (By 31st March 2024) Action-Submit the approved annual plan by the deadline.	Mar-24	Mar-24	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_003f	N/A	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.	The intention is to adopt a continuous planning cycle within the Health Board. However, the immediate proposal ahead of 24/25 would be: 6. Post-Submission (After 24 March 2024) Action- Communicate the ratified plan to all stakeholders and commence its execution. Action- Monitor progress against the plan on a regular basis, making adjustments including remedial actions as necessary.	Mar-24	Mar-24	Amber	31/07/2023 - The forum will need to be agreed and ratified, and the role of the Core Delivery Group clarified. However, it would seem prudent to utilise any repurposed Planning Steering Group. The rationale for using said forum, is that any savings plan is not materially different, in part or full, from the development of any operational plan, as the process and steps are often one and the same. Equally, it is submitted that any savings plan should be developed in conjunction with operational plans to remove any ambiguity or risk of contradiction. For example, the delivery of a savings scheme for one directorate can have ramifications and consequences for another (unintentionally). Developing plans in a synchronous and convergent manner will verify the correct alignment and assumptions throughout. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_004a	N/A	Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 1. Resource Allocation (Starting immediately and ongoing) Action - Assess the needs of each scheme lead, taking into account the value and complexity of their respective schemes. This will help us allocate resources and support effectively and efficiently.	Aug-23	~~Aug-23~~ Oct-23	Red	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1.~~1~~Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2.~~2~~The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_004b	N/A	Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 2. Support Structure Development (September - October 2023) Action - Develop a robust support structure that provides scheme leads with access to expertise in operational planning, finance, governance, and project management. This includes establishing clear communication lines and creating a comprehensive repository of resources and guidance.	Oct-23	Oct-23	Amber	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1.~~1~~Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2.~~2~~The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_004c	N/A	Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 3. Support Implementation (November 2023 - March 2024) Action - Implement the support structure and monitor its effectiveness throughout the planning and execution phases of the savings scheme, ensuring triangulation and assumptions are stress tested. This will involve regular check-ins with scheme leads and adjustments to the support provided as necessary.	Mar-24	Mar-24	Amber	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1. Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2. The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_004d	N/A	Ensuring access to support for scheme leads including operational planning, finance, governance and project management. This will vary dependent on value of the scheme.	In recognition of recommendation 4, we agree that comprehensive support for scheme leads is crucial for the successful implementation of our plans. This includes operational planning, financial management, governance, and project management support, all of which are critical components of any effective savings plan. In response, we will take the following actions: 4. Continuous Review and Improvement (After March 2024 and ongoing) Action - Review the support provided regularly to ensure it continues to meet the needs of scheme leads and contributes effectively to the success of the savings scheme. This will involve gathering feedback from scheme leads and using this to inform improvements to the support structure. We are committed to ensuring our scheme leads have the resources and support they need to be successful, and we believe these actions will help us achieve that goal.	Mar-24	Mar-24	Amber	31/07/2023 - The Director of Strategy and Planning can analyse and make clear recommendations from the respective projects teams as to what resource is needed. However, there are two key points to highlight: 1. Not all of the resources needing to be deployed are at the discretion or within the gift of the Director of Strategy and Planning 2. The current Operational Planning team only has 2.5WTE members. Whilst this is not the only team under the Director of Strategy and Planning, it is important to note the potential limitations of the Operational Planning team. Notwithstanding the above points, the process and timelines set out within the management response would remedy the recommendation. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_005	N/A	Documented programme documentation setting out executive and operational leads responsibilities, a clear scope with defined baseline, parameters and clear milestones/trajectories, actions, risks, and agreed savings target with identified cash releasing amount, signed off by executive lead and finance needs to be developed.	For noting in the response: This response, can be supported by the formal documentation described for point 1. Furthermore, to accompany the Project Initiation Documentation; there is also the project management software PACE for the overall operational management of the savings scheme. These two project support documents when executed in accordance with Master Action C (Amalgamation of TI key deliverables) creates not only a very clear and robust process but ensures that: 1. There is a clear Work Breakdown Structure – setting out the sequencing and interoperability of the project/programme and the owners of each task; resulting in absolute clarity of roles and responsibilities and timelines. 2. The Project Documentation has clear Demand and Capacity analysis, including a baseline assessment, milestones and trajectories with triangulation across planning, finance and workforce. all of the above are part of the thematic alignment (within Targeted Intervention) with an Action Plan setting out clear actions and sub-actions, which it is submitted will provide the delivery vehicle to address this recommendation. Finally, there will be the triangulation within the MDS for each saving scheme. By identifying a clear baseline, the activity planning assumptions will be triangulated, within the financial and workforce MDS tabs.	Sep-23	Sep-23	Amber	31/07/2023 - The processes and documentation are already in place. There may need to be a rapid assessment of bringing these respective documents into one place and to ensure there is no need for teams to duplicate documents. However, this should not be an overly onerous exercise. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_007a	N/A	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.	The cultural aspects of this recommendation have applicability beyond the savings element alone, as a holistic responsibility for managers and leaders across the Health Board.	Mar-24	Mar-24	Amber	31/07/2023 - Clear progress being made with Executive accountability sign off for 2023/24. With onward delegation at the discretion of each Executive lead. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB-SGR-1508	Aug-23	Independent Review	Savings Governance Review	Open	N/A	Finance	Finance	Executive Director of Finance	Director of Finance	HDUHB-SGR-1508_007b	N/A	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.	In implementing a recent external review of financial management (ARCUS) releasing and focusing time for business partners is integral and will include such communication and support.	Mar-24	Mar-24	Amber	31/07/2023 - Finance education programmes are being refreshed and will include expectations and responsibilities for savings. An update on progress against the recommendations will be presented to ARAC on 17 October 2023
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_004	Medium	R4. Management should ensure that the services and functions holding patient records locally are reminded of their requirement to comply with the Retention & Destruction Policy.	As identified in the recommendation above following a report reviewed by the non pay panel it identified that services across the Health Board were utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and there was a feeling that a number of records currently in storage could be destroyed because they have passed the necessary retention period. This information was contained within the records brief presented to the Executive Team in November and will also form part of the work undertaken be the project group and sub groups. As part of the scoping working the groups will be required to identify any records outside of retention guidance and the relevant costs of destruction. As clarified above this work will be progressed early in the new year.	Mar-19	~~Jul-21~~ ~~Nov-22~~ ~~Mar-23~~ Mar-24	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The Health Board continues to operate with the imposed UK government destruction embargo in situ, meaning no patient records can be destroyed. The relevant inquires could be completed early in 2023 and destruction processes can immediately go back into operation. The review of the offsite and private storage facilities, continues as part of the IG work programme and is identifying various records held at the localities. Work has also commenced in terms of returning Hywel Dda records to the central health records storage facilities, from private storage. Relocating records to one central management team will ensure retention and destruction schedules are followed diligently. 28/03/2023 - Each service area has an identified Information Asset Owner (IAO), who has responsibility for the management (including the destruction of the records). Following the lease of a new offsite storage facility the plan for the project moving forward will be to identify those services with greatest need of support from various viewpoints.Following this a plan will be agreed how the services implement strict records management arrangements, agree if there is a requirement to relocate records to the health records storage facility and ensure robust destruction procedures are implemented.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section1. Management should review the current arrangements in place with third party storage providers to establish whether they meet the required Health Board standards.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ Mar-24	Red	03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – The IG work programme to review storage facilities is ongoing and to date 4 locations have been reviewed, including 2 private providers (Lloyd & Pawlett and Logic Document) and the health records storage facilities based at Dafen and Llangennech in Llanelli. Concerns remain in regards the private storage providers and an SBAR was presented to the Executive Team in October 2022 proposing that the management and storage of all Hywel Dda records be streamlined to one Executive lead. Clearly this is a considerable project to undertake and complete and it will require significant support from a wide range of services and identified IAO's. Work has commenced in terms of developing a project plan and schedule of work, but initial progress has been made by relocating A&E and pharmacy records, with other services to follow. Once all records are relocated to the Health Board storage facilities this will negate any concerns. 28/03/2023 - As the knowledge centre of the organisation where record management is concerned the change would not be severe for the health records service and would simply be an extension of the business model currently operated for the acute patient record, to accept wider record types. This work has already commenced with the relocation of A&E cards for GGH and PPH and Pharmacy records and others will follow over the next 12 months as the digital records project is progressed.
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_006	High	R6, section2. Management should establish what information is stored with the third party storage providers and that the retention and destruction of information is being undertaken in line with the Welsh Government arrangements.	Again as identified in finding 3 and 4 early this year a financial report was presented to the non pay review panel. The report identified that the Health Board was utilising private storage companies to store a wide range of records and Health Board information. There were significant costs associated with the storage facilities and the report was presented to the Health Records Manager for comment. Following the comments received it was identified that potentially not all service/departments utilising private storage may have confirmed contractually arrangements in place. Further discussion lead to the records management brief presented to the Executive Team in November 2018. Again as part of the relevant project groups there will be a requirement and responsibility for the groups to confirm: *What records/information they have in storage *What are the costs (per box per month/year) *Are there any exit costs *Is there an agreed formal contract in place between the Health Board and the company Again this work will be driven by the main project group with sub group implementation planned for early next year.	Mar-19	~~Mar-23~~ Mar-24	Red	19/04/2022 - update provided to ARAC: The Information Governance (IG) team has implemented an audit programme which will review all corporate and third party storage facilities utilised by the Health Board. The audit programme will form part of the IG annual work plan. The reviews will ensure identification of the various record types stored at the localities, confirm contractual arrangements, the security arrangements that may be in operation, the compliance levels from a governance perspective and also provide the opportunity to identify any new risks. To date, reviews have been completed at Lloyd & Pawlett Storage, Pembrokeshire and Logic Document Storage, Llanelli. All reviews are reported back to IGSC on a bi-monthly basis and the report confirms the risk rating at the time of the review, the recommendations which require action by the third party providers and the risk rating following completion of the recommendations. Any risk deemed of a high nature will be place on the IGSC risk register and managed accordingly. Work will be ongoing for the next 12 months with regular updates provided to IGSC until all recommendations have been completed. The resolution of this recommendation will be significantly supported by the implementation of the new storage and scanning facility at Dafen. This facility will provide the required storage capacity to allow records to be removed from costly third party providers and returned to the control and governance of the Health Board ahead of conversion into scanned format. Notice has already been served to one provider and relocation of a percentage of records will begin in April 2022. Further relocations will take place, with completion by March 2023. 03/05/2022 - update from internal audit: this will be picked up in this year's plan. An assurance report is due to take in place in Q4. 09/11/2022 - update received from Internal Audit that the scheduled follow up has been deferred to q1 2023/24, and will obtain progress updates and revised timescales in the meanwhile 17/11/2022 – Please see update provided for recommendations R4 and R6 section 1. The SBAR presented to the Executive Team in October 2022 proposing to move the management, handling, scanning and destruction of all Hywel Dda records to one Executive lead and retained within the health records storage facilities will ensure all storage, governance, destruction issues are fully resolved. 28/03/2023 - identified what records (an other items) are being held in private storage, how we intend to relocate them back into the Health Board, under on service/lead and how destruction processes will be implemented.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB1819-33	Feb-19	Internal Audit	Records Management	Open	Limited	Central Operations	Digital and Performance	Steven Bennett	Director of Operations	HDUHB1819-33_007	Medium	R7: Management should establish refresher sessions to ensure existing staff receive records management training.	Ad hoc Health Records training sessions have been completed for all ward clerks and secretaries across the Health Board apart from at Bronglais and these training sessions will be completed by February 2019. Recently the Health Records Manager and Head of Governance have discussed the possibility of introducing joint IG/Health Records training sessions. Further discussions are planned for next year with the potential to implement across the Health Board in 2019. It is correct that after receiving robust departmental induction and on the job training, staff within the Health Records service currently do not receive any update or refresher training. The responsibilities within the service and the staff roles have not altered when compared to the duties undertake 10 years ago and the majority of the tasks are exactly the same, as they always have been. The Health Records Manager will discuss this recommendation with the Deputy Director of Operations and the Deputy Managers and identify if this is an essential requirement and the most effective format to deliver refresher training if required.	Feb-19	~~Jun-21~~ ~~Nov-22~~ ~~Mar-23~~ ~~Apr-23~~ ~~May-23~~ 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 ben provided to Health Records staff. The recommendation will stay red until the folow up Records Management audit takes place later this year.
SSU-HDU-2021-03	Apr-21	Internal Audit	Glangwili Hospital Women & Children's Development, issued April 2021	Open	Limited	Strategic Development and Operational Planning	Women and Children's Services	Lisa Humphrey/Project Director	Director of Strategic Development and Operational Planning	SSU-HDU-2021-03_007	Medium	R7. Management will seek NWSSP:SES Framework support in dealing with the SCP performance – particularly for the anticipated period where the SCP will be operating without payment.	Agreed	Jul-21	~~Jul-21~~ ~~Jul-23~~ Oct-23	Amber	10/01/2022- Report re-opened. Internal Audit confirmed rec 7 remains open until the project is completed as it related to the ongoing monitoring of contractor performance. Rec to be noted as amber as initial action has been taken, but it cannot be fully implemented until completion of the contract. 02/03/2022 & 03/05/2022- Expected to remain open until July 2023. 03/05/2022- outstanding rec expected to remain open until July 2023. Exec Lead amended from Director of Operations to Director of Strategic Development and Operational Planning as remaining recommendation is for Strategic Development and Operational Planning Directorate to implement. 12/08/22-Date remains July 2023 30/08/2022 - Director of Strategic Developments and Operational Planning confirmed no change. 10/11/2022 - Head of Captial Planning confirms no change. 10/01/2023 & 01/02/2023-Head of Captial Planning confirms no change - ongoing monitoring of contractor performance which will continue until completion of the contract planned for July 2023. 16/03/2023- update remains as above. 28/04/2023- Update remains as above. 05/09/2023- Ongoing monitoring is continuing of the contractors performance until completion. The latest forecast completion date has changed to 13/10/2023. Recommendation changed from red to amber as this is dependent on contractor completion.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_001a	N/A	R1a. Whilst WG's COVID-19 Hospital Discharge Service Requirements (Wales) (referred to hereon as 'WG Requirements') are deemed temporary until the end of the COVID19 emergency period, the Health Board's Discharge and Transfer of Care Policy does not reflect the current requirements and continues to be live on the Health Board's Clinical Written Control Documentation intranet page	Review and update the Discharge and Transfer of Care – Adults Policy, Policy number 370 to reflect the Discharge Service Requirements process, as this still remain current.	Mar-22	~~Mar-22~~ ~~Mar-23~~ N/K	External	08/12/2021 - The Original management responses were presented at ARAC October 2021, these management responses were asked to be strengthened. 31/10/2022- agreed by Director of Primary Care, Community and Long Term Care that this recommendation is changed to 'external'. Discharge requirements are being reviewed at an All Wales basis, in light of developments following Covid-19.Once these are reissued (the All Wales review is expecting to be completed imminently), the UHB discharge policy will be refreshed. The current discharge policy will be requested to be extended for three months, whilst the UHB awaits guidance from WG following the All Wales review, as well as awaiting ministerial advice on the Delayed Transfer of Care (DTOC), which will also feed into the amended policy. Revised date of March 2023 timescale provided, and the recommendation changed from red (overdue) to external (outside the gift of the UHB to implement) whilst the outcome of All Wales review is awaited. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002a	N/A	R2a. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	It is accepted that an integrated (joint) approach to delivering effective and efficient Discharge 2 Recover and Assess models is essential. It will be difficult however to establish consistency given the three LAs may have differing approaches to delivery. We should however as 'systems' ensure that we strive to achieve the 'standards' outlined in the Discharge Requirements. The importance across the Region is that the key principles and standards within the discharge policy are met and considered within the partnership boards. A baseline assessment has been undertaken previously in relation to these standards and each County System has a plan in place to deliver these (the Carms plan is mentioned in the report).	Sep-22	~~Sep-22~~ ~~Aug-23~~ 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002b	N/A	R2b. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	A community dashboard is being developed by Performance team which will allow us to report 'how much and how well' against these standards which will give us the opportunity to review at three County level. NB such a dashboard is not consistent across the whole of Wales. Our work will contribute to 'pathfinding' at All Wales level.	Apr-22	~~Sep-22~~ N/K	Red	31/10/2022- Focusing on the ask of the original recommendation, across the Regional UEC Programme Delivery Group undertakes a monthly review of the agreed high level 3Cs outcome measures (Conveyance, Conversion and Complexity) and, to highlight any worsening trends, and focus through the delivery groups the expectation will be that focused outcome measures will be agreed by each Policy Goal Delivery Group, with exception reporting feeding up to the programme delivery board. This will develop equitable outcomes across the Hywel Dda patch, even if separate models across the counties is required and regardless if a dashboard is in place. Through the Policy Goals 5 & 6, the outcome measures that have been identified will be shared with all the Policy Goals Delivery Groups as required. Recommendation to be requested to be closed once the above is being reported through the Delivery Groups and explicit within the workplans, approximate date not yet known, this will be a long term recommendation to fully implement with the date currently not known. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this is now being reported through the UEC Delivery Groups and explicit within the workplans. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_002c	N/A	R2c. The provision of health and care services differs across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. There is opportunity for the Health Board to review the differing arrangements to identify and share best practice from each county, with potential for achieving a single, consistent model.	As part of the UEC programme Policy Goals (PG) 5 and 6 will provide oversight of this. PG 5 & 6 UEC workstream meetings will be scheduled to progress this work and ensure alignment with the national PG5 & 6 workstream.	Jul-22	~~Jul-22~~ N/K	External	31/10/2022-This recommendation is being driven through the delivery groups of the UEC programme, as described above. These recommendations are to be included in the workstream workplan, along with the WG guidance once received. Timescale not yet known as awaiting WG guidance. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003a	N/A	R3a. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Following a recent staff survey one of the key recommendations is to develop better, very practical and locally delivered discharge planning training. A plan is in development to do this, working in partnership with the Improvement Team, and to focus this on home first principles, understanding the D2RA principles and purpose, build better relationships across the MDT and communication through the SharePoint system. This training will need to be incorporated in agency and temporary staff induction to ensure consistency of the discharge process being applied. SharePoint does give us the opportunity to identify the time between someone being admitted and added to the system, this gives us a baseline and therefore monitor the impact. For patients discharged in October (319 patients) who were added to SharePoint the average number of days between admission and being added to the system: Bronglais – average 9.1 days Glangwili – average 16.8 days Prince Philip – average 14.0 days Withybush – average 10.9 days	Apr-22	N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_003b	N/A	R3b. Regular training on discharge planning is not provided to key staff which may contribute to the lack of a 'whole system' approach due to poor understanding of their roles, responsibilities and interdependencies within the wider discharge process. A common theme arising from our enquires was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Important to note that there is still work to be done on data quality,, which is being considered via performance teams and UEC board. This will be part of project work associated with Policy Goals 5 and 6 of the UEC programme. Success of any training however is dependent on 'ownership' of discharge planning processes by acute and community staff. A regional task and finish group is being established to discuss how the conversation about future plans can commence on admission and information can be provided to facilitate a conversation.	Apr-22	~~Sep-22~~ N/K	External	31/10/2022- The national online Training package is on hold due to awaiting WG guidance, therefore recommendation will remain as 'external' (outside the gift of the UHB to currently implement). Once guidance received it will be explored if the training could form part of the UHB mandatory training programme. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss update of recommendation progress. Recommendation changed to external whilst UHB is waiting for WG guidance. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_006	N/A	R6. Lessons learned reviews are not undertaken to identify and address failure points, or areas of good practice.	Where sub optimal discharges occur these are reported via our Datix system and investigated accordingly. Any lessons learned are then brought to our joint QA Senior management team for discussion. However a regional solution to share learning should be developed alongside the county approach.	Apr-22	~~Jun-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 confirrmed 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_007	N/A	R7. The Expected Date of Discharge (EDD) should be used to inform the discharge planning process. However, the purpose and value are misunderstood, resulting in inconsistent use and non-compliance with WG requirements. WG's SAFER Patient Flow Guidance issued in February 2018 states that all patients should have an EDD based on the clinical and functional criteria for discharge and should be set with the assumption of ideal recovery and no avoidable delays. This is reinforced within the WG COVID-19 Discharge Flow Chart (Appendix B) which requires an EDD and clear Clinical Plan within 24 hours of the patient being admitted in hospital.	The report does not clearly articulate that a critical component of realistic EDD is dependent on clinicians determining on day one of admission the clinical goals the patient needs to achieve during acute admission. Similarly the MDT needs to also determine the functional deficit on admission and the minimum the patient needs to achieve in terms of functional gain during admission. Collectively this is known as establishing Clinical Criteria for Discharge (CCD). Without CCD it is impossible to determine EDD and appropriate discharge pathway. MDT engagement in working towards the EDD is pivotal and at present, the delays inherent in patient assessment do not facilitate this. Whilst clinical teams are encouraged to set the EDD within 24 hours, it is not uncommon for this to be set to a default e.g. 2-4 weeks after date of admission rather than based on MDT discussion EDD is usually recorded on SharePoint but not the CCD – both of which are set out clearly as important early steps in the discharge planning process. SharePoint has agreed with stakeholders set of definitions to aid the understanding of these dates. It must be recognised that workforce compromise in acute hospitals across nursing, senior clinicians and therapy is contributing to us not being able to deliver this effectively. Acute sites do not get consistent MDT attendance at board rounds due to resource constraints amongst therapists and social services. Staffing and services have seen wards struggle to sustain the board rounds alongside patient care. The focus has been on sustaining the Board Rounds and maintaining those communications Development work has been re-implemented with wards(COVID depending) – this includes addressing content of and engagement in Board Rounds. Implementation of development plans will be on a rolling basis and prioritised based on COVID situation, engagement and urgency for improvement. They will include action plans covering EDD's, general content, afternoon huddles and medical engagement. This development work will form part of the implementation plan for UEC Policy Goal 5, optimal hospital care and discharge practice from the point of admission. Community has invested in DLNs, Senior Flow Managers and additional therapists who are based in the hospital to try and encourage this practice.	Apr-22	~~May-22~~ ~~Mar-23~~ N/K	Red	31/10/2022- As part of Quality & Safety, Policy Goal 5 has been identified as one of the 4 workstreams (Acute care) which is facilitated by improvement Cymru and Institute for Healthcare Improvement (IHI). This recommendation will be added to the Policy Goal 5 workplan. Under the Digital programme the Director of Finance has commissioned an external company to deliver a Digital system which will predict the Expected Date of Discharge (EDD) at the point of admission. Informatics have identified systems which provide automated arrangements. Approximate March 2023 date for rollout. 09/11/2022 - confirmed with internal audit that a follow up review is scheduled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request meeting to discuss if this recommendation has been explicitly added to the PG5 workplan. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 10/7/2023- USC lead confirrmed 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_008	N/A	R8. Only one acute site is compliant with the requirement for two daily board rounds (as per WG Requirements). WG Requirements stipulate the responsibilities and required actions from each of the identified roles within the D2RA process, including Health Boards, Local Authorities and Adult Social Care services, Local Health and Social Care Partners, Voluntary Sector and Care Providers. Our review highlighted that although representatives from the aforementioned services are involved in various stages of the patient discharge process, there is a lack of a whole system approach to discharge planning.	Counties have reviewed and strengthened their whole system flow process. Whole system 'Board Rounds' are also undertaken daily as part of the daily touchpoint meetings across acute, community and primary care. A programmatic and phased approach we are taking is to ensure that Board Rounds are operating effectively on all wards once a day. As outlined above our review has demonstrated that Board Rounds were not being conducted appropriately (as per SAFER guidance). As such we have introduced the targeted / focused approach outlined in point above.	Apr-22	~~Jun-23~~ ~~Aug-23~~ N/K	Red	31/10/2022- Related to the Policy Goal 5 Delivery Group Safer review and outcome measures. Approximate timescale of August 2023. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request progress of this recommendation. 20/02/2023- The Transforming Urgent & Emergency Care Programme Internal Audit report brief has been agreed which will incorporate the recommendations from this report, and work is due to commence and planned to be submitted to April 2022 ARAC meeting. 03/05/2023- Assurance and Risk Officer met with Integrated System Director who advised there a need for clarity of responsibilities with regards to discharge planning, as this spans both acute, community and primary care. Internal Audit will be undertaking a review of discharge processes by the end of quarter 3 2023/24, which will follow up on the recommendations made in this report. 07/07/2023 - LTC are now involved in the discharge planning/coordination task and finish group which is Health Board wide. 10/07/2023- USC lead confirrmed 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.
HDUHB-2122-34	Dec-21	Internal Audit	Discharge Processes	Open	N/A	Primary Care, Community and Long Term Care	Primary Care, Community and Long Term Care	TBC	Director of Operations/Director of Primary Care, Community & Long-Term Care	HDUHB-2122-34_009	N/A	R9. A common theme arising from our enquiries was that the discharge planning process often starts too late and only once the patient is medically optimised. Key information (such as existing care or support arrangements, or lack of) to inform patient requirements at the point of discharge is not sought early enough in the patient journey, resulting in discharge delays whilst appropriate care packages are put in place.	Actions outlined in 4 / 3.8 and 4 / 3.12 apply	Apr-22	~~Jun-22~~ N/K	Red	31/10/2022- Director of Primary Care, Community & Long-Term Care confirmed this recommendation is to remain open- even if it is picked up under UEC as it is clear from recent reviews across all sites that in the main the discharge planning process commences at too late a stage following admission. 09/11/2022 - confirmed with internal audit that a follow up review is scheuled for FY 2023/24, which will take in to account any changes to the current discharge processes, and existing recommendations can be updated or removed as appropriate. 15/12/2022- emailed Assistant Director of Nursing to request 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 confirrmed 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.
SSU-HDU-2122-06	Feb-22	Internal Audit	Waste Management	Open	Reasonable	Estates	Estates	Senior Environmental Officer	Director of Operations	SSU-HDU-2122-06_001b	Low	1.1.b The Waste Policy should be updated (at its next review) to define the Executive Lead for waste management.	1.1.b Update the Waste Policy during next review (due 2023) with Exec Lead.	Oct-23	Oct-23	Amber	11/11/2022-Progress to be requested in early 2023 to ensure this is on track. 27/04/2023- Senior Environmental Officer confirmed Waste Policy on track for update by October 2023.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
SSSU_HDU_21 22_07	Aug-22	Internal Audit	WGH Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	SSSU_HDU_2122_07 _007a	Medium	R7a. Identity checks should be undertaken to ensure correct labour rates are being applied.	Agreed	~~Aug-23~~ Oct-23	~~Mar-23~~ ~~Jul-23~~ Oct-23	Amber	12/08/22-Cost advisors are dealing with this, statement evidence to be provided to Internal Audit. 07/09/22- Head of Operations to send evidence to IA to close this recommendation. 10/01/2023- Internal Audit to check evidence submitted by the Estates team and if this can now be closed. In the interim a March 2023 date has been provided. 14/11/2022- Internal Audit will be reviewing progress made on recommendations from this report in Q4 2022/23. 26/04/2023- Draft follow up report states partially implemented – it was clear that the external project manager had scrutinised CV of SCP staff. However, noting the labour-intensive nature of the works and the SCP intention to change a number of key staff, it is important that a fully auditable trail is maintained linked to staff rates being applied. Revised timescale of July 2023. This report will be superseded by the follow up report once it is received at ARAC in May 2023. 11/07/2023- Capital Development Manager confirmed this action has been partially actioned and noting that would be ongoing as resources change with the SCP team. The action has been initially undertaken and ongoing consideration as IHP resources change. Action turned from red to amber and revised date of October 2023 which is the current end of scheme date.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_001	Medium	R1. Review and update the policy to ensure it accurately reflects current practice for the prevention and management of falls.	In-patient falls group set up and Task & Finish group established to update Falls Policy.	Dec-22	~~Dec-22~~ ~~N/K~~ ~~Jun-23~~ Sep-23	Red	20/01/2023 - Extended period of bereavement/sickness leave for Head of Nursing (Scheduled Care) resulting in meetings being postponed. Meetings now re-established and policy review in progress. Request has been made for final extension; date to be confirmed. 10/03/23 - The work that has been progressed so far was received at SNMT (09/03/23). Current Policy has been extended to June 2023 to ensure that all updates have been incorporated. 30/04/2023 - Recommendation is on track to be completed by 30/06/2023 07/07/2023 - Policy draft version out for global consultation July 23. Policy to be reported to SNMT for approval 10/08/23 and the Clinical Written Control Documentation Group for approval on the 07/09/2023. 11/09/2023- on track for revised date end September 2023. Falls inpatient policy approved in SNMT, it was taken to policy group last week and there are a few minor amendments needed which they are happy to take chair actions on when complete
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_002	Medium	R1. Consider re-launching the updated policy with an awareness campaign to ensure all clinical staff are au fait with the requirements	Falls policy following completion to be ratified through relevant Governance committees. Relaunch following approval	Feb-23	~~Feb-23~~ ~~N/K~~ ~~Jul-23~~ Oct-23	Red	10/03/23- Once ratified further awareness raising of the revised policy and tools will be undertaken-Jul23 30/04/2023 - Recommendation is on track to be completed by 31/07/2023 07/07/2023 - Policy draft version out for global consultation July 23. Policy to be reported to SNMT for approval 10/08/23 and the Clinical Written Control Documentation Group for approval on the 07/09/2023. To then be launched through global email and relevant committee/meetings and other development opportunities (e.g. conferences) through a multiprofessional lens. 11/09/2023-On track for revised date end October 2023, when policy approved this will launched in the UHB and disseminated internally.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_005	Medium	R3. Develop a delivery plan for the Falls Strategy identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Delivery plan will be developed in line with frailty work which is being taken forward via Transforming Urgent and Emergency care programme	Apr-23	~~Apr-23~~ ~~Jun-23~~ ~~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.
HDUHB-2223-19	Oct-22	Internal Audit	Falls Prevention and Management	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing and Quality Improvement /Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-19_006	Medium	R4. Develop and implement a falls prevention and management training programme. This should form part of the Health Board's Falls Strategy.	Quality Improvement Practitioner (falls lead). Is working with the national falls task force to identify an e-learning training package. Once training package is ratified then it will be aligned to our internal falls strategy.	Apr-23	~~Apr-23~~ ~~Jun-23~~ 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.
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_001	Low	R1. The entire catalogue of documentation must be reviewed and updated. All documents must have a date reviewed, and a due date for the next review to assist with confirming its relevance. We note that this could be partially or wholly addressed by the cyber security programme Policies and Procedures workstream.	We will add this recommendation to the policies and procedures workstream of the cyber programme to undertake a documentation review and ensure they are updated.	Mar-23	~~Mar-23~~ ~~Jun-23~~ Sep-23	Red	16/01/2023 - One policy updated and approved. 5 going to next IGSC. 17/05/2023 - Two Digital policies remaining which have been to SRC for approval and require minor changes, following this the recommendation can be closed. 11/07/2023 - Update pending
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_002	Medium	R2. The Health Board should have one asset management system that contains all necessary data for its identification and remote monitoring. It should contain enough information on each asset so that its make/model/os/SNo./location, assigned user etc is recorded.	The Health Board has procured the FreshService Asset Management module which is part of our Service Management tool. This will be integrated with our various management platforms to provide a single asset register for the Health Board. This work forms part of the Asset Management Workstream of the cyber programme.	Aug-23	~~Aug-23~~ 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 occuring to undertake all the tasks associated with the asset workstream of our cyber programme. 11/07/2023 - Update pending
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_003	Medium	R3. Suppliers should be monitored regularly, at annual review points, to ensure all contractual obligations, including claimed standards and accreditations for themselves and their staff are being maintained.	This recommendation is being picked up as part of the supply chain security workstream of our cyber programme where assurances will be sought at contract award and annual renewal of their standards and accreditations.	Jul-23	Jul-23	External	16/01/2023 - Work in progress. On track. 17/05/2023 - The Health Board is waiting for NWSSP to complete the All Wales Cyber assurance process which we will adopt. Rec status changed to External as outside the gift of the HB to complete rec at present. 11/07/2023 - No further progress to date
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_004a	Medium	R4a. All network management tools should be correctly configured so as to be able to identify and categorise alerts by importance/severity, and to assist with capacity management.	The Asset Management workstream will be integrating the Solarwinds Network Management tool with FreshService. This will allow for more granularity of alerting and using the automation features we can automatically alert support teams when high priority incidents occur.	Feb-23	~~Feb-23~~ ~~Jul-23~~ ~~Aug-23~~ N/K	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
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_005b	High	R5b. All equipment that utilises obsolete/unsupported, or insecure operating systems should be located, updated, removed, replaced, or isolated as a matter of urgency. An asset management process should be created, documented, and implemented to ensure the obsolescence of all equipment is monitored so that this situation cannot recur.	This work is already underway, and the latest dashboard is shows that over 99% of the desktop estate has been updated and the last devices remaining are a challenge due to legacy systems in use. The "securing the servers" workstream is improving patching compliance, deploying new anti-virus platform, and removing legacy objects and a dashboard is under development. Monitoring is now undertaken through NESSUS and Windows Defender which highlight old items.	Sep-23	Sep-23	Amber	16/01/2023 - Upgrades completed. Awaiting update. 17/05/2023 - New Anti-Virus platform has been fully deployed and the securing the servers workstream is working through the remaining legacy operating systems. There are 510 legacy desktop devices remaining and 136 servers. 11/07/2023 - Current figures to be updated
HDUHB-2223-24	Oct-22	Internal Audit	IT Infrastructure	Open	Reasonable	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-24_006	Low	R6. All data held, and that is about to be created by the digitisation project, should be reviewed and its data-quality dimensions established as per the HMG data quality framework. An assessment of the likely required network capacity should be undertaken to ensure that the network can handle the increased traffic.	The review of scanned images is a component of the Digitalisation of Health Records Project and CITO (our supplier) complies with the relevant ISO certification for health records scanning. The scanning communications take place between the scanning providers and our Azure platform therefore this process sits outside our network. However, network upgrade projects are underway at WGH and PPH hospitals and this will include capacity assessment.	Mar-24	Mar-24	Amber	08/03/2023 - Update from 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 wioth Head of Medical Records)
SSU_HDU_222 3_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_0 03	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.
SSU_HDU_222 3_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_0 04	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.
SSU_HDU_222 3_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_0 08	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.
SSU_HDU_222 3_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_0 09	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.
SSU_HDU_222 3_D	Oct-22	Internal Audit	Decarbonisation	Open	N/A	Strategic Development and Operational Planning	Estates	Executive Director of Strategic Development & Operational Planning	Director of Strategic Development and Operational Planning	SSU_HDU_2223_D_0 15	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-23	Nov-22	Internal Audit	Cyber Security	Open	Substantial	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-23_002	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).
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_003b	High	R3.2 The WLS Team should support directorates and services in their development of action plans to address areas of non-compliance with the Standards.	The WLS Team will support directorates and services that engage with them in their development of action plans to address areas of non-compliance with the Standards.	Sep-22	~~Sep-22~~ ~~Mar-23~~ ~~Jul-23~~ N/K	Red	05/12/2022 - This report superseded HDUHB-2122-12. 19/05/2023 - Risk 1232 has been updated accordingly to reflect progress. Action plans to be developed for services who have completed self-assessments. 11/07/2023 - All Directorates have now completed their self-assessment and drafted mitigating actions to improve any shortcomings. 11/09/2023 - Digital team to touch base with Welsh Language team to develop specific compliance action plan (e.g. Switchboard spot check failures)
HDUHB-2223-29	Dec-22	Internal Audit	Follow-up: Welsh Language Standards	Open	Limited	CEOs Office (Welsh Language)	CEOs Office (Welsh Language)	Yvonne Burson / Enfys Williams	Director of Communications	HDUHB-2223-29_004	Medium	R4. The WLS Team to establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Establish a Welsh Language Steering Group in order to capture and review the organisation's compliance with the Standards as soon as capacity allows.	Mar-22	~~Mar-22~~ ~~Mar-23~~ ~~Apr-23~~ Sep-23	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)
HDUHB-2223-14	Dec-22	Internal Audit	Individual Patient Funding Requests	Open	Reasonable	Medical	Medical	Head of Effective Clinical Practice & QI	Medical Director	HDUHB-2223-14_001	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	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.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_002	N/A	R2. Consideration should be given to establishing the Programme Group as a formal Committee of the Board.	To be considered as part of the overall governance requirements of the programme.	Jan-24	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'To be considered in advance of the Outline Business Case stage'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024. 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.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_003	N/A	R3. The terms of reference of the Programme Groupshould clearly defined activities within and outside of scope.	Agreed.	May-23	~~May-23~~ 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.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_004	N/A	R4. When linkage is required to the Executive Team/ Executive Steering Group, the accountability arrangements should be clearly defined.	Agreed.	Jan-24	Jan-24	Amber	24/02/2023- Under suggested timescale the Internal Audit report states 'As required'. Approximate timescale to be clarified with Lead Officer. 16/03/2023- approximate timescale provided as January 2024.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_005	N/A	R5. Linkage to the Major Infrastructure PBC will be defined.	To be considered as part of the overall governance requirements of the programme.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_009	N/A	R9. The master programme should be activity/ task based.	Agreed.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_013	N/A	R13. An activity-based resource schedule will be produced for the Outline Business Case stage.	A resource plan has been agreed for the current stage, however a full exercise is required for the next stage.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_014	N/A	R14. Existing Health Board staff (including the SRO and Executive Team) will be advised of the expected level of commitment anticipated for the production of the Outline Business Case.	Agreed.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_015	N/A	R15. Adequate representation will be secured from all key functions e.g workforce, clinical, finance, IT, hotel services etc.	Agreed.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
SSU-HDUDB-AHMWWP-0223	Feb-23	Internal Audit	A Healthier Mid & West Wales Programme	Open	N/A	Strategic Development and Operational Planning	Strategic Development and Operational Planning	Eldeg Rosser	Director of Strategic Development and Operational Planning	SSU-HDUDB-AHMWWP-0223_016	N/A	R16. Having identified the resource requirement to prepare each aspect of the Outline Business Case, the Health Board should seek to build its own internal resource/ expertise.	Agreed.	Sep-23	Mar-24	Red	05/09/2023- This work will be completed following Strategic outline case (SOC) completion and submission to WG.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-002	Medium	R2.1 Ensure POL audits are completed as soon as possible for the remaining MH&LD sites and risk scores are correctly calculated in line with procedure.	We will complete POL audits for the outstanding Older Adult, Primary Care and Older Learning Disability Community Teams	Aug-22	~~Mar-23~~ ~~Jun-23~~ ~~Aug-23~~ Oct-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past. 16/05/2023- Deputy Directorate Support Manager confirmed Health & Safety Officer has reviewed the completed audits and action plans, and they need to be streamlined. H&S Officer revisiting Community Sites with Business Managers and Team Leads. Revised timescale of end of June 2023. 05/07/2023 - Health & Safety has completed all but one of the Community audits, the last one taking place on the 17/07/23, then waiting for H&S Officer to forward on streamlined audits and action plans. This is due to H&S having to re-visit audits on in-patient wards due to Capital Bid Project work and Project feasibility forms. Revised timescale of the end of August 2023. 07/09/2023-Deputy Directorate Support Manager confirmed all audits have been completed, however awaiting 4 audits to be finalised by the H&S officer. Revised date of October 2023.
HDUHB-2223-33	Feb-23	Internal Audit	Follow-up: Prevention of Self Harm	Open	Reasonable	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Liz Carroll	Director of Nursing, Quality and Patient Experience	HDUHB-2223-003	Medium	R2.2 For the POL audits already completed, review and update the overall risk scores in line with procedure.	Risk scores will be rectified and the Risk Assessment Document will be amended.	Aug-22	~~Mar-23~~ ~~Jun-23~~ ~~Aug-23~~ Oct-23	Red	14/02/2023 - This report superseeds the report HDUHB-2122-45. The recommendations as written in the original report HDUHB-2122-45 was as follows: 2.1 Ligature audits must be completed at least annually, and more frequently where required, for example if there are changes to the environment or patient profile. Revised recommendation in this new report provides a revised timescale of March 2023. Red RAG status applied as timecale of original recommendation in original report has past. 16/05/2023- Deputy Directorate Support Manager confirmed risk scores will be reflected in the streamlined audits and action plans by end of June 2023. 05/07/2023 - Confirm that risk scores are being amended, and audits and action plans will be forwarded by the Health & Safety Officer by the end of August 2023. 07/09/2023-Deputy Directorate Support Manager confirmed this forms part of the work of recommendation 2.1 All audits have been completed, however awaiting 4 audits to be finalised by the H&S officer. Revised date of October 202
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_002	Medium	R2. The UHB should liaise with Specialist Estates Services to agree a framework approach to ensuring the SCP completes contractual documentation in a timely manner.	Future assurance – at future contracts	Mar-24	Mar-24	Amber	14/03/2023- IA confirmed this recommendation is for future contracts, and the suggestion of a 12 month deadline (March 2024) would be sensible as there are likely to be more contracts executed with this specific contractor in that period – which should allow us to close the recommendation.
SSU_HDUHB_2223_07	Feb-23	Internal Audit	Glangwili General Hospital Fire Precautions Works: Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU_HDUHB_2223_07_009	Medium	R9. Delegated limits should be reviewed to provide an upper financial limit for Project Manager approvals. Where external resource is used to support items such as room clearances; these instances should be recorded/ approved by the UHB.	Enhanced approval mechanisms will be implemented. However, the requirement for external resource will be reduced with the approval of soft FM support for the project at the January Project Group.	Jul-23	~~Jul-23~~ N/K	Red	26/04/2023- on track. 14/07/2023- Capital Development Manager to discuss this action with the team to establish if this can be closed. 11/09/2023- information to be sent shortly to close.
SSU-HDUHB-2223-02	Feb-23	Internal Audit	Glangwili Hospital - Women & Children's Development, issued February 2023	Open	Reasonable	Women and Children's Services	Strategic Development and Operational Planning	Project Director	Director of Operations	SSU-HDUHB-2223-02_003	Low	R3. Management should undertake a lessons learnt review of the project following completion.	An interim lessons learnt exercise was undertaken in 2021. A Capital Governance Review was also undertaken in 2021 whichhas picked up on learnings from previous audit reports on the scheme. A lessons learnt exercise will be carried out 6-12 months after scheme completion in line with best practice.	Dec-24	Dec-24	Amber	16/03/2023- Lessons learnt review will take place when construction activity is complete. Target date December 2024.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001a	N/A	R1a. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business case will be the case for change, which will outline the proposed plan. Timeline: • Strategic Options Appraisal– February 2023	Feb-23	~~Feb-23~~ ~~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.
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001b	N/A	R1b. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business 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	Amber	11/09/2023 - Head of Digital Operations to pick up with Digital Director.
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_001c	N/A	R1c. The Health Board should define a plan and targeted deadline with the Regional Digital Group to agree a way forward for the Regional Data Repository.	The recent work commissioned around the development of a data fabric for the Health Board has provided a strategic direction, and an options appraisal of the leading cloud providers. The Health Board will be developing a business case for the movement of data from on premises to the cloud. As part of this business case will be the case for change, which will outline the proposed plan. Timeline: • Design / Delivery –October 2023 – March 2024	Mar-24	Mar-24	Amber	11/09/2023 - Head of Digital Operations to pick up with Digital Director.
HDUHB-2223-22	Mar-23	Internal Audit	Fitness For Digital - Use of Digital Technology	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	HDUHB-2223-22_003	N/A	R3. The Health Board should relaunch both their Strategy and Digital Response to reinforce the message of the need for change to achieve the digital and overall ambitions.	The Health Board acknowledges that the previous Digital Response was not fully socialised across all areas of the organisation and will be ensuring that the next version of the digital enablement plan is closer aligned to the Health Board's strategy "A Healthier Mid and West Wales".	May-23	~~May-23~~ ~~Aug-23~~ Dec-23	Red	11/07/2023 - Response is now available on Intranet. A comms plan is currently being developed to enable a wider reach.
HDUHB-2223-17	Mar-23	Internal Audit	Patient Experience	Open	Reasonable	Nursing	Nursing	Assistant Director (Legal & Patient Support)	Director of Nursing, Quality and Patient Experience	HDUHB-2223-17_001	Medium	R1. Establish a plan for review and formal launch of the Charter for Improving Patient Experience.	The formal plan for review and launch of the Charter for Improving Experience will be presented to the Listening and Learning Sub-Committee.	May-23	~~May-23~~ ~~Jul-23~~ Oct-23	Red	21/04/2023-In target to be completed by May 2023; work is ongoing in accordance with the Quality and Engagement Act charter. 6/7/2023 – plan developed for review of charter and for presentation to Listening and Learning on 12/07/23 for approval. 11/09/2023- the task and finish group will be established as soon as the UHB have some clarity from WRP who are running the workshop and designing an all Wales LFE process. First meeting is being held on 14/09/2023.
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_001a	Medium	R1. Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	All Heads of Nursing to discuss at Professional Nurse Forums (PNF) the importance of timely completion of Purpose T risk assessments and completion of associated care plans.	Apr-23	~~Apr-23~~ N/K	Red	25/04/2023 - HoN BGH has confirmed that this recommendation is implemented in BGH. 04/05/2023 - Deputy HoN has confirmed that this recommendation is completed in PPH. 11/07/2023- recommendation completed for WGH. 12/09/2023- AMAT system confirmes completed for WGH, BGH & PPH. Awaiting confirmation report is completed for GGH.
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_001c	Medium	R1. Ward level checks should be undertaken to ensure compliance with NICE guidance and the Health Board's Prevention & Management of Pressure Ulcer policy, specifically that: • Purpose T risk assessments are completed for all inpatients, on admission and weekly thereafter. • Where a patient is assessed as being at risk of pressure damage, a care plan is developed and implemented.	Spot check audits in relation to Purpose T Risk Assessment and associated Care plans to be undertaken as part of the agreed standardised Audit development framework plan.	Jun-23	~~Jun-23~~ 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 confirmes completed for BGH and PPH. Awaiting confirmation from other sites.
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_002	High	R2. Investigation and closure of open incidents should be prioritised, with a timescale for completion.	All staff need to be reminded of the importance of timely investigation of incidents in line with Patient Safety flow chart.	Apr-23	~~Apr-23~~ N/K	Red	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 states confirmation still required from BGH, GGH & MH&LD Directorates. 14/09/2023- completed for BGH and MH&LD
HDUHB-2223-16	Apr-23	Internal Audit	Safety Indicators – Pressure Damage & Medication Errors	Open	Reasonable	Nursing	Nursing	Assistant Director of Nursing	Director of Nursing, Quality and Patient Experience	HDUHB-2223-16_003	High	R3. In line with the patient safety flow chart: • Management review of incidents must be undertaken within 72 hours. If this is not feasible in the short term due to service pressures, an improvement plan should be developed to support achievement. • Incident investigation must be completed within 30/60 days • Investigation of pressure damage incidents must include completion of the focussed review	All areas to develop improvement plans as to how the 72 hour target is to be metwith target dates, this will need to be monitored via the Improving Together Meetings	Jul-23	~~Jul-23~~ N/K	Red	12/07/2023- Deputy Head of Nursing, PPH confirmed recommendation completed for PPH. 12/09/2023- AMAT system states confirmation still required from BGH, GGH & MH&LD Directorates. 14/09/2023- Completed for MH&LD.
HDUHB-2223-28	Apr-23	Internal Audit	Regional Integration Fund	Open	Reasonable	Finance	Finance	Director of Finance	Director of Finance	HDUHB-2223-28_001	High	R1. The UHB as "Host" for the RIF Finances, work with the Regional Partnership Board to ensure an agreed Memorandum of Understanding is in place explicitly setting out the Health Board and other key partners roles and responsibilities for the governance and accountability arrangements of RIF for the next financial year.	We will ensure that we work with the RPB to finalise the MoU which clearly sets out the key roles and responsibilities for the governance and accountability arrangements for RIF for the next financial year.	Jun-23	~~Jul-23~~ N/K	Red	11/05/2023 - Originally intended to be completed by 30/06/2023, but it will need to be approved by the Board before it can be signed off (meeting scheduled for July 2023).
SSU-HDUHB-2223-06	Apr-23	Internal Audit	Withybush General Hospital - Fire Precautions Phase 1	Open	Reasonable	Estates	Estates	Project Director	Director of Operations	SSU-HDUHB-2223-06_006	Medium	R6. A review should be undertaken to analyse and learn lessons of performance issues at this project, so that similar issues and other similar projects can be mitigated at an early stage.	Agreed – a lessons learned exercise will be undertaken covering the performance issues raised above and results used to inform future projects of this type. We will contact NWSSP SES to discuss the facilitation of this exercise given the wider learning possible.	Feb-24	Feb-24	Amber	
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_002	Medium	R2. Mechanisms should be in place to ensure job plan review meetings are arranged within the 15 month period of the last review.	Proposal to allocate clinicians with allocated quarters in which job plan reviews should be carried out each year. Job plan communications and non-compliance process will then mirror that of the appraisal process, which has proved effective. This approach may need to be approved by the LNC before implementation.	Jul-23	~~Jul-23~~ ~~Aug-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_005	High	R5. Service management should ensure that all agreed consultant sessions recorded on job plans are accurately reflected in ESR through the prompt submission of a change form to NWSSP Payroll Services.	A review of the process surrounding job planning will be undertaken by a group linked to the medical workforce effectiveness workstream. This group will ensure managers are reminded of their responsibilities which includes accurately recording the detail of job plans in allocate and also producing the paperwork for changes to sessions agreed as part of the process.	Jun-23	~~Jun-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006a	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	A regular audit of job plans and ESR records will be developed and administered by the medical workforce team.	Jul-23	~~Jul-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006b	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Original baseline to be reviewed with discussions to commence with managers and individual consultants to understand difference between ESR and allocate.	Jul-23	~~Jul-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006c	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Roll out schedule for correcting any inconsistencies to be developed & agreed.	Jun-23	~~Jun-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006d	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Changes to be actioned in ESR where necessary.	Jun-23	~~Jun-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_006e	High	R6. The Medical HR Team should also review the accuracy of consultant sessions recorded in ESR to their job plans as part of their additional pay elements review.	The first report has already been produced to generate the baseline assessment and once actions have been taken in 3.3 it will then be re-run twice per annum to ensure the process remains robust and medical workforce are paid accurately and on time. Arrangements in place for bi-annual audit.	Dec-23	Dec-23	Amber	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. 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.
HDUHB-2223-20	May-23	Internal Audit	Job Planning	Open	Limited	Medical	Medical	Head of Medical Education and Professional Standards	Medical Director	HDUHB-2223-20_007	High	R7. Quantify the total over/underpayments for the 12 identified in this audit and take action to recover/pay.	Finance Business Partners to work with relevant Service Delivery Managers and Medical Workforce to quantify total over/underpayments for the 12 identified in this audit and take action to recover/pay.	Jul-23	~~Jul-23~~ N/K	Red	19/06/2023: From June PODCC: an action plan has been developed collaboratively between key medical, operational and Workforce and OD stakeholders, to ensure that there is a clear consensus of what needs to be done and by whom. The internal audit report has discussed at the Audit and Assurance Risk Committee (ARAC). Once all actions are complete, the updated report will be re-submitted to ARAC. 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.
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	HDUHB-2223-25_001	High	R1. A single, overarching programme should be created for digitalisation. It should include all projects with an outline delivery schedule and key milestones to facilitate progress and measurement. Financial projections should be included for all projects, and combined as necessary to indicate total programme cost. Project and programme progress reports should accurately report: • all costs to date, comparison against budget/plan. • Progress against milestones, interim objectives. • Immediate risks • Next steps • RAG status on achieving overall objective	We will aim to establish an overarching programme to provide the necessary governance and assurance to the Board, and would enable the bringing together of the two current workstreams in a more formal approach.	Jul-23	~~Jul-23~~ 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.
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	HDUHB-2223-25_002	Medium	R2. Once costs are projected (MA1) a full Cost Benefit Analysis should be prepared to include the projects effect on the boards cashflow and overall financial effect. It should be updated accurately with the latest 'known' information and realistic estimates included as necessary. This process should be constantly maintained and reported through all appropriate channels regularly as considered appropriate.	In order to comply with Recommendation 1, a full review of the costs will be undertaken, which will include the on-going revenue costs for the continued roll out of the digitalisation of health documentation across the Health Board.	Sep-23	Sep-23	Amber	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.
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	HDUHB-2223-25_003	High	R3. A benefits tracker for the current project(s) should be completed showing expected realisation dates and effects/values. (Either for each project separately, or a combined one for the overall digitalisation programme.) There should be clarity as which part of the whole digitisation programme the benefits are attributable to so as to avoid double counting, and the tracker should include the following: • Benefit owners should be identified • Current baselines should be established and recorded. • Measurement criteria should be clarified and agreed. • Measurement methodology and monitoring, (kpi/automation as appropriate) should be agreed. • Expected benefit delivery schedule should be agreed.	To fulfil Recommendation 1, the current digital benefits realisation framework will be retrospectively applied to the new overarching programme, and it will detail a full benefits plan with associated metrics for tracking said benefits.	Sep-23	Sep-23	Amber	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.
HDUHB-2223-25	May-23	Internal Audit	Records Digitisation	Open	Limited	Central Operations	Digital and Performance	Deputy Director of Operations	Director of Operations	HDUHB-2223-25_004	Medium	R4. Feedback from the tests (reported February 2023) should be used to refine/improve the processes and address any issues raised during testing. Larger scale UAT with testers representative of all groups and grades of users from all disciplines and areas should be repeated on the final proposed system prior to going live.	As we have only undertaken a soft launch of the product (specifically in Medical Records) a limited number of staff were used to UAT the system. For assurance purposes, during the quality assurance of the ingested records, 15 staff were accessing the system routinely, both from medical records and digital, to validate the records. Before full roll-out across the Health Board a full UAT test plan, and wider stakeholder engagement will be undertaken.	Dec-23	Dec-23	Amber	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.
HDUHB-2223-06	Jun-23	Internal Audit	Agency & Rostering	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	HDUHB-2223-06_001a	Medium	R1. Final rosters should be subject to senior review and oversight to ensure efficient rostering to minimise the use of agency staff.	Roster team to continue with regular roster audits, recording findings and reviewing with the Ward Manager. The Senior Nurse Manager and Deputy Head of Nursing to be invited to the roster review meetings; a roster audit report issuedto the service with actions recorded and followed up at the next review meeting.	Sep-23	Sep-23	Amber	08/09/2023-On target to complete end September 2023. Regular audits are carried out, the Senior Nurse Manager and Deputy Head of Nursing are invited to the roster review meetings to discuss the audit findings
HDUHB-2223-06	Jun-23	Internal Audit	Agency & Rostering	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	HDUHB-2223-06_002	Medium	R2. Establish arrangements for the appropriate prior approval of over-establishment shifts required at short notice or outside of Senior Nurse Manager core working hours.	Review each roster area to ensure sufficient managers that work out of hours are trained to be able to add shifts and approve. Refresher training to be made available to all areas. List of Managers working out of hours to be requested from the service. Roster team to share escalation process out of hours with all managers that may working out of hours. Roster Team to send a reminder on the process for approving shifts outside of working hours to Senior Nurse manager.	Sep-23	Sep-23	Amber	08/09/2023- On target to complete end September 2023.Refresher training sessions have been made available to roster areas. The escalation process has been shared with all managers that are working out of hours and the Roster Team have sent a reminder of the process for approving shifts outside of working hours to Senior Nurse Managers
HDUHB-2223-06	Jun-23	Internal Audit	Agency & Rostering	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	HDUHB-2223-06_003	Medium	R3. Processes for resource priority and escalation, including approval requirements, should be formally documented and communicated to relevant staff including roster preparers and Senior Nurse Managers.	The priority for filling shifts and processes for escalating to bank and framework/non-framework agency to be formally documented and shared with all relevant staff. In addition a costing sheet to be developed to demonstrate the cost incurred should bank, additional hours, overtime, On Framework or Off Framework be used, and shared with relevant staff.	Sep-23	Sep-23	Amber	08/09/2023- On target to complete end September 2023.
HDUHB-2223-06	Jun-23	Internal Audit	Agency & Rostering	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	HDUHB-2223-06_004b	Medium	R4. Shifts escalated to bank/agency in Health Roster less than 28 days before the shift date should be prioritised to bank before releasing to agency.	Roster team to monitor 2nd line approval is completed to allow roster to be published 6 weeks in advance to ensure priority is given to bank staff filling shifts, metric to be included in roster audit and reviewed in follow up meeting with Ward Manager, Senior Nurse Manager and Deputy Head of Nursing.	Sep-23	Sep-23	Amber	08/09/2023- On target to complete end September 2023. The Roster team to monitor that the 2nd line approval is completed by Senior Nurse Managers as per the timetable to ensure rosters are published 6 weeks in advance.
HDUHB-2223-06	Jun-23	Internal Audit	Agency & Rostering	Open	Reasonable	Workforce & OD	Workforce & OD	Senior Workforce Manager	Director of Workforce & OD	HDUHB-2223-06_006a	Medium	R6. Directorates should be provided with regular reports on agency use to ensure adequate and consistent monitoring, until they are confident in doing this independently in the Health Roster system.	Additional training to be put in place for Roster Managers to ensure they are confident in running reports on agency usage independently in the Health Roster system.	Sep-23	Sep-23	Amber	08/09/2023- On target to complete by the end of September. Additional training sessions have taken place with more scheduled. Training is part of the ongoing support the Roster team offer to all new and existing roster managers.
HDUHB-2223-09	Jun-23	Internal Audit	Financial Management	Open	Reasonable	Finance	Finance	Senior Business Finance Manager (Corporate)	Director of Finance	HDUHB-2223-09_002	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~~ N/K	Red	In progress, with August 2023 delivery dependant on the Operational Delivery Framework being finalised.
HDUHB-2223-39	Jun-23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	HDUHB-2223-39_010b	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	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	Amber	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.
HDUHB-2223-39	Jun-23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	HDUHB-2223-39_012	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	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
HDUHB-2223-39	Jun-23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	HDUHB-2223-39_013	High	R13. Consignment stock should be separately identifiable on the stock record, and stored separately to Health Board-owned stock.	In the interim, a review to be undertaken of current locations and volumes of consignment stock, with a view to identifying suitable independent storage areas, and inventory lists. Scan for Safety and the related inventory management system (IMS) will ultimately address this.	Sep-23	~~Sep-23~~ Oct-23	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 - 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. 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.
HDUHB-2223-39	Jun-23	Internal Audit	Theatre Loan Trays & Consumables	Open	Limited	Scheduled Care	Central Operations	Service Delivery Manager for Theatres	Director of Operations	HDUHB-2223-39_014	High	R14. Periodic stock checks should be undertaken to reconcile physical stock balances to the stock record, and identify and investigate any discrepancies.	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	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 - 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.
HDUHB-2223-18	Jun-23	Internal Audit	Lessons Learned	Open	Reasonable	Nursing	Nursing	Assistant Director Legal and Patient Support	Director of Nursing, Quality and Patient Experience	HDUHB-2223-18_003	Medium	R3. The Health Board should reinforce the full and accurate completion of the lessons learned section for incidents and complaints recorded in Datix by the responsible directorate/service officers.	A small task and finish group will be established including the corporate concerns team, legal services and operational colleagues to devise a lessons learned procedure, including the use of datix. The aim will be to devise directorate wide learning plans, rather than individual action plans to strengthen the governance and monitoring around actions. This will enable easier identification of repeated themes/trends and dissemination.	Sep-23	Sep-23	Amber	
HDUHB-2223-18	Jun-23	Internal Audit	Lessons Learned	Open	Reasonable	Nursing	Nursing	Assistant Director Legal and Patient Support	Director of Nursing, Quality and Patient Experience	HDUHB-2223-18_004	Medium	R4. Consideration should be taken to include incident investigation and reporting into the toolkit currently being developed to aid staff in ensure a consistent approach is taken for the recording of cases in Datix.	An incident reporting process and tools to aid investigation are already in place and contained within the SharePoint site for all staff access. The concerns investigation training is ongoing and well attended which provides support to staff on investigation methodologies and practical skills. The Health Board will engage with the all Wales work to develop an incident investigation framework which will provide the investigation procedural requirements for all NHS bodies. Alongside this will be the implementation of a separate investigation module on Datix which will be utilised for all concerns investigations.	Dec-23	Dec-23	Amber	
HDUHB-2223-37	Jun-23	Internal Audit	Strategic Change Programme Governance	Open	Limited	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Finance	HDUHB-2223-37_002	High	R2. Strategic programmes should be managed as such from the outset, with appropriate programme management resource and a formal programme plan demonstrating alignment with the organisations objectives and setting out the aims, milestones and anticipated outcomes.	The strategic programmes of change within the Health Board are described by the Planning Objectives agreed annually by the Board. The Executive team will establish a formal process to assess the resource requirements for each and align corporate resources accordingly.	Jul-23	~~Jul-23~~ N/K	Red	11/07/2023 - This is an open Targeted Intervention Master Theme action residing in Planning.
HDUHB-2223-37	Jun-23	Internal Audit	Strategic Change Programme Governance	Open	Limited	Finance	Strategic Development and Operational Planning	Executive Director of Strategy and Planning	Director of Finance	HDUHB-2223-37_003	High	R3. The programme plan should form the basis of monitoring programme delivery against milestones and achievement of identified aims and outcomes. This would encourage transparency, consistency and completeness in assurance reporting to the Board.	Linked to the ongoing Targeted Intervention work the Health Board will review its processes and documentation for managing programmes.	Aug-23	~~Aug-23~~ N/K	Red	11/07/2023 - This is an open Targeted Intervention Master Theme action residing in Planning.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HDUHB-2223-37	Jun-23	Internal Audit	Strategic Change Programme Governance	Open	Limited	Finance	Strategic Development and Operational Planning	Director of Finance	Director of Finance	HDUHB-2223-37_004	High	R4. Implement the recommendations arising from the Director of Corporate Governance/Board Secretary's review of the governance arrangements in place for Health Board savings schemes.	The recommendations of the review will be implemented in full.	Jul-23	~~Jul 23~~ Sep-23	Red	11/07/2023 - All finance function related items closed as complete with the exception of Arcus review, where a proposal will be concluded by September 2023. All remaining items are supported by ongoing business processes, with some related to the recommendations as set out in the Targeted Intervention Master Theme actions that are outstanding.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_001	High	R.1. St Nons. Ensure that door sets than can resist fire and smoke for 30 minutes are provided in the following locations: Throughout Units, many doors were defective, these were on escape routes. The terms door set refers to the complete element as used in practice: • The door leaf or leaves. • The frame in which the door is hung. • Hardware essential to the functioning of the door set, 3 x hinges. • Intumescent seals and smoke sealing devices/Self closure. • Self-closers to be fitted to all doors and not compromise strips and seals of fire doors.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec 21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 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.
BFS/KBJ/SJM/00113573	Dec-19	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. St Nons (Secure EMI unit)/ St Brynach's (Day Hospital) / Bro Cerwyn (Offices) BFS/KBJ/SJM/00113573	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KBJ/SJM/00113573_002	High	R2. St Nons. Reinstate the fire resistance in the following location(s): Compartmentation issues throughout unit, due to Dampers showing fault on system.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec 21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ Aug-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed advanced, first and second phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the M 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.WWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_001	High	R1. Compartment •A Compartmentation survey of all the listed blocks above including floor to roof (Loft separation between stairwell and accommodation / office areas) must be carried out to ensure that fire and smoke cannot pass. • All Loft hatches are to be fire resisting to a minimum of 30 minutes. • Data cables, pipes and ducting need to be fire stopped, noted within St Thomas block but to include any other area not noted within all other blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec-21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit theUHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 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.
BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Jan-20	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters. Withybush General Hospital, Kensington, St Thomas, etc. BFS/KS/SJM/00175424/00175421/00175428/00175426/00175425	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS.KS/SJM/00175424/00175421/00175428/00175426/00175425_002	High	R2. Fire Resisting Corridors Ensure that the means of escape is kept free from fire and smoke for a period of 30 minutes by ensuring that: • Bedroom / flat doors, Kitchen, cleaners and Laundry room doors, are all to be a minimum fire resistance of FD30s with a self-closer. (Pembroke county, Springfield, St Thomas, Kensington blocks) these doors should not be wedged open and any intumescent smoke seals that is damaged (Painted over) or missing should be replaced. At the time of the inspection I noted a number of doors being held open with wedges, the use of these Wedges holding doors open in all Blocks should be prohibited as it could promote the spread of fire, if doors are required to be left open then they will have to be self-closing 30-minute fire door linked in to the fire detection system. • Excessive gaps in fire doors should be repaired or the door needs to be replaced so the gap is a max 3mm (Within All Blocks). • Transom lights above doors should be replaced, they should be constructed to provide 30 minutes fire resistance to the means of escape, these were mainly noted within the Pembroke county, St Thomas, Kensington blocks but if they are present within any other block within the means of escape these need to also be addressed. • Lobby doors need to be replaced in both first floor RH offices within the Springfield and Kensington blocks.	Full action plan held by Estates.	~~Mar-20~~ ~~Dec 21~~ ~~Apr-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	Amber	12/01/2021- Revised letter from MWWFRS confirmed this item is to be completed in line with the agreed first phase works: Stage 2 / Phase 1 works relate to all remaining escape routes at WGH and all remaining work at St Caradogs, St Nons to be completed by end April 2022. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 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.
BFS/KS/SJM/00114719 - KS/890/03	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719 - KS/890/03	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147199_03_001	High	R1. Compartmentation – All Horizontal Corridor Escape Routes To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Aug-21~~ ~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	~~Dec-21~~ ~~Apr-22~~ ~~Dec-22~~ ~~Mar-23~~ ~~Jul-23~~ ~~Aug-23~~ Oct-23	Amber	This work is part of the phase 1 WGH Fire Enforcement Programme. 12/08/2022- MWWFRS have extended to March 2023 as they have accepted UHB presentation of the extra complexity of the work involved which requires extra time to implement. Letter dated 25/07/22 from MWWFRS confirms this. 11/11/2022- a revised completion date of March 2023 had previously been accepted by the Project Manager (PM) and subsequently agreed by MWWFRS who had formally extended the FEN dates. Following the latest update to this Committee extensive further works have been identified including additional Fire Doors and Fire Stopping requirements. This work being identified from forward look surveys as part of the pre planning process in place with the supply chain and UHB teams. The impact on programme of the above has meant that the date noted above has now been extended to July 2023 (including contractors contingency float); a period of 4-month extension. This extension has been fully assessed by the PM and appropriate due diligence checks have been made prior to the acceptance of this programme. This programme impact has been communicated to the MWWFRS ahead of the next progress review with them currently planned for mid-November 2022. 20/12/2022- This programme update has been fully reported to MWWFRS in a formal meeting held 08/12/2022, and they fully accept the need for this adjustment. They have noted that they will look to revisit the UHB prior to the current set end date of March 2023 so that an appropriate extension can be given at that point. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is July 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 11/09/2023- MWWFRS letter confirms extension to October 2023.
BFS/KS/SJM/00114719-KS/890/04	Feb-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: Withybush General Hospital. BFS/KS/SJM/00114719-KS/890/04	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	BFS/KS/SJM/001147199_004	High	R1. Compartmentation – All Other Compartmented Areas. To undertake whatever works are necessary to ensure that any / all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Withybush Hospital are addressed. Fire resisting structures are to continue to slab / upper floor level / roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Apr-22~~ Apr-25	~~Dec-24~~ Apr-25	Amber	This work is part of the phase 2 WGH Fire Enforcement Programme. 13/11/2020- Letter dated 05/11/2020 from MWWFRS this notice is extended to 30 April 2025 as agreed in the programme for Phase 2 Works (presented to them on the 02 October 2020). Recommendation changed back from red to amber. 27/06/2022- Phase 2 works remain on programme to be completed by April 2025. 12/08/22-unchanged- Phase 2 at WGH, WG has provided approval letter to proceed to BJC Phase 2, which is due to be submitted to UHB in early 2023 and then to WG after the scrutiny process.. 11/11/2022- unchanged, same as previous comment from 12/08/22. 20/12/2022- A programme completion date will be developed as the above BJC work is progressed to encompass the work content and complexity of this Phase 2 project. Early indications are that due to the multiple Decant needs of Ward areas the programme may need to be extended as part of the due diligence work within the Business Case. As this becomes more developed, MWWFRS will be fully involved in these discussions so that appropriate changes can be made to the Phase 2 Enforcement dates. This matter has been discussed with MWWFRS who appreciate that a revision may be required to this programme should the nature of the works dictate that an extension to this timeline becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2025 date. 26/04/2023- the UHB has recently presented a reduced scope of works for Phase 2, which the MWWFRS are considering, with a decision likely to be received the second week of May 2023. Subject to this being approved, there will be a significant reduction in cost.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
KS/890/08	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire , SA31 2AF KS/890/08	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/08_01	High	R1.Compartmentation – All Horizontal Corridor Escape Routes (Agreed Phase 1 Works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Horizontal Escape Routes within Glangwili General Hospital are addressed as agreed in the programme for Phase 1 Works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ ~~Jul-22~~ ~~Feb-23~~ ~~Aug-23~~ 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 the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Forecasted completion date presented to, and agreed by, MWWFRS is November 2023. 21/04/2023- communication from MWWFRS confirmed a formal extension of six months to 31/08/2023, these will be reviewed on a six monthly basis pending request to extend. 31/08/2023- MWWFRS letter confirms extension to 31/01/2024.
KS/890/09	Nov-20	Mid and West Wales Fire and Rescue Service	Enforcement Notice Premises: West Wales General Hospital, Glangwili, Dolgwili Road, Carmarthen, Carmarthenshire , SA31 2AF KS/890/09	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	KS/890/09_01	High	Item Number 1 - Compartmentation. (Agreed Phase 2 works). To undertake whatever works are necessary to ensure that any/all breaches in fire resisting compartmentation that affect the Wards, Theatres, Plant Rooms, Offices, Surgeries, Specialist Units and any other compartmented spaces within Glangwili General Hospital are addressed as agreed in the programme for Phase 2 works (presented to us on the 02 October 2020). Fire resisting structures are to continue to slab/upper floor level/roof level and pass through any false ceiling provided.	Full action plan held by Estates.	~~Oct-20~~ ~~Feb-21~~ Aug-24	Aug-24	Amber	13/11/2020- Letter dated 05/11/2020 from MWWFRS confirming enforcement notice KS/890/06 is withdrawn and replaced by KS/890/07, KS/890/08, KS/890/09 dated 04/11/2020. KS/890/09 to be completed by 31/08/2024 as agreed in the programme for Advanced Works (presented to them on the 02 October 2020). Original completion dates shown on tracker taken from original KS/890/06 enforcement notice. 11/11/2022- The expectation was that the BJC would be completed by Quarter 4 of the 2022/23 FY. The UHB has recently been informed by the SCP that due to capacity issues and the extent and complexity of the works, this date will now be circa August 2023. The UHB have asked for further clarification on this from our PM and a review of any opportunities to improve on this position. This has the potential to delay the start of works on Phase 2 until circa November 2023. On the wider programming the impact on programme of Phase 1 would in any case align well with the revised programme of Phase 2. MWWFRS have already been briefed on this and this will be set out in a formal meeting with them mid-November 2022. Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Discussions have been undertaken with MWWFRS who appreciate that a revision may be required to the programme, should the nature of the works dictate that an additional period of time becomes necessary. 20/12/2022- It is important to note that Phase 2 works will be extremely complex given the delivery of these FEN works to busy clinical areas. The due diligence work required during the Business Case development will confirm both commencement dates and programme delivery dates for this work. Regular discussions continue with MWWFRS, including a formal meeting held on 08/12/2022, who appreciate that a revision may be required to the FEN dates should the nature of the works dictate that an additional period of time becomes necessary. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of April 2024. 26/04/2023- it is unlikely this works will be completed by August 2024 due to the scope reduction and complexity of the works. MWWFRS are fully briefed on the UHB position and will consider an official extension when the works programme is presented to them. The business case is currently being drafted.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_002	High	Item 1- R2. The following door should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. ● Bryngofal – door 690, door from main corridor to command area and the cut door in the medical infirmary. ● Residential blocks (2 to 7) - a number of flat / bedroom doors within these residences (for this action refer to point 1 fire door survey).	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivey plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_003	High	Item 1- R3. All doors on rooms within Block 2 housing Combi boilers are to be fitted with an air transfer grille, it should only be fitted with one that is capable of sealing both by thermal initiation and by interface with smoke sensors either directly or via a fire alarm panel(Dependant on the type of ventilation required for the appliance). The air transfer grill should conform to a relevant standard e.g.BS 8214:2016. If these appliances do not require this type of ventilation.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Works to Residential blocks (2 to 7) forms part of the advanced works developed by design team. Overarching delivey plan for the site is to March 2025.There is a further piece of work beyond March 2025 re. BJC which will completed prior to March 2025 for the remaining works. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_005	High	Item 1- R5. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. All remaining doors under future phasing Overarching delivey plan for the site is to March 2025.Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_007	High	Item 3- R7. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 within the following areas. •Bryngofal red zone storage area main building previously a bathroom. • The demountable structures. • And any other room converted into a risk room within the Prince Phillip site. All work involving the fire alarm should be carried out in accordance with BS 5839-1 current edition, HTM 0503 B Section 4 and paragraph 4.6.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Mar-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to amber.
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_008	High	Item 4- R8. All door release devices (Including floor pneumatic release devices) should work in accordance with the relevant British standard: BS 7273-4:2015 actuation of release mechanisms for doors and comply with WHTM 05-02 Appendix C: Door Closers and Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. • Diabetic unit • This action should be carried out over the whole site and as part of the fire door survey mentioned in item 1 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Oct-22 Mar-24	~~Oct-22~~ Mar-24	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. This recommendation will be picked up in phase 1 as part of the EFAB funding for 2023/24. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Will be addressed in Phase 1. Completion date March 2024.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KS/AMD/00106219	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: PRINCE PHILLIP HOSPITAL, BRYNGWYN MAWR, LLANELLI, SA14 8QF BFS/KS/AMD/00106219	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00106219_013	High	Item 9- R13. The emergency lighting must be extended to cover the external exit routes and exit doors of the TY Bryn Template The system shall be installed, maintained and tested in accordance with a relevant standard. For a relevant standard please refer to BS5266-1:2016 Emergency lighting code of practice for emergency lighting of premises. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-25	~~Oct-22~~ ~~Aug-23~~ Mar-25	Amber	11/11/2022- A meeting is planned for mid-November 2022 with MWWFRS to consider all investment programmes across the UHB Estate and the PPH position will be fully explained as part of this briefing. It is expected that the MWWFRS will be supportive of this approach given that we already have a programme of prioritised works which will be undertaken over the next 6 months. Should the EFAB bids be unsuccessful then the HDdUHB would need to adjust the investment programme to rely on Discretionary programme investment in the first instance. This will then require a Business Case approach for the majority of the work programme which will inevitably extend the timelines. If this was the case, there would need to be follow up discussions with MWWFRS/WG to formalise this position. It is anticipated that the EFAB position will be clear by the end of December 2022 so the UHB can plan accordingly in terms of any escalation to WG. 20/12/2022- Formal meeting with MWWFRS on 08/12/2022 confirmed the positive progress on the above plan. A 4 Stage programme has been developed and the specific content of work within each of the 4 Stages has been set out for consideration for MWWFRS. This plan is currently with MWWFRS for formal approval but initial comments at the above meeting were very positive in terms of the pro-active and structured manner in which the UHB is approaching this work. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position.Overarching delivey plan for the site is to March 2025. Recommendation moved back from red to amber.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_001	High	R1. A fire door survey is required at the Tenby cottage hospital site due to a number of defects found at the time of inspection. The findings of this survey must be completed within the mentioned timescale. Fire resisting doors need to be fitted with: • A self-closing devices including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ ~~Mar-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_002	High	R2. During the inspection of the site breaches in compartmentation were identified. The breaches in compartmentation would not support the existing evacuation strategy (please see paragraph above). In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. WHTM 05-02 Chapter 5 and paragraph 5.12. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ ~~Mar-23~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of completion by March 2023. Recommendation moved back from red to amber. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2024. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/AMD/00115940	Apr-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: HYWEL DDA, TENBY COTTAGE HOSPITAL, GAS LANE, TENBY, SA70 8AG BFS/KS/AMD/00115940	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/AMD/00115940_003	High	R3. • Sluice room R24 is to be upgraded to a fire hazard room. • Any other room which has been changed to a fire hazard room within the premises. The fire separation between any fire hazard room and the means of escape of the building should provide a minimum 30 minutes' standard of fire resistance in accordance with WHTM 05-02 Table 6, 5.40-5.42, the fire separation should also conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Oct-22~~ Mar-24	~~Oct-22~~ ~~Mar-23~~ Mar-24	Amber	08/07/2022- UHB working with MWWFRS to agree the standards appropriate for this site and to confirm actions necessary, if any. 07/09/2022- Head of Estates Risk & Compliance to check with MWWFRS. 02/11/2022- The required standard has now been confirmed by MWWFRS and funding is in place to complete these works by end of March 2023. This has been set out in discussions with the MWWFRS. 20/12/2022- on track for completion by March 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position. Revised date of March 2024 provided and agreed by MWWFRS. Recommendation moved back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_001	High	R1. All doors to patient bedrooms are to be fitted with appropriately designed free-swing self-closing devices, as stated in (Table 6 WHTM 05-02).	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Funding and timescale to be agreed following the findings of the AFT survey. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 15/11/2022-AFT survey now completed. Detailed costs obtained for 106 repairable doors. Site review with NWSSP-SES to agree prioritisation of door replacements for EFAB funding. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_003	High	R3. The following doors should be replaced with fire doors providing 30/60 minutes fire resistance (Dependant on the location of the door). Panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance. • Medication room (LSU) – this is a stable door and is not providing suitable fire resistance.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_004	High	R4. Throughout the site various fire doors were found to be missing smoke seals. The seals should be attended to as part of the fire door survey mentioned above.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_005	High	R5. The cross-corridor doors in "Picu" was missing a self-closing device. A self-closing device is required on this door to ensure it closes fully into its rebate.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 02/11/2022- Assurance and Risk team are awaiting confirmation that all works have been completed/planned for this financial year. 15/12/2022- Head of Estates Risk & Compliance to confirm with GGH colleagues if this recommendation is now implemented. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.
BFS/SM/AMD/00107788	May-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters CWM SEREN ST DAVIDS PARK HAFAN DERWEN, JOBS WELL ROAD, CARMARTHEN, SA31 3BB BFS/SM/AMD/00107788	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/SM/AMD/00107788_008	High	8. A hold open device (or alternative solution) is required on the "Step Down" kitchen door. Fire resisting doors need to be fitted with: • A self-closing device including fire alarm activated Self closers. • Intumescent strips and smoke seals. • Three brass/steel hinges. Fire doors should conform to a relevant standard e.g. WHTM 05-02 Appendix C: Doors and door-sets Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 7273-4:2015 Actuation of release mechanisms for doors BS 8214:2016 - timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	~~Nov-22~~ Mar-24	~~Nov-22~~ ~~Oct-23~~ Mar-24	Amber	27/06/2022- Survey by AFT been undertaken costs are due back next week. 07/09/2022- Head of Estates Risk & Compliance to send revised action plan to Assurance and Risk team. 20/12/2022- seeking clarification for door work required and prioritise work. MWWFRS aware of this work and the money required, as discussed at the formal meeting on 08/12/2022. Awaiting formal revised date from MWWFRS. Estates service has provided revised date of October 2023 based on investment being received in April 2023. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position and the revised date of March 2024. RAG status of recommendations changed back from red to amber.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329500	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Blue Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329500_006	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 thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_001	High	R1.A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required, adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_004	High	R4.All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_006	High	R6. An assessment should be undertaken to ensure there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout blue block. For example: - •Top of the staircase from Angharad Ward All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329501	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Green Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329501_008	High	R8. An assessment should be undertaken to ensure all Internal and external escape routes are illuminated by emergency lighting that with operate if the local lighting circuit fail. The system should conform to BS 5266.	Full action plan held by Estates.	Dec-22	Dec-25	Amber	15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329501) confirms date for completion December 2022. 10/01/2023- Head of Estates Risk & Compliance to check if this has been implemented. 13/01/2023- A scheme has been completed to address all vertical escape routes with new emergency lighting, all remaining areas of the block will be considered as part of the main firecode scheme as agreed with MWWFRS. Revised date of December 2025 provided to encompass all works at the BGH site. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position with the timescale to December 2025. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329498	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Purple Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329498_006	High	R6. An assessment should be undertaken to ensure that there is suitable 30-minute fire resistance sub compartments and 60 minutes fire resistant compartmentation throughout the block. All openings in the walls, floors, partitions, and ceilings throughout the premises provided for the passage of service piping ducts or cables, are to be sealed or brushed to a 30-minute standard of fire resistance.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329498) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_001	High	R1. A number of fire resisting doors were found to have defects. All fire resisting doors throughout the premises are to be examined and repaired or replaced to ensure they are effectively self-closing onto their rebates. Gaps between door edge and frame are to be no more than 3 mm	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_002	High	R2. Self-closing devices on all fire resisting doors are to be checked and if required be adjusted, repaired, or replaced so the doors close completely into their rebates.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_003	High	R3. All self-closing devices are to be regularly inspected and maintained.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_004	High	R4. All fire doors should have intumescent strips and smoke seals	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_005	High	R5. All fire door vents should be designed in accordance with the required British Standard.	Full action plan held by Estates.	Oct-27	Oct-27	Amber	08/07/2022- MWWFRS letter states phase 2 completion is October 2027. Phase 1 will be completed in advance of this (letters states January 2025)- further survey to be undertaken at BGH site due to its complex environment. 15/11/2022- MWWFRS letter dated 31/08/2022 (same reference- Admin - General/00329500) confirms date for completion Phase 1 January 2025, and Phase 2 October 2027. 25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
Admin - General/00329499	Jun-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Failures Red Block, Bronglais General Hospital, Caradoc Road, Aberystwyth SY23 1ER	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	Admin - General/00329499_006	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 thay are comfortable with the current position of October 2027. 26/04/2023- The Programme Business Case has been submitted to WG, awaiting scrutiny comments from WG.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_001	High	R1. It was noted whilst carrying out the inspection that there were a number of faults found with a high number of the fire doors at this premises. These doors should be repaired or replaced. Any panels or partitions above or at the sides of the doors should provide a similar degree of fire resistance as the door installed. • All doors mentioned within the fire door survey carried out in September 2021. Fire doors should conform to a relevant standard e.g. Appendix C and Table 6 WHTM 0502, Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_002	High	R2. During the inspection breaches in compartmentation were identified throughout the premises. The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. 1. All compartmentation breaches identified within the compartmentation survey carried out in November 2021 & February 2022. 2. Smoke hoods within the attic area need to be installed correctly. 3. Broken and missing ceiling tiles need to be replaced. 4. Confirm the fire resistance of the various roller shutters which open onto the means of escape within the premises.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_003	High	R3. It was noted that the stairs within G124 were not protected as per paragraph 3.48 WHTM 05-02 - Stairways should always be remote from each other so that in the event of fire at least one is available for evacuation purposes. • Install a Fire Door set to comply with the above statement. • Within the old Cleddau ward a set of doors are to be installed either within the partition or within the external glazed wall. This is due to the extended travel distance from the ward to the closest exit. • Final exit door to courtyard GF1 area needs replacing. • Doors between G14 & G22 marked as D57 needs replacing.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address these defects – scheme led by design. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_005	High	R5. Extend the existing fire detection and warning system by providing automatic smoke/heat detection in the following areas: • X-ray Dept . • Remote indicator lights must be provided for detectors in concealed spaces e.g., roof voids, heads of lift shafts. It was noted that these devices were missing in various locations around the premises. • Confirm the roller shutters in various locations of the premises automatically close on the activation of the fire alarm system and or comply with the cause and effect strategy. • Confirm that there is a suitable cause and effect strategy for the premises.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_006	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 thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_007	High	R7. It was noted in the inspection that the emergency lighting installed may not be to the standard of BS5266–1:2016 Provide an emergency lighting system (which is to be independent of all other systems), to illuminate: • In all Internal and External escape routes. On completion of the emergency lighting system, the commission certificate is to be completed by a competent person and a copy made available to the Fire and Rescue Authority.	Full action plan held by Estates.	~~Mar-23~~ Mar-25	~~Mar-23~~ Mar-25	Amber	25/01/2023- MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
BFS/KS/JEL/00115068	Sep-22	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Premises: SOUTH PEMBS HOSPITAL, FORT ROAD, PEMBROKE DOCK, SA72 6FY	Open	N/A	Estates	Estates	Director of Estates, Facilities and Capital Management	Director of Operations	BFS/KS/JEL/00115068_008	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 thay are comfortable with the current position to be implemented by March 2023. 25/04/2023- EFAB funding now secured to address this. Date of completion is March 2025. This date was included in the presentation to MWWFRS in December 2022, following the meeting MWWFRS wrote to the UHB on 20/01/2023 to confirm they agreed with the timeframes presented.
NE/BFS/00173907	Apr-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	NE/BFS/00173907_002	High	R2. During the inspection breaches in compartmentation were identified: •Electrical Cupboard G37a The breaches in compartmentation would not support the existing evacuation strategy. In the event of fire, breaches in compartmentation, will allow fire and smoke to spread unchecked throughout the building. This would have an impact on the means of escape and render the evacuation strategy of the building ineffective. All breaches in compartmentation should be fire stopped to provide the appropriate fire resistance in accordance with building regulations. The fire resistance should conform to a relevant standard e.g. Appendix A (including Table A1, A2) of Approved Document B Volume 2 Buildings Other Than Dwelling Houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
NE/BFS/00173907	Apr-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	NE/BFS/00173907_003	High	R3. Doors leading to Wards R45 & R53 and Cross corridor doors separating Nurse space from circulation area to be inspected as part of a PPM survey. The fire separation should conform to a relevant standard e.g. HTMW – 5 - 2 Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
NE/BFS/00173907	Apr-23	Mid and West Wales Fire and Rescue Service	Letter of Fire Safety Matters Template 26, Prince Philip Hospital, Dafen, Llanelli. SA15 8QF NE/BFS/00173907	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	NE/BFS/00173907_004	High	R4. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. • 1164a & 1164b • 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	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_002	High	R2. 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	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_004	High	R4. The doorstops fitted to the frames of the following fire resisting doors were found to be missing and require installing •Door id 0042. The door stops and frames 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.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_005	High	R5. The gap between the door frame and the wall located •Door id 0053 should be in filled with a material that will provide the same degree of fire resistance as the wall. 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.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_007	High	R7. The control measures identified in the current risk assessment for the safe use of dangerous substances must be maintained. Oxygen Cylinders should be stored in accordance with HTM 02 - 01	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_008	High	R8. The following 30-minute fire resisting door was found to be damaged/defective. These doors must be repaired/replaced. •Id 0089 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	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_009	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. •Id 0048 •Id 0076 •Id 0080 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.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_010	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 0046 •Id 0069 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.	Sep-23	Sep-23	Amber	
NE/BFS/00173908	Apr-23	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	NE/BFS/00173908_012	High	R12. Remove existing lock fastenings from door(s) indicated/located •Final exit Occ Therapy Room If the door(s) is/are required to be kept locked it/they should be fitted with an approved type of emergency security fastening that can be operated from the escape side of the door(s) without the use of a key, which is conspicuously indicated as to its method of operation. This work should be done to conform to a relevant standard e.g. Section 6 General provisions of Approved Document B Volume 2 Buildings other than dwelling houses. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Aug-23	~~Aug-23~~ N/K	Red	11/09/2023-Head of Estates Risk & Compliance to confirm shortly that this has been implemented.
NE/BFS/00337255	May-23	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	NE/BFS/00337255_002	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	
NE/BFS/00337255	May-23	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	NE/BFS/00337255_004	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
NE/BFS/00337255	May-23	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	NE/BFS/00337255_006	High	R6. The following 30-minute fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •**E**F55 Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
NE/BFS/00337255	May-23	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	NE/BFS/00337255_007	High	R7. During the inspection the self-closing devices on the doors located at; •**E**F 06 •**E**F 01 •**E**F 15 •**E**F 22 Were found to be ineffective and should therefore be checked and maintained to a satisfactory standard so that the doors close completely into the rebate. Self-closing devices should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice. Compliance with this or an equivalent standard will normally satisfy the requirement.	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_001	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	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_002	High	R2. During the inspection breaches in compartmentation were identified: •**S**witchgear Room – ward 3 •**B**40 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.	Sep-23	Sep-23	Amber	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_004	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. •**B**35 Fire resisting doors need to be fitted with •**A** self-closing device •**I**ntumescent strips and smoke seals. •**T**hree brass/steel hinges. Fire doors should conform to a relevant standard e.g. Appendix B (including Appendix C Table B1) of Approved Document B Volume 2 Buildings other than dwelling houses. BS 8214:2016 - timber-based fire door assemblies – Code of practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_005	High	R5. A fire warning system must be extended.The scope and extent of the fire alarm system should be informed by the significant findings of your fire risk assessment •**S**toreroom R35 All work involving the fire alarm should be carried out in accordance with the relevant standard e.g., BS5839	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_006	High	R6. The following fire resisting doors were found to be damaged/defective. These doors must be repaired/replaced. •**2**241 Fire doors should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Mar-24	Mar-24	Amber	
NE/BFS/00141802	May-23	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	NE/BFS/00141802_007	High	R7. The intumescent strips and cold smoke seals on the following fire resisting doors were found to be damaged/missing. The strips and seals should be replaced in order to prevent the passage of smoke and flame. •**2**160 •**2**176 •**2**170 The intumescent strips and cold smoke seals should conform to a relevant standard e.g. BS 8214:2016 - Timber-based fire door assemblies – Code of Practice Compliance with this or an equivalent standard will normally satisfy the requirement	Full action plan held by Estates.	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
NE/BFS/00141802	May-23	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	NE/BFS/00141802_008	High	R8. During the inspection the self-closing devices on the doors located at; •2243A •2231 •2172 A/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.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_002	High	R2. 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.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_003	High	R3. 'Fire Door - Keep Shut' signs should be provided on the outside face of each fire door located • 2090 A/B • 2091 A/B	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_004	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	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_005	High	R5. During the inspection the self-closing devices on the doors located at; • 2119 Were found to be missing 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.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_006	High	R6. During the inspection the self-closing devices on the doors located at; • 2074 • 2080 A • 2100 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.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00173901	May-23	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	BFS/NE/jel/00173901_007	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. • 2075 • 2076 • 2089 • 2097 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.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00334401	Jun-23	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	BFS/NE/jel/00334401_001	High	R1. The following rooms are to be cleared of all storage • R04 This work is necessary to reduce the risk of spread of fire.	Full action plan held by Estates.	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
BFS/NE/jel/00334401	Jun-23	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	BFS/NE/jel/00334401_003	High	R3. 'Fire Door - Keep Shut' signs should be provided on the outside face of each fire door located • 1115B	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00334401	Jun-23	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	BFS/NE/jel/00334401_005	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.	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
BFS/NE/jel/00334401	Jun-23	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	BFS/NE/jel/00334401_006	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. • 1112 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.	Full action plan held by Estates.	Sep-23	Sep-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_001	High	R1. The fire safety measures evaluated in the fire risk assessment must be implemented.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_002	High	R2. The inspection hatch in the wall of the following room: •B51 Switchgear room Requires to be re inserted.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_003	High	R3. The opening in the ceiling located in •B31 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.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_004	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.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_005	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: •1131 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	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_006	High	R6. The existing fire warning system must be extended as necessary to conform fully to BS 5839-1:2017 Category L1 •B35: Clean Utility •B29: Storeroom All work involving the fire alarm should be carried out in accordance with BS 5839-1:2017. Timeframe for completion: 3 Months	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_007	High	R7. It should be ensured that The fire alarm actuation points are not obscured.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_008	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	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_009	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.	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345962	Aug-23	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/00345962	Open	N/A	Estates	Estates	Rob Elliott	Director of Operations	1012/BFS/EH/00345962_010	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	Full action plan held by Estates.	Nov-23	Nov-23	Amber	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_002	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_003	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_004	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_005	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_006	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_007	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	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_008	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_009	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	
1012/BFS/EH/00345963	Aug-23	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	1012/BFS/EH/00345963_010	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	
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_001	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Jun-23	~~Jul-23~~ Mar-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_004	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ ~~Jun-23~~ Mar-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_005	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	~~Aug-23~~ Jul-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_006	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_007	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	External	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_008	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_009	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Jul-23~~ ~~Dec-23~~ Jul-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_010	Low	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Aug-23	~~Aug-23~~ Jul-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_011	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ Dec-23	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_012	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	~~Sep-23~~ Mar-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_013	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-23	~~Mar-23~~ Mar-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_014	High	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Mar-24	Mar-24	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_015	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Mar-24	Red	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).
NHSW_CRU_CAFR	Feb-22	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report	Open	N/A	Digital and Performance	Digital and Performance	Digital Director	Director of Finance	NHSW_CRU_CAFR_022	Medium	Not included on tracker due to sensitivity of the report	Not included on tracker due to sensitivity of the report	Sep-23	Sep-23	Amber	01/08/2022 - Report was received at SRC In Committee in June 2022. The number of recommendations is based on the detail as listed in section 7 of the report, whereby 4 areas were considered with specific actions noted for each, totalling 25. Due to the sensitivity of the document, the individual recommendations will not be listed on the tracker, however progress will be monitored via bi-monthly service updates to the Digital Directorate, and for ARAC reporting purposes their RAG status will be noted on the open recommendations tab of this spreadsheet (but not the individual recommendations themselves).

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
PR_RCR0616	Jun-16	Peer Review	Respiratory Cancer Review, issued June 2016	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	Director of Operations	PR_RCR0616_001	N/A	R6. Health Board strategic review of services where sustainability of current service model is challenging.	Being reviewed as part of TCS programme.	Ongoing	N/K	Red	10/02/2022 - Recommendation owner amended to reflect recent changes in SDM role. 10/01/2023- Weekly meetings continue between the Clinical Lead and SDM. Recruitment remains a challenge within Respiratory with Consultants and Middle Grades supporting services, this continues to put huge stress on the respiratory system . The plan to train-up known junior doctors remains ongoing but this is a medium term plan. Realistic and operational short term plans are now in place to release specialist physicians from work that other physicians can undertake (acute on call, General ward rounds), in order to free up specialist time providing input on a health board wide basis. . This of particular relevance to Lung cancer where Dr Robin Ghosal has taken responsibility as Lung Cancer lead running the Lung Cancer service single handed. This interim service provision will continue until we can recruit. We do currently have a locum consultant working remotely managing the general chest waiting lists across the sites to alleviate pressure on sub speciality work Following our Away Day an IMTP is currently being drafted which includes the succession plan for the Lung Cancer Service and this involves the planning and recruitment of one of our existing Middle Grade Doctor to become a Consultant to support the robust provision 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 long working as the only consultant for the lung cancer service. A succession plan is in place but recruitment remains difficult. A risk is to be added to Datix to capture the difficulties in recruiting and the risk to the sustainability of the service due to the dependency on one consultant. Once the risk is added this recommendation will be raised to the Director of Operations to request the recommendation be closed.
PR_HDUHBLR0120	Jan-20	Peer Review	Hywel Dda UHB Lung Report, issued January 2020	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Anna Thomas	TBC	PR_HDUHBLR0120_001	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 new 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.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_004	N/A	All children and young people transferring across or between networks will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management plan. The health records summary will be a standard national template developed and agreed by Specialist Children's Surgical Centres, representatives of the Congenital Heart Networks and commissioners.	No action until template created	N/K	N/K	External	03/07/2023 - (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.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_009	N/A	Each Local Children's Cardiology Centre must be staffed by at least one Consultant Paediatrician with expertise in cardiology (PEC) who is closely involved in the organisation, running of and attendance in the Local Children's Cardiology Centre. Each PEC must have received training in accordance with the Royal College of Paediatrics and Child Health and Royal College of Physicians one-year joint curriculum in paediatric cardiology (or gained equivalent competencies as agreed by the Network Clinical Director). • Each PEC must spend a minimum 20% of his/her total job plan (including Supporting Professional Activities) in paediatric cardiology (in accordance with the British Congenital Cardiac Association definitions). • Each PEC must be part of a Congenital Heart Network. • Each PEC must work with a link/named Consultant Paediatric Cardiologist from either the Specialist Children's Surgical Centre or Specialist Children's Cardiology Centre and take responsibility for the running of regular joint paediatric cardiology clinics with the visiting Consultant Paediatric Cardiologist. • Each PEC will hold an honorary contract with the Specialist Children's Surgical Centre and/or the Specialist Children's Cardiology Centre and have the opportunity to attend clinical and educational opportunities in order to maintain expertise and facilitate good working relationships there as part of their job plan. • All patients under the care of a local children's cardiology centre should have a named paediatrician (ideally a PEC) responsible for coordinating care for children and young people after discharge from a CSSC, for referrals to local services and for communication between health professionals.	Job plan review	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~Mar-23~~ Oct-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - every cardiac clinic has a PEC when held, and covers all sites. Further clarification on job plans required and a revised timescale. 30/06/22- all clinicians actively participate within the network and work in collaboration with the tertiary consultants. Job planning activity yet to be completed but will now be revisited following appointment of new clinical lead. Job planning will also support the development of formalised honorary contracts. 18/8/2022 - Awaiting job planning & honorary contract 30/11/2022 - Job plans to be completed (in progress) during Q4 2022/23- 1 honorary contract arranged. 04/04/2023 - PEC cover maintained for all cardiac centres. All PECs undertake suffcent clinical duties to meet the 20% desired contribution to CHD activity. All PECs participate in network activity.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_012	N/A	Each Local Children's Cardiology Centre must have a cardiac physiologist with training in congenital echocardiography.	Capacity to be explored to assess requirements and develop business case as necessary.	Jun-22	~~Jun-22~~ ~~Aug-22~~ ~~Oct-22~~ Oct-23	Red	30/11/2022 - Initially unable to agree additional Echo technician capacity due to existing constraints in capacity- however, discussions and solutions are being revisited with Echocardiology team and Cardiology SDM. Unable to assign a date at this time. 19/01/23 - Discussion under way with Cardio-Respiratory department who would need to identify resources. Potential revised date to be identified after this discussion. 04/04/2023 - No capacity available at this time. Discussions are ongoing. Potential requirement for funding and recruitment.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_021	N/A	A Practitioner Psychologist experienced in the care of paediatric cardiac patients must be available to support families/carers and children/young people at any stage in their care but particularly at the stage of diagnosis, decision-making around care and lifecycle transitions, including transition to adult care. Where this service is not available locally the patient should be referred to the Specialist Surgical Centre or Specialist Children's Cardiology Centre.	Review current psychology provision/pathways - revise scoring and comments accordingly. Service to develop actions as appropriate	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_022	N/A	Young people must have the opportunity to be seen by a Practitioner Psychologist on their own. Psychological support must also be offered to parents/family or carers.	Response requested from lead officer.	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - There has recently been some additional successful recruitment to the psychology team within HDUHB- but their capacity remains constrained in terms of ability to manage additional conditions- discussions to assess potential CHD input are scheduled to take place in Q1 2023/24. Pathway to UHW remains intact.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_023	N/A	Patients must be offered access to a Practitioner Psychologist, as appropriate, throughout family planning and pregnancy and when there are difficulties with decision-making, coping or the patient and their partner are concerned about attachment.	Response requested from lead officer.	Nov-22	~~Nov-22~~ Oct-23	Red	30/06/22 No funding from local IMTP submission- but there is access to psychology via UHW for prioritised cases. 30/11/2022 - no update received 19/01/2023 - A CYP working group has been established which is chaired by Dir of Ops and Psychology provision is being assessed by that group;This recommendation is reported to QSEC. There is an ambition to deliver psychology services from a local service perspective.The revised date will depend on the outcome of UHB review. 04/04/2023 - Given patient/service user cohort sits within maternity services, request made to Head of Midwifery for an update on current provision.
PR_CHDP1021	Oct-21	Peer Review	Congenital Heart Defect Provider, issued October 2021	Open	N/A	Women and Children's Services	Women and Children's Services	Nick Davies/Dr Sian Jenkins	Director of Operations	PR_CHDP1021_024	N/A	All children at increased risk of endocarditis must be referred for specialist dental assessment at two years of age, and have a tailored programme for specialist follow-up.	Ensure communication channels / process is robust between CHD and dental, and right clinical staff aware.	Mar-22	~~Mar-22~~ ~~Jan-23~~ Oct-23	Red	24/03/2022- update requested from lead officer on 03/03/2022 with a deadline of 16/03/2022. No response received. 03/05/2022 - discussions have commenced with the dental pathways, awaiting further response to progress the recommendation. 30/06/22- HB Dental leads continue to review the process- update requested from deputy director today 18/08/2022 - Awaiting update 30/11/2022 - Paeds service still awaiting update from HB Dental service- SDM has chased. 25/01/2023-AMD- Dental has identified a pathway in SBUHB and is assessing whether this is a primary pathway that would be accessed by HDUHB patients. 09/03/2023 - Discussion with DoN at the IT meeting to clearly identify what sits outside of our direct influence/ responsibility- this may be one as dental services have their own management structure. Update on issues in relation to dental risks from a patient-facing perspective: all patients at risk are advised to have good dental care and see a dentist regularly. Difficulty accessing NHS dentists is a potential contributor to increased risk. SM to provide an update on the timeline for the coding rollout if any available.Including advice on dental and other IE prophylaxis now every clinic letter. 04/04/23 Update on issues in relation to dental risks from a patient-facing perspective: all patients at risk are advised to have good dental care and see a dentist regularly. Difficulty accessing NHS dentists is a potential contributor to increased risk. Tertiary colleagues however, have access to specialist dental input if indicated. HD pathway is being defined by AMD (Dental) but no update receved from AMD at time of this submission.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_001	N/A	R1. No Pathologist sitting in the MDT. There is no pathology input (other than prior emails) to the MDT meeting due to time constraints on the pathologist.	Need a regional approach for pathology.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ ~~Mar-24~~ 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.
PR_CC0122	Jan-22	Peer Review	Colorectal Cancer (Third Cycle), issued January 2022	Open	N/A	Cancer Services	Cancer Services	Lisa Humphrey	Director of Operations	PR_CC0122_002	N/A	R2. Single handed Consultant Oncologist in BGH. There is a single-handed experienced oncologist in Bronglais hospital supporting the management of the patients in the north of the health board.	Need to ensure that there is cover in place for the BGH Oncology Locum Consultant.	Mar-22	~~Mar-22~~ ~~Jul-22~~ ~~Mar-23~~ Mar-24	Red	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 appoimted Dr C Barringtom to cover the LGI Oncology service within HDUHB.The work on the updated strategy is still ongoing.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_001	N/A	R1. The swift establishment of a Health Board Orthopaedic Steering Group to oversee the implementation of our recommendations and deliver Orthopaedic improvements as oneHealth Board and not hospital by hospital.	June 2022 -Recommendation was accepted by HDUHB. GIRFT findings and recommendations to be presented to the Quality Safety and Assurance Committee for consideration and agrement for a Steering Group to be convened	Jun-22	~~May-23~~ Oct-23	Red	"22/06/2022 - SBAR prepared for Operational Quality Safety and Experience Assurance Committee to consider the finding and recommendations outlined within the GIRFT report and support the establishment of an Orthopaedic Steering Group to oversee and progress actions in respect of recommendations highlighted, to be report via the Operational Planning & Delivery Group structure 18/04/2023 - Steering Group is being set up with first meeting before end of June 2022. 09/06/2023 - The decision was made not to proceed with the establishment of an Orthopaedic Steering Group as it was more favourable to proceed with the proposed Regional Orthoapedic Network Board (the Memoradum of Understanding of which has been accepted by the Board) to plan on a Regional basis as agreed by the Arch Recovery Group 20/06/2023 - As discussed in ARAC, recommendation to remain Red until the memorandum of understanding is approved by Board 24/08/2023 - Update from ARAC: Memorandum of Understanding to be discussed at ARCH group in September 2023 (July's meeting was cancelled). 25/09/2023 - Andrew Carruthers, Director of Operations, is the lead for the Health Board on the South West Wales Regional Orthopaedics work between HDUHB and SBUHB. The programme board will work closely with the Welsh National Clinical Strategy for Orthopaedics (NCSOS) exploring the National Clinical Strategy and the GIRFT recommendations. The Orthopaedic management team has furnished data to support further discussions around comparative regional resource allocation (Theatres, clinics and workforce).
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_004	N/A	R4. HDUHB leadership to provide more clarity and regular updates to all staff, and importantly clinicians, about immediate and longer-term plans. There is an urgent need to re-engage with clinicians to rebuild trust and ensure that they are listened to and involved at each stage of restart and change proposals. It is imperative that clinicians are an integral part of the "sign off" and delivery of changes.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Jun-22	Oct-23	Red	18/04/2023 - At portfolio level, SDM, service manager and service support manager meets with the Clinical Lead on a weekly basis to discuss and agree on portfolio, strategic and operational issues. List of meetings clinical leads are invited to, to follow. 09/06/2023 - SDM, Service Manager and Service Support Manager meets with the Clinical Lead on a weekly basis to discuss and agree, action and escalate, as required, specialty strategic and operational issues at local, Regional and national level. This is cascaded to clinicians on all sites via the Local clinical leads and via the monthly Departmental meeting, as appropriate. The longer term strategy for orthopaedic provision remains to be confirmed and will be addressed by the Regional Orthopaedic Network Board. 2023/24 Orthopaedic Delivery is reflected in the Annual Plan. 25/09/2023 - Portfolio meetings continue to be held on a weekly basis and Andrew Carruthers, Director of Operations, is the lead for the Health Board on the South West Wales Regional Orthopaedics work between HDUHB and SBUHB. Additionally, Orthopaedics are involved in the Clinical Services Plan review being led by the Executive team and the Transformation Programme Office. This work will initially focus on the development of an issues paper to inform future development of our services - weekly meetings are held with the service management team and a targetted Stakeholder Engagement Session was held on 22/09/23. Lead clinician and Clinical Director are both sighted and involved in discussions with orthopaedic clinicians across the Health Board. CSP structured and in place until March 2024.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_007	N/A	R7. Patients for elective surgery to be assessed as part of the pre-admission process and any equipment that may be required be delivered to the patient's home prior to admission. For emergency admissions (e.g. fracture neck of femur), these should be assessed early on during their admission to agree their likely support package, which can be tweaked if the patient's condition changes. Currently, a Social Services assessment of patients does not start until the patient has been fully optimised and ready for discharge. This is significantly delaying patient discharge and resulting in inefficient use of valuable beds, thereby reducing elective surgical admissions. We need a risk share between the hospitals and Social Services as elective patients are disadvantaged due to lack of bed availability.	June 2022 - Recommendation was accepted by HDUHB - the proposed Orthopaedic Steering Group and any sub groups created will review and implement change as required	Jul-22	~~Jun-23~~ Dec-23	Red	30/06/2022 - Process for elective and emergency admissions is currently being reviewed by the Occupational Therapy Service to remove variation in practice across counties. Pre-covid process was that Furniture Height Forms were completed by all the elective hip/ revision replacement patients prior to Preadmission appointment and returned at that appointment. This was forwarded to the OT department for assessment, and they arranged equipment delivery prior to admission or alternatively OTs contacted patients on advice of impending admission date to capture this data. Knee replacement patients were managed similarly, but only those identified by the pre-assessment service as requiring support. Early discussions have taken place with Social Services in Pembrokeshire regarding a pilot to refer surgical patients, on being listed for surgery (potentially at prehabilitation) to Reablement so that immediate assessments can be undertaken to identify aids, physio and third sector support that can be offered to the patient whilst they await surgery. Social Services are also keen to earlier support for emergency patients Currently existence of Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staff shortfalls. An MDT (multidisciplinary team) approach in managing revisions and complex admissions requiring referral from WGH, BGH (Bronglais General Hospital) and community facilities to these surgeons for treatment at GGH is in the planning phase, which will also consider the total pathway of care for these patients 18/04/2023 - Equipment being delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. 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 - EQiiP project run by Pre-assesment is focussed on streamlining processes Health Board wide due to lack of consistency. There continues to be delays to discharge of medically fit patients due to delays in social services assessments.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012h	N/A	R12h. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure plans include 3 session days and 6 day working across orthopaedic surgery and all supporting services e.g. physiotherapy.	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	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.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012i	N/A	R12i. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Patients admitted for elective surgery should have their assessment undertaken prior to admission to ensure all equipment and needs are in place prior to admission. In the case of emergency admissions, assessments by physiotherapists, occupational therapists and social services should happen early in the pathway to ensure early mobilisation and discharge. Waiting until patients are fully optimised before this process begins adds significant delays to discharge planning. Risk share in this space is essential.	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	Red	30/06/2022 - Phased expansion towards 3 day sessions and 6 day working will be dependent on workforce recruitment and agreement of an appropriate resource plan. (Refer to Update for Rec 7) 09/06/2023 - Elective patients - All elective patients are pre-assessed and equipment is delivered and installed to elective patient's home prior to discharge is in place. Risk share with social services to be reviewed. Unscheduled admissions - Board rounds and ward-based MDT (multidisciplinary team) meetings enables the early identification of emergency admission patients to services who will require involvement in discharge planning. The ethos is that support packages are arranged as early as possible, but it is acknowledged that this can be affected by staffing challenges within OT and social services. 25/09/2023 - A number of actions are replicated within recommentation 12. An EQiiP project is currently being run by Pre-assesment and focusses on streamlining processes Health Board wide due to a lack of consistency. There continues to be discharge delays for medically fit patients due to delays in social services assessments. Work is being undertaken through NHFD groups around early mobilisation and is captured through NHFD reported KPI's. This work also advises on the reasons for being unable to mobilise patients. Updates to be obtained from NHFD groups and Pre-assessment EQiiP project.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012j	N/A	R12j. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Ensure pre-operative assessment is as efficient as possible to ensure lists are filled and to reduce cancellation on the day	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 documention across the Health Board. The pilot commenced at BGH on 11/9/2023 and rollout will continue at PPH & GGH week beginning 9/10/2023, then finally at WGH the week beginning 16/10/2023. 3 month pilot. Feedback will be expected through the Scheduled Care QSESC directorate meetings.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_012k	N/A	R12k. Set out a short term elective recovery restart plan which identifies the most effective and efficient way to treat as many patients successfully as possible. This will require the "ring fencing" of sufficient elective surgery beds at pace, using an effective demand and capacity methodology to ensure waiting lists reduce every month and the development of green pathways which are resilient for 12 months of the year. It will need better relationships with all other Health Boards and provision of mutual aid. CEOs of the Health Boards must meet and ensure that immediate changes are put in place collaboratively at pace to start to reduce waiting lists. The plans should consider the following: Utilise day surgery wherever possible adopting the HVLC programme, the 11 pathways for orthopaedics, ensuring "top decile" outcomes and using the GIRFT theatre principles and expected productivity as a steer.	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	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 3 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.
RNOH_GIRFTOR_0522	May-22	Peer Review	Getting It Right First Time (GIRFT) Orthopaedic Review	Open	N/A	Scheduled Care	Scheduled Care	Lydia Davies	Director of Operations	RNOH_GIRFTOR_0522_013	N/A	R13. Create and implement a workforce plan both short, medium, and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery. Where immediate resource shortfalls exist, innovative workforce solutions should be developed to ensure that workforce gaps don't become the main risk to reducing waiting lists and to the success of future change plans. Improved workforce planning (including recruitment and retention strategies) must be in place urgently. The NCSOS will be providing a detailed consultant workforce review and also recommendations for a wider programme review the whole MSK workforce, we fully support this approach.	June 2022 -Recommendation was accepted by HDUHB - Create and implement a workforce plan both short, medium, and long term which supports the Health Board plans and identifies resource gaps and risks which may affect plans for recovery.	N/K	Oct-23	Red	30/06/2022 - As our theatre capacity increases we shall gradually appoint into the Consultant vacancies. AHPs - SBAR prepared to highlight staffing priorities to meet T&O service demands including trauma. There is a plan to increase theatre capacity which captures theatre staffing required to support including anaesthetics. 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. The development of a Regional Network Board will prioritise plans for the longer term and identify associated workforce across SW Wales 25/09/2023 - The National Blueprint for Orthopaedic Surgical Delivery in Wales document was published from the work undertaken by the National Clinical Strategy for Orthopaedics (NCSOS) and identified the workforce requirements in order to balance capacity and demand. An inaugural Orthopaedic Clinical Implementation Group (CIN) has been set up for 13/10/2023, represented by Clinical Lead, Orthopaedic operational management, Senior Nurse Manager, Scheduled Care General Manager & Director of Acute Services.
PAHDUHB_0323	Mar-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	PAHDUHB_0323_001	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.
PAHDUHB_0323	Mar-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	PAHDUHB_0323_002	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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_001	N/A	R1. Clinical leadership within the OOH service requires expansion to include leadership at system wide level and on- shift. Action: Review leadership roles and recruit to expand both at system level and operational level.	This is accepted as an area requiring attention. Exploration of the capacity of leadership is now the subject of discussion within the senior team along with at the Improving Together sessions recently instituted by executives. Limited numbers of GPs with an interest in OOHs remains a challenge so longer term development opportunity may be needed. The operating relationship with leads in TUEC and UPC opens up further reconciliation needs.	Jun-23	~~Jun-23~~ ~~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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_003	N/A	R3. There appears to be lack of clarity on shift regarding business continuity and escalation. Action: Develop an escalation plan with clear routes and methods of escalation. Communicate this with all operational staff.	Existing escalation plans will be reviewed such that they are tailored to meet the localised needs across each of the three counties and will embrace the SOPs already developed and in service. Pre shift escalation systems are already in place with the new rates of remuneration for sessional doctors (Jan-23) which includes flexibility to increase capacity in targeted way as has been seen over Bank Holiday periods and during the Adastra outage. This includes the application of targeted rates along with shift bundling.	Sep-23	~~Sep-23~~ 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_004a	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review options for consolidation of bases.	Bases have been consolidated overnight from five to three since 2020 in the interests of patient safety and better management of expectation. This temporary service change remains under review as the underlying intention remains to operate from five bases. Latterly shift fill has not shown any significant improvement. Key to improving this is to develop the MDT model such that the interested medical parties in the numbers available can be spread across five centres.	Sep-23	~~Sep-23~~ 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_004b	N/A	R4. There are issues with staffing some of the bases on a regular basis. There needs to be consideration of either consolidation of bases or the introduction of a rural model. Action: Review rural models in operation in Cumbria with a view to implementation in the West.	The TUEC Director has made arrangements to pilot a model which is based on the Airedale service which is soon to commence in the Carmarthenshire area and will offer support to the residential care sector. In addition the OOHs team will seek to understand the arrangements specific OOHs impacts as a result of the Airedale model's operation in Cumbria.	Jun-23	~~Jun-23~~ 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 .
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_006	N/A	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts. Action: Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST.	Jun-23	~~Jun-23~~ ~~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 chanegs at WAST, and several APPs leaving, this has delayed the full implementation of the recommendation, however improvements beginning to be noticed and a new cohort of APPs are currently embedding. Ongoing financial constraints are also impacting on the ability to fully implement this recommendation as at August 2023
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_007a	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: OOH and UPCC to work collaboratively on development of a workforce plan for increasing the MDT	Collaborative working with WAST and other teams within HDUHB has commenced with a view to developing the model.	Jun-23	~~Jun-23~~ ~~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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_007b	N/A	R7. It is vital that development of the MDT is taken forward. There are opportunities to work collaboratively with UPCC and OOH to create rotational roles and generic job descriptions. The HEIW Urgent Practitioner Framework should be utilised to expand the scope of practice within the MDT. Action: UPCC to utilise the UPC Framework to expand scope of practice of practitioners	OOHs Clinical Lead sits on national group discussing UPC framework – continued development of this is in place.	Jun-23	~~Jun-23~~ ~~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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_008	N/A	R8. Staff advised that they don't have protected time to undertake clinical supervision. Action: Review provision of protected time for supervision activity	Management team identifying opportunities to facilitate protected time for supervision whilst accepting majority of doctors are sessional/ locum and so will require additional payment for such sessions.	Jun-23	~~Jun-23~~ 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 miplementation 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_010a	N/A	R10. The service relies mainly on sessional GPs to provide shift cover. Consideration needs to be given as to how to attract new GPs to the role. There is an opportunity to work collaboratively with UPCC to create salaried, rotational posts. In addition on-boarding of GPs willing to work in OOH has been hampered due to this being managed by Medical recruitment. Action: Workforce plans need to be developed for OOH and UPCC increasing the number of salaried/ rotational posts.	Development of a broader workforce plan which incorporates PC/ UPCC	Dec-23	~~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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_010b	N/A	R10. The service relies mainly on sessional GPs to provide shift cover. Consideration needs to be given as to how to attract new GPs to the role. There is an opportunity to work collaboratively with UPCC to create salaried, rotational posts. In addition on-boarding of GPs willing to work in OOH has been hampered due to this being managed by Medical recruitment. Action: Recruitment of GPs to be moved away from medical recruitment and placed within OOH.	Review arrangements which involves risk considerations will be undertaken and a preferred approach which works for the HB will be established.	Dec-23	~~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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012a	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review utilisation of HCSW in base and in cars, link with CTM to understand how they deploy their HCSW.	Promoting further use of HCSW in OOHs is active. As part of Internal Service Review all JDs being discussed as 1:1 and emphasis being made to using skills. CTUHB will be approach on this arrangement also	Sep-23	~~Sep-23~~ 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012b	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation of HCSW in bases in the West could support a rural model of care.	Explore with CTUHB. Ties in with TUEC programme work Skill set to be scopes and compared with opportunities and needs.	Jun-23	~~Jun-23~~ ~~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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012c	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Review how utilisation and training of HCSW in community hospitals could support medicines administration, link with Pharmacy and Social Services.	Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared to opportunities and needs Engagement to facilitate better understanding of the need and to establish what opportunities might exist whilst remaining a compliant approach to care.	Dec-23	~~Dec-23~~ 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_012e	N/A	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs. Action: Consider training for staff in VoD and management of catheters.	Requires wider engagement with DN /ART to assess frequencies and demand profiling to inform workforce modelling.	Sep-23	~~Sep-23~~ 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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_013a	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Consider a workshop bringing together UPCC, Clusters and OOH to work on an integrated plan	Being led by TUEC Programme Director.	Sep-23	Sep-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_013b	N/A	R13. As part of the wider development of Urgent Care. UPCC and OOH should collaborate to develop integrated plans for delivery of care 24/7. There should also be links into the Accelerated Cluster Development to review what the offer is in primary care to support the urgent care agenda. Action: Review use of dedicated slots for UPC offered in GMS, consider whether any slots can be utilised by OOH.	To discuss with PC, Cluster and UPC leads	Sep-23	Sep-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 16/08/2023 - to review the ownership of the recommendation due to changes in management structures.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_015a	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: develop policies that support clinicians to undertake tasks related to remote prescribing.	Remote prescribing being received with excessive caution on the part of OOH clinicians. DMD supporting the development of a compromise.	Sep-23	Sep-23	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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_015b	N/A	R15. Management of remote prescribing within the Health Board is preventing effective remote working and support being provided by the 111 Clinical Support Hub. Action: Review policy for booking F2F slots to allow remote clinicians to book slots	Some negative feedback received from clinicians and DMD supporting a compromise.	Sep-23	~~Sep-23~~ Dec-23	Amber	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.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_016	N/A	R16. Clinicians raised concerns about the appropriateness of calls sent across from 111, which could have been closed by 111. Action: Consider a table top review of calls sent across by 111 deemed inappropriate	Data gathering has continued with the recent restoration of Adastra and its concentrator. Analysis of call profiles to be undertaken and interpretations to be compared.	Sep-23	Sep-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
PR_OHPR0423	Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Open	N/A	Central Operations	Central Operations	David Richards	Director of Operations	PR_OHPR0423_017	N/A	R17. Clinicians were concerned about calls being held on the 111 advice queue from early afternoon and then being passed to OOH at 6:30pm on weekdays. Action: Gather data to determine the extent of this issue and raise via Joint Operational group.	Similar data profile noted above to be gathered to assess validity of claim	Sep-23	Sep-23	Amber	26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_002	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	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
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Digital and Performance	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_003	N/A	R3. HDUHB to develop a relationship between clinical coders and consultants to improve data collation.	Awaiting management response.	Jul-23	~~Jul-23~~ Nov-23	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
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_005	N/A	R5. WGH to review emergency appendicectomy minimal access rates and develop an improvement strategy.	Awaiting management response.	Jun-23	~~Jun-23~~ N/K	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.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_006	N/A	R6. GGH to review emergency readmission within 30 days following emergency appendicectomy and develop an improvement strategy.	Awaiting management response.	Jul-23	~~Jul-23~~ N/K	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.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_007	N/A	R7. BGH to review their Emergency laparotomy pathway in order to improve length of stay rates.	Awaiting management response.	Jul-23	~~Jul-23~~ N/K	Red	06/09/2023 - Mr Harries to discuss audit process with consultants, Mr Soare to lead on the Audit at BGH
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_008	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	~~Jul-23~~ N/K	Red	01/06/2023 - Meeting being arranged with the Glangwili General Hospital site triumverate, shceduled care triumverate team and the General Surgery Clinical Lead/Management team
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_009	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.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_010	N/A	R10. HB should review pathway of care for patients having elective colorectal cancer surgery with the aim of reintroducing Enhanced Recovery	Awaiting management response.	Sep-23	~~Sep-23~~ Nov-23	Amber	01/06/2023 - Meeting to be arranged with Rachel Lewis for implementation of ERAS. Mr Rao and GS Management team 06/09/2023 - First meeting has taken place for implementation of ERAS. The documentation has been presented and approve by the documentation group meeting. Mr Simone Sebastiani is taking the lead on this and will present at the joint business meeting on 05/10/2023.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_012	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	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
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_014	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	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_015	N/A	R15. HB to increase day case rates for HVLC pathways paraumbilical hernia and laparoscopic cholecystectomy by reviewing criteria for day surgery and defaulting patients having these procedures to day surgery.	Awaiting management response.	May-23	~~May-23~~ Nov-23	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.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_016	N/A	R16. HB to standardize HVLC pathways in elective inguinal hernia, paraumbilical and gallbladder surgery.	Awaiting management response.	May-23	~~May-23~~ Nov-23	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.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_018	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	Red	01/06/2023 - Picked up alongside reccomendations 14,15 & 16
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_019	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	Red	01/06/2023 - Picked up alongside reccomendations 14,15 & 16
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_020	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	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 unsheduled care patient flow pressures.
RNOH_GIRFTGS_0523	May-23	Peer Review	Getting It Right First Time (GIRFT) General Surgery Review	Open	N/A	Scheduled Care	Scheduled Care	Caroline Lewis	Medical Director	RNOH_GIRFTGS_0523_022	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
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_001	N/A	R1. The outbreak has not yet concluded and the high level of latent TB infection in the population implies further risk. This risk is heightened because the active disease in this population is predominantly pulmonary and therefore more infectious. Although the level of active TB infection is low in West Wales, delayed presentation in unrecognised cases may lead to further outbreaks and deaths. The level of awareness amongst the public and their health care professionals must be therefore increased and maintained. This also applies to trainee health professionals.	To manage the risk of the outbreak and raise awareness amongst the public and Healthcare Professionals, to reduce the risks of any future outbreaks.	Jun-23	~~Jun-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_002	N/A	R2. Any future outbreaks should be overseen by PHW from the outset with a TB - specific standard operating procedure for the conduct and recording of outbreak management. The current SOP and OCT policy needs to be updated in this respect. The latter needs to be developed alongside modern data analysis and WGS typing so that outbreaks are identified and contained. Comprehensive contact networks of all cases should be recorded electronically and plotted with social network analyses undertaken to ensure links between cases are uncovered quickly and easily.	To work with PHW to create a Standard Operating Procedure and updated OCT policy. Development of a revised methodology for managing contact networks and analyses to ensure links between cases are uncovered quickly and easily.	Jul-23	~~Jul-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_003	N/A	R3. Funding should be identifiable ahead of time for outbreaks of infectious diseases so that such outbreaks can be managed in a timely and effective manner without the need for time-wasting discussion.	To develop an agreed service modeland contingency plans for resourcing any future outbreak	Jul-23	~~Jul-23~~ N/K	External	16/05/2023 - A meeting was held in May 2023 between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A furterh meeting is planned for the end of May 2023 with plans to submit and present this in June 2023.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_004	N/A	R4. The local TB service has improved but still has inadequacies. In particular, cross-cover arrangements need to be in place for annual, sick and study leave in order to prevent delays in treatment. Pharmacy and administrative support needs improvement. Succession planning for the TB Specialist Nurse also needs to be clear	Development of a resilience plan for both future outbreaks and maintaining current TB case management. Agree a plan for Pharmacy, administrative and Specialist nursingsupport required for TB management.	Jun-23	~~Jun-23~~ ~~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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_005	N/A	R5. At a national level, the Cohort Review Programme needs to be supported with adequate funding for each contributing health board.	To agree a plan with WG, other HB's & External Partners to agree an adequate funding model	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.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_006	N/A	R6. Welsh Government should support both the Cohort Review Programme and the proposal for a National Service Specification that includes the development of a TB pathway to tackle delayed diagnosis (e.g. investigating cough lasting longer than three weeks).	To work with WG and PHW to agree a way forward for the cohort Review Programme and the National Service Specification	N/K	N/K	External	16/05/2023 - A meeting was held last week between Medical Director, Respiratory Consultant lead, Local Public Health Team Consultant, Strategic Head Community and Chronic Conditions and SDM for PPH, Respiratory, Diabetics & Endocrinology. It was agreed that a joint response was the best way forward which will contain HDUHB's action plan. Public Health Consultant's team have begun to compile an action log into which responses will be fed. An SBAR is also being prepared to outline internal plans. A further meeting is planne WG/PHW have not provided a completion date for this recommendation to date.d for the end of May 2023 with plans to submit and present this in June 2023.
PHW_LTOER_1222	Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Open	N/A	Medical	Prince Phillip Hospital	SDM for Respiratory & TB	Medical Director	PHW_LTOER_1222_007	N/A	R7. Wales does not seem to be properly prepared for the challenges of new migrants, refugees, and the occurrence of future drug resistance. These factors should be included in a future TB plan supported and funded by Welsh Government.	To work with WG and at an All Wales level to agree a TB Plan which addresses the shortfalls highlighted for new migrants, refugees and the occurrence of future drug resistance.	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.
RCP_VYBGH0919_19	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_001	N/A	1.1 Improve networking and collaboration with other sites and health boards	1.1 Operational and financial progress is being made around clinical pathway and service commissioning with Powys and BCU (S Gwynedd). Particularly diagnostics, cardiology and acute stroke.	Mar-21	~~Mar-21~~ ~~Mar-23~~ N/K	Red	23/03/2022- GM working closely with other sites of the Health Board to ensure safe services, e.g. through channels such as the senior Ops team meetings. Good collaboration between community and acute services. GM looking at scheduled care elements. Real challenges in terms of tertiary level pathways and getting the right patient in the right place for the right clinical supervision. Exploring joint consultant posts with Powys and Betsi, however progress has been significantly hampered due to Covid. This is in the recovery phase and the UHB has restarted this process with neighbouring Health Boards post Covid. Clinical advisory group for Mid Wales in place which started pre-Covid. Working with Powys to establish optimal flow for their patients using Hywel Dda services, and how to work together to deliver care. This is less developed with Betsi. GM is hopeful to make significant progress and have a programme of work in place by March 2023. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Quarterly commissioning meetings in place with Powys to develop pathways, and the Mid Wales Clinical Advisroy Group in place which explores joint appointments with Powys, surgical pathways and identify improvements. The site also works collaboratively with other Health Board sites, and links with clinical groups and peer reviews. Site lead advising that recommendation can be closed from the Lead Executive. 20/04/2023 - BGH would need more resources if further work would be required for this, especially in terms of the Scheduled Care pathways and Commissioning. Recommendations to be presented to the Director of Operations for approval to close. 18/07/2023 - Medical Directorate have confirmed transfer of ownership to MD as per DITS session in July 2023.
RCP_VYBGH0919_19	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_001	N/A	1.2 Improve networking and collaboration with other sites and health boards	Additionally internal cross divisional planning is emergency – particularly critical for BGH is working with Scheduled Care to develop a bespoke elective plan that ensures travel reduction for patients and enables the site to fully utilise theatres (subject to workforce plan) and support patients to access care from their local hospital wherever possible. Though progress on this has been affected by Covid.	Mar-21	~~Mar-21~~ ~~Mar-23~~ N/K	Red	23/03/2022- Covid has been problematic in progressing this recommendation however there are Immensely improved relationships between BGH and scheduled care. Working with team to deliver elective care and repatriate back where appropriate. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - BGH have a large capacity to deliver int erms of Theatre space, with greater engagement received from Powys' Consultant Surgeon for Scheduled Care. Plans for the new hospital will require for this continued engagement to be in place. Request to be made to Lead Execuitve to close this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_001	N/A	1.6 Improve networking and collaboration with other sites and health boards	Virtual systems such as "attend anywhere" – a visual platform for OP consultation are being trialled with intention to roll out for a number of specialties The above links to the Mid Wales telemed plan which aims to increase capacity and capability for virtual consultation to reduce travel burden. This is a piece of work on going with Powys and to an extent BCU – though improvements, which we hope to sustain, have been made due to Covid which required a significant degree of rapid change The aim is to improve primary care access	Apr-21	Mar-24	Red	23/03/2022- GM to liaise with officer on digital strategy of the UHB for current progress on virtual systems. A lot of changes still taking place and Covid still presents challenges for this. Revised date of March 2024 provided 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/23)-Collaboration with HEIW and Universities has improved with regular meetings with the AMD for med ed (covering whole HB) and liaison meetings with the universities. 10/03/2023 - Attend Anywhere system in use, and BGH are also taking part in the Telemed roll-out. Assurance and Risk team to enquire if BGH's participation is reported anywhere to support closing this recommendation. 20/04/2023 – Complete- BGH have put this into practice, are trying to network, however the patients prefer to be treated locally. The culture and the willingness of the people to change would be also needed. Recommendations to be presented to the Director of Operations for approval to close. 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.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_004	N/A	4.2 Develop new teaching and qualification opportunities for trainees and specialty doctors	BGH wishes to progress a new round of discussions with the Deanery which aims to attract Core Trainees to come here. A minimum of 4 posts could be supported on rotation. BGH remains accredited for such and now that consultant numbers have increased, this is a real possibility.	Dec-20	~~Dec-20~~ N/K	Red	23/03/2022- GM will pick up with recommendation owner for current position of this recommendation. 05/05/2022- Requested revised timescale from GM, no response received as of 18/05/2022. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 10/03/2023 - BGH are not able to do the core training for trainees in the current set up. BGH are accredited but cannot recruit. The new SAS contract came into force last year (2022) for specialist grade, which provides mid-grade specialist with acknowledgement of their skills. There is a SAS tutor in place (from Surgery) for support. Leadership and management training is offered to clinical fellows and SAS doctors. All trainees are provided with self-directed learning and teaching time (quality improvement) with a few doctors following into the teaching path now. There is a monthly middle grade meeting where the doctors can discuss training, issues, and areas for improvement. There is also a regular meeting for junior doctors with consultants in attendance where training for juniors is part of the agenda. Due to the improvements made the GM is requesting this recommendation be closed. 20/04/2023 - BGH have developed everything within their gift. BGH are unable to develop anything further from the site. The qualification would need to be formally recognised to encourage core trainees to not leave BGH and go into formal training.. A Medical Education strategy would assist in establishing if this is a priority. Recommendations to be presented to the Director of Operations for approval to close. 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.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_005	N/A	5.2 Develop the postgraduate education centre, including clinical skills and simulation equipment	Improve facilities for RESUS simulation Increase education opportunities across the staffing groups to include nursing, therapists etc.	Sep-22	~~Sep-22~~ N/K	Red	23/03/2022- some RESUS training had taken place, but the space became unavailable. Now looking at new plan to provide appropriate training. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting this recommendation to be closed as lack of funding does not allow this recommendation to be fully implemented. There is however a designated RESUS officer just for Ceredigion, which has helped provide more RESUS training dates. Due to lack of funding BGH are discussing opportunities to access training space through the University Medical School. 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close. 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.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_005	N/A	5.1 Develop the postgraduate education centre, including clinical skills and simulation equipment	Funds have been made available to develop the Postgraduate centre and a planning group is having meetings to agree design. There is also a plan to develop a medical education hub within Aberystwyth | University. Both developments will include clinical skills facilities.	Sep-22	~~Sep-22~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed as no funds available at this time with the intention to be part of the Capital plan. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. The original management response in this report was made on the assumption that funds were available which was incorrect. 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close, once 'mini' paper has been produced. 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.
RCP_VYBGH0919	Sep-19	Royal College of Physicians	Visit to Ysbyty Bronglais, issued September 2019	Open	N/A	Medical	Unscheduled Care (BGH)	Head of Medical Education & Professional Standards	Medical Director	RCP_VYBGH0919_005	N/A	5.3 Develop the postgraduate education centre, including clinical skills and simulation equipment	The aim is to utilise global teaching opportunities including via virtual means, also to improve the seminar room as part of the wider PGC works and established a research skills and a simulation room.	Dec-21	~~Dec-21~~ Mar-25	Red	23/03/2022- Funds have not been made available as stated in the management response; this was a misunderstanding at the time of writing the management response. Looking to progress with our corporate partners (National Library for Wales and Aberystwyth University) an integrated education and training centre. Currently refreshing and revising our strategic approach to education for all specialities that utilises that opportunities presented by BGH's unique location and its aspiration to become a university hospital. Looking to develop Business Case. Revised date of March 2025 provided. 23/09/2022- GM confirmed he will discuss with County Director for Ceredigion to discuss the progress of these recommendation. 16/01/2023 - Assurance and Risk Team to meet with BGH General Manager to establish the relevance of these recommendations and if they should be closed. 24/01/2023 - (from email received on 25/10/2022)-We have started simulation training and have recruited a simulation training faculty. Equipment and training has been purchased. This can now be removed. 10/03/2023 - GM is requesting for this recommendation to be closed. BGH are part of ongoing discussions for the postgraduates build which requires WG Capital investment. However, it is felt that this is not achievable in the current conditions. Plans are to be developed and project group to be set up for the existent site with capital required from WG to be achieved. BGH feel the risk for not having this will impact in poor training and will be reflected in not doing enough to support activities. A major issue is the lack of space for teaching and meetings. BGH have 3 available rooms which are fully booked all the time. This will affect the trainees' satisfaction. This impact to be incorporated into the existent BGH Datix risk (1586-Harm associated with lack of space). 20/04/2023 - Project group had been initiated with the County Director, however when funding became an issue this was stopped. BGH needs the UHB steer and commitment if it is to carry on with this capital programme and re-instate the Project Group. Possible mitigations in place with regards to space and facility on Medical Education risk register to be shared with BGH management team so they can reference that, as at the moment BGH don't have any power to act on any change. BGH General Manager to produce a 'mini' paper to highlight the project needs, costs, plan etc, if it was to be reinstated. Recommendations to be presented to the Director of Operations for approval to close, once 'mini' paper has been produced. 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.
WLC_PCTWL	Mar-19	Welsh Language Commissioner	Primary care training and the Welsh language, issued March 2019	Open (External rec)	N/A	Primary Care, Community and Long Term Care	Workforce & OD	Heledd Kirkbride	Director of Primary Care, Community and Long Term Care	WLC_PCTWL_002	N/A	R2. Health boards and primary care clusters need to audit the linguistic skills of the primary care workforce and work to improve the quality of data that exists.	Primary Care Officer to identify what language skills data is being collected at all 4 services. See comments outside the gift of HB, being delivered at an All Wales Level.	Mar-20	~~Mar-20~~ Mar-25	External	21/12/2020 - rec is being taken forward by the Welsh Government. 12/09/2022- Head of Assurance and Risk to discuss transferring the remaining recommendation to the Director of Primary Care, Community and Long Term Care if appropriate. 11/10/2022- Report moved from Workforce & OD to Primary Care Directorate. Director of Primary Care, Community and Long Term Care confirmed 03/10/2022 that Primary Care Officer will provide an update on the outstanding 'external' recommendation. 07/11/2022- There has not been any progress in creating a system to note the language skills of Primary Care staff. Welsh Government acknowledges the need for a national system. However new Strategy More than just words: Welsh language plan in health and social care notes 2022-2027 includes the following action: An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection, collation of data across the health and social care sectors including services that are provided in Welsh. Timeline – by 2025. Therefore an update is awaited on developments. 28/02/2023- there is no further update on the above. 27/06/2023- confirmed at Primary Care QSE meeting that there is no further progress on this.
WRP_NRCETSNHSW_0323	Mar-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	WRP_NRCETSNHSW_0323_001	N/A	R1. Complete the review of the Transfusion Policy.	Confirm that the Transfusion Policy has been reviewed, updated and approved by the Transfusion Committee.	Aug-23	~~Aug-23~~ Oct-23	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_003	N/A	R3. Develop a formally approved procedure setting out the organisation's governance process in relation to the development and approval of local procedure specific consent forms.	Set out the existing process in a Produce document for approval by the Mental Capacity and Consent Group.	Jun-23	Sep-23	Red	15/06/2023- lead officer provided revised date of September 2023 as they hadn't anticpiated how long their phased return would be. 07/09/2023- The Head of Consent and Mental Capacity will be taking this to MCA & Consent Group for approval on the 25/09/23.
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_004	N/A	R4. Implement a requirement for all clinicians who take consent from patients to complete a recognised training programme. It is recommended that the frequency of this should be at least once per revalidation cycle for the relevant professional group, it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.	Discuss this recommendation with the Medical Director, Director of Nursing, Quality and Patient Experience, and the Director of Therapies and Health Science to determine the most appropriate approach.Implement agreed approach.	Sep-23	Sep-23	Amber	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.
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_006	N/A	R6. Develop a database of patient information leaflets used within the consent process.	Convert the EIDO audit spreadsheet into a database.	Jun-23	~~Sep-23~~ Dec-23	Red	15/06/2023- lead officer provided revised date of September 2023, as they hadn't anticpiated how long their phased return would be. 07/09/2023- at the next meeting of the MCA & Consent Group on the 25/09/23, the Head of Consent and Mental Capacity will be requesting an extension to December 2023, as they won't have time to complete this before the meeting.
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_007	N/A	R7. Put a process in place to comply with the 'Criteria for use of Procedure Specific Patient Information Leaflets following publication of RMA2020-01 namely – Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk.	Write that required procedure and take to Mental Capacity and Consent Group for approval.	Oct-23	Dec-23	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.
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_008	N/A	R8. Undertake a peer review of the organisation's consent process using the All Wales peer review tool. In addition to monitoring the organisation's consent process it will enable compliance with requirement No. 6 of WRP RMA2020-01 Consent to Treatment –monitoring compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of provision of procedure specific patient information leaflets.	Consult with the Deputy Medical Director regarding appropriate timing. Discuss process for audit with relevant clinical leads. Plan and schedule the audit.	Dec-23	Dec-23	Amber	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.
WRP_NRCETS NHSW_0323	Mar-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	WRP_NRCETSNHSW_ 0323_009	N/A	R9. Continue to monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets.	Hold discussions with Scheduled Care, Women and Children's Directorate and Radiology to ensure processes are in place to monitor and assess shortfalls in use, provision and documentation of patient information leaflets.	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.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_TRO0116	Jan-16	HIW	Thematic Review of Ophthalmology 2015/16 issued January 2016	Open	N/A	Scheduled Care	Scheduled Care	Victoria Coppack	Director of Operations	HIW_TRO0116_001	N/A	R6: Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	N/K	~~Mar-22~~ ~~Mar-23~~ ~~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 followups 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 Inpsection 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.
HIW_21037_ WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSC W_001a	High	The Health Board should ensure that all issues identified in the fire safety report and the point of ligature risk assessment are resolved in a timely way. The Health Board must submit an updated action plan / progress report to HIW, within three months from the date of the quality check, so that we can assess progress made to improve and support patients' safety.	Advanced Fire Safety works to be completed Welsh Government Funding Approached. This will resolve all Fire Safety issue identified in the report. Advance work to commence October/November 2021- anticipated date of completion June 2022.	Jun-22	~~June 22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~May-23~~ ~~N/K~~ ~~Jul-23~~ N/K	Red	04/11/2021 - works are scheduled to commence on the ward on the 8th November 2021, with anticipated completion in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - chased, no update received. QAST update 11/07/22 requested update May 2022, none received to date. QAST update 07/09/22 requested update 18/07, none received to date. QAST update 01/11/22 requested update Sept/Oct, none received to date. QAST Awaiting an update chased Dec 22, Jan 23, Feb 23. 09/05/2023 - Fire works expected to be competed by end of May 2023. 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.
HIW_21037_ WGHSCW	Sep-21	HIW	St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September)	Open	N/A	Mental Health & Learning Disabilities	Estates	Liz Carroll	Director of Operations	HIW_21037_WGHSC W_002b	High	The Health Board must produce an action plan detailing how they will address the issues raised in the IPC audit with clear timescales, and, within three months from the date of the quality check, provide HIW with an updated action plan, so that we can further assess progress made.	Interior walls to be repainted where necessary to comply with IPC. Timescale 3 months, November 2021.	Nov-21	~~Nov-21~~ ~~Jan-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~May-23~~ ~~N/K~~ ~~Aug-23~~ N/K	Red	04/11/2021 - once the Advanced Fire Safety works have been completed, Estates will commence with the required painting works. This is anticipated to start in January 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team requested an update from the service in February 2022, but no update provided in time for the ARAC April 2022 audit tracker paper. 18/05/2022 - chased, no update received. QAST update 11/07/2022 chased update February, April and May 2022 none received from the service. QAST update 07/09/22 chased service 18/07, no response received, Due date Oct 2022. QAST update 01/11/22 chased Sept / Oct, no response. 20/12/2022- All IPC issues with furniture have been addressed as all communal dining and lounge furniture has been replaced. Advanced for works were delayed and currently underway and sue to end in May 2023. As per information above when these works are complete then painting work ban be progressed. QAST update Feb 23 Advanced for works were delayed and currently underway and due to end in May 2023. As per information above when these works are complete then painting work ban be progressed. 03/07/2023 - QAST chased for update June 23 - this is corrective work after the action above is completed. QAST update 07/09/23 all actions chased 10/08/23 no update from service as to if completed / future target date for completion.
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_014	High	WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	The HB is in the process of undertaking a review of the ED nurse staffing across all acute sits at the HB - this is being led by the Nursing staffing lead, this was commissioned by the Executive Director of Patient Experience and Quality. The findings will be presented to the Directorate management team and executive team once complete.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	23/02/2022 (BGH) - The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. Doctors' rotas reviewed every day to ensure appropriate cover. The Executive Director of Patient Experience and Quality agreed that if ED have to surge into minors, then one additional RN to be put on duty for nights. 18/05/2022 - WGH position established as same as BGH (as above). QAST update 11/07/22 PPH & GGH chased for update Feb, April and May 2022, none received. QAST update 07/09/22 The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E / AMAU have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST Update 01/11/22 - 27/10/22 (BGH) Free access to kitchen beverages and sandwiches stocked in fridge . Excellent rapport between WAST and Emergency staff regarding fundamentals of care (WGH) Confirmation from WGH that hot food and drinks provided to all patients waiting in department or awaiting handover. QAST Update 27/10/22 update (BGH) Staffing levels reviewed using BEST audit tool which requires need for uplift in staffing levels. Recruitment remains challenging so Dept focusing on retention . Staffing deficit impacting on offload delays . Exec team asked to consider implementation of financial incentives for all permanent staff to improve consistency in care . WGH The department staffing level is reviewed 3 times a day and where gaps are identified, a risk assessment is undertaken to maintain the department in as safe a manner as possible – for both nursing staff and clinical staff. The service management for A&E have reviewed the staffing. This has yet to be agreed by HDD board but priority staffing are being reviewed with a view to approval of elements asap. QAST update 09/05/2023 - no further update received or new date expected received. QAST Update 07/09/23 all actions chased 10/08/23 no target date / repsonse received by QAST to date.
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_015	High	WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_016	High	WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_017	High	WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_018	High	WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_019	High	WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	N/A – for WAST consideration	N/A	N/A	External	
HIW_20175_N RWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAS T0921_020	High	WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	N/A – for WAST consideration	N/A	N/A	External	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAST0921_03d	High	Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	The Health Board would look at other organisations practices and roles, which are not embedded into our current service delivery models and would welcome further discussion with WAST, other HB's and HIW in relation to this.	Dec-22	~~Dec-22~~ ~~Mar-22~~ ~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ N/K	Red	No update received from QSE team on progress against this recommendation as at March 2022. 31/03/2022 - HIW tracker update provided by the Patient Safety and Assurance Team on 16/03/2022. The Patient Safety and Assurance Team had not requested an update from the service at the point of preparing this report due to timing issues with the quarterly updates required for HIW. 18/05/2022 - not yet due no update received. QAST update 11/07/22 due December 2022, no update therefore requested. QAST update 11/07/22 & 07/09/22 due December 2022, no update requested. QAST update 01/11/22 chased all sites, no further update received. 23/01/2023 - HIW tracker update provided by the Patient Safety and Assurance Team on 20/01/2023. QAST update 20/03/2023 Chased all sites for a response, awaiting response. QAST update 09/05/2023 no update. QAST chased June 23, no update or new expected date received. QAST update 07/09/23 all actions chased 10/08/23, no new target date or update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAST0921_05	High	If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - The HB have a Hand over policy which was jointly written with WAST colleagues, which clearly identifies roles and responsibilities. The policy is in the process of being updated and a task and finish group has been setup chaired by Head of Nursing and has representatives from WAST, and key staff across the organisation. 23/02/2022 (BGH) - Ambulance offload policy arrangements are ongoing. Meetings due to be held in February. Acute stroke pathway has been in place long standing and the crews can handover immediately to teams in the CT scanner area. 18/05/2022 - position in WGH same as BGH (above). QAST update 11/07/22, no update from PPH & GGH to date. 07/09/22 GGH & PPH Ambulance offload policy being updated currently with WAST representatives on group, individual department handover processes are in appendices within this policy. QAST update 01/11/22 chased sites , no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds . Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified. QAST update 09/05/2023 no further update received.
HIW_20175_NRWAST0921	Sep-21	HIW	National review of WAST (HDUHB responses to national review logged on tracker) issued 28 September 2021	Open	N/A	Acute Services	Acute Services	Alison Bishop	Director of Operations	HIW_20175_NRWAST0921_09b	High	Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	This work internally is continuing, the draft policy has been shared with wider group that met in January. Awaiting feedback from discussions with HIW following January meeting.	Mar-22	~~Mar-22~~ ~~Oct-22~~ ~~N/K~~ ~~Jan-23~~ ~~N/K~~ ~~Apr-23~~ N/K	Red	17/11/2021 - Working group in place to take forward 16/02/2022 Previous management response - There is a check list which staff use to support identifying fundamentals of care – and a HCSW is allocated to review patient's fundamentals whilst they are on the ambulance and are to maintain a record of this, fundamentals of care include nutrition, hydration, and pressure damage care. This document will be reviewed with the Handover Policy. 23/02/2022 (BGH) - Ambulance offload policy, embedded in which is the Care of the patient in the ambulance policy. Actions are awaiting to be agreed by the Health Board with a meeting due in early March to discuss, led by Unscheduled care HoN with Task and Finish Group. 18/05/2022 - requested, none received. QAST update 11/07/22 requested update from PPH & GHH Feb, March, April and May 2022, none received. QAST update 07/09/22 for GGH & PPH Ambulance offload policy, includes the Care of the patient in the ambulance. Task and finish group includes WAST representatives and is led by an Unscheduled care HoN. Utilisation of Pit Stop in GGH and portacabin PPH. QAST update 01/11/22 chased all sites, no further update received. QAST update 27/10/22 (BGH) Excellent rapport and team work with WAST and Emergency staff . Red release becoming increasingly challenging due to lack of flow to wards and available beds .Increase in self presentation of critical patients via reception taking priority over ambulance arrivals . Increase of extrication of patients from vehicles outside (WGH) Ambulance offload policy updated for HDUHB and awaiting approval at ownership group in next few weeks. Department handover processes are within document and will be shared/displayed for familiarity when ratified. Patients able to use facilities within the main ED department. Rapid assessment area available to support appropriate care delivery when patients are awaiting offload. QAST update 09/05/2023 - no further update received. QAST update 07/09/23 all actions chased 10/08/23, no new target date or update received
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_004b	N/A	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ N/K	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.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_005b	N/A	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Requirement to complete recruitment process and appoint for the GCWP post. This post will support close working relationships between the GCWP and the SPOC and ensure good communication and working relationships between primary care and secondary care.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ N/K	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.
HIW_NRMHCPC0322	Mar-22	HIW	National Review of Mental Health Crisis Prevention in the Community, issued March 2022	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Amanda Davies	Director of Operations	HIW_NRMHCPC0322_017	N/A	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	To complete the work that is already underway to outline the steps regarding the development and recruitment of the MH practitioner role.	Sep-22	~~Sep-22~~ ~~N/K~~ ~~Dec-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ N/K	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.
HIW_BWPPH1022	Oct-22	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	HIW_BWPPH1022_001	N/A	Patients are assessed in a timely manner if they have physical health problems and for doctors on the ward to feel supported by their colleagues on the general wards	Senior medical staff from Mental Health Services and General Acute Services in Prince Philip Hospital to liaise and discuss how communication to support timely assessments and support can be improved upon for doctors.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jul-23~~ 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 uppate 07/09/23 Clinical Director of MH has asked if this remains an issue for sevice, 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.
HIW_BWPPH1022	Oct-22	HIW	Bryngofal Ward – Prince Phillip Hospital, Issued October 2022	Open	N/A	Mental Health & Learning Disabilities	Estates	Kay Isaacs	Director of Operations	HIW_BWPPH1022_003	N/A	Appropriate and safe curtains are to be placed in patient bedrooms	Estates to review the environment in bedrooms and identity work plan to replace curtains.	Nov-22	~~Nov-22~~ ~~N/K~~ ~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ ~~N/K~~ Sep-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.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007a	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To seek advice from the Health Promotion Team and source suitable promotional material for the department.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 All actions chased 10/08/23 no update or target date supplied.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007b	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure that the health promotion materials are bilingual (English and Welsh)	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 All actions chased 10/08/23 no update or target date supplied.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_007c	N/A	R7. The health board is required to provide HIW with details of the action taken to make relevant health promotion material available to patients and carers visiting the Emergency Unit.	To ensure staff are aware how to access to materials in other languages as required by the local population.	Mar-23	~~Mar-23~~ ~~N/K~~ ~~Jun-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 All actions chased 10/08/23 no update or target date supplied.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_011a	N/A	R11. The health board is required to provide HIW with details of the action taken to: • help patients understand their 'journey' through the unit • provide patients and their carers with regular updates about their care and treatment.	To arrange provision of new information screens for the department.	May-23	~~May-23~~ 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.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_014c	N/A	R14. The health board is required to provide HIW with details of the action taken to ensure the designated viewing room is free of cardboard boxes and other items which are not required.	To facilitate working with '2 Wish' charity regarding the refurbishment of relatives/viewing room	Sep-23	Sep-23	Amber	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update received.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_016a	N/A	R16. The health board is required to provide HIW with details of the action taken to ensure suitable arrangements are in place to accommodate patients presenting with mental health needs and waiting to be assessed.	To engage with the estates and the Mental Health Teams regarding creating a safe space to review Mental Health patients in the department	Jun-23	~~Jun-23~~ ~~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.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_017a	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	To ensure work alongside estates to review refurbishing staff changing rooms, shower facilities and toilets	Sep-23	Sep-23	Amber	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update received.
HIW_20230315_EUGGH	Mar-23	HIW	Emergency Unit, Glangwili General Hospital 05, 06 and 07 December 2022 (Publication date 17 March 2023)	Open	N/A	Unscheduled Care (GGH)	Unscheduled Care (GGH)	Senior Nurse Manager	Director of Operations	HIW_20230315_EUGGH_017b	N/A	R17. The health board is required to provide HIW with details of the action taken to respond to the staff responses in relation to the facilities within the unit.	Reviewing the opportunity to utilise charitable funds to facilitate improvements to the area in the ED Performance meeting	May-23	~~May-23~~ N/K ~~Jun-23~~ N/K	Red	QAST update 09/05/2023 - chased, awaiting progress. 03/07/2023 - QAST Chased for update June 23 no update or new expected date received. QAST update 07/09/23 All actions chased 10/08/23 no update or target date supplied.
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_001a	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level eg Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions a)**D**evelopment of standards for physical health screening to be incorporated into Service Specifications. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_001b	N/A	R1. The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Performance against the assessment accountability within the Mental Health (Wales) Measure is routinely monitored by the MH/LD Directorate with oversight through all of the MH/LD directorates committees. Quarterly reports are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures providing oversight of ongoing actions to improve. Current waiting time challenges and risks are reflected on the health boards corporate level Risk Register (Risk 1032). A Comprehensive Assessment Tool (CAT) was launched April 2023 to deliver consistent assessment standards, including expected timeframes for assessment, across Inpatient and Community Adult and Older Adult mental health pathways, capturing clinical assessment information within electronic care records in a way that can be more easily audited. Documented guidance is in place to underpin practice and training is being delivered to support implementation. Initiatives to improve physical health monitoring are taking place at a service level eg Tool being piloted as a standard clinic form for Clozaril Clinics within CMHTs, Clinical Pharmacy roles being trialled to support Physical Health Clinics in Early Intervention in Psychosis Teams. Further Actions b)**F**urther development of Care Partner to capture physical health screening in line with above standards through electronic forms. Please see overarching Clinical Audit Action (Recommendation 34)	Nov-23	Nov-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_002	N/A	R2. The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	WARRN is used as a standardised approach to formulation based risk assessments across the MH/LD Directorate. A cohort of WARRN trainers deliver monthly training sessions for initial and refresher training. The presence of a WARRN is verified through Care and Treatment Planning audits undertaken monthly by team leaders. The MH/LD Directorate is linked into All Wales work surrounding development of a national approach to safety planning. Further Action c)**R**eview of WARRN training provision and monitoring of uptake to inform longer term, sustainable approach and ability to provide targeted practice development in response to lessons learnt from SI's. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_004	N/A	R4. The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Routine offer of Carers Assessment is built into the Comprehensive Assessment Tool referenced in recommendation 1 and is explicitly referenced in its accompanying guidance. Documentation of routine offer of Carers Assessment is incorporated into CAT forms on the Electronic Patient Record. WARRN and Care and Treatment Planning Reviews also prompt staff to offer Carer Assessment and document outcomes to this. The Health Board is signed up to the Investors in Carers scheme and all teams across the MH/LD Directorate are actively benchmarking services against the schemes standards. There are Carer Leads on all Inpatient Wards and specific support for dementia carers can be accessed through Admiral Nurses and Dementia Wellbeing Teams. Further Action d)**A**ll teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_006	N/A	R6. The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Daily Board Rounds plus scheduled Ward Rounds take place across Inpatient areas. The structure, format and approaches to quality assurance of Ward Rounds vary across services. There is feedback to indicate that short notice for Ward Rounds impacts on Service User and Carer involvement. Further Action e) 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	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_007a	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- - MDT attendance by Ward & CMHT (Care Coordinators) - Pre-discharge Care and Treatment Planning Meetings - Directorate wide access to Electronic Patient Records - Current pilot of Medicines Transcribing and e-Discharge (MTeD) system - Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow - Sector Approach within OA Mental Health Services promoting continuity of care Further Actions f) Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53). Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_007b	N/A	R7. The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	A range of systems and practices underpin prompt communication and information sharing between inpatient and community teams during the discharge process:- - MDT attendance by Ward & CMHT (Care Coordinators) - Pre-discharge Care and Treatment Planning Meetings - Directorate wide access to Electronic Patient Records - Current pilot of Medicines Transcribing and e-Discharge (MTeD) system - Daily Bed Conferences and Acute Pathways meetings that involve inpatients, community, liaison, local authority and Police representatives to discuss patient flow - Sector Approach within OA Mental Health Services promoting continuity of care Further Actions g) And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated. Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_008	N/A	R8. The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	There are a range of mechanisms that support embedding practice for timely and effective communication and information sharing relating to patient discharge process however no single specific training to outline expected standards in place that is monitored. Further Action h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Oct-23	Oct-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_009	N/A	R9. The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	There are a range of current practices in place in relation to the documentation of inpatient MDT meetings which are supported by admin roles. Further Actions as per recommendation 6.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_010	N/A	R10. The health board must ensure that adequate administrative support is available within inpatient mental health units.	All Inpatient Wards are supported by Ward Clerk roles. A recent Quality Improvement project was undertaken by the MH/LD Directorate to focus on releasing Ward Management time spend on admin tasks. This led to a pilot of a new band 4 admin role to complement existing band 2 Ward Clerk roles. Further Action i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_011	N/A	R11. The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	Mechanisms to prompt patient, family, carer and/or advocate views to inform inpatient care and discharge plans are incorporated within Care and Treatment Planning process and within the Comprehensive Assessment Tool and guidance. The Electronic Patient Record has functionality to enable sensitive information (potentially provided by patients, family, carers) to be recorded separately. All inpatients are offered advocates on admission which is documented in the Electronic Patient Record and routinely monitored by the MH/LD Directorate. Quarterly reports to provide assurance on practice surrounding the offer of advocates are provided to the Health Boards Mental Health Legislation Scrutiny Group, Mental Health Legislation Committee and reported through Quality Safety and Experience structures. Advocates regularly visit wards and participate in Ward Review/MDT Meetings. Inpatient services operate a 'named nurse' model which promotes engagement with patients, family, carers and / or advocates to inform person-centred care planning. Inpatients are allocated a community Care Co Ordinator prior to discharge to support discharge planning. We will develop an auditing mechanism to routinely audit records to be assured that family carers and advocates are able to provide their views to inform inpatient care and discharge planning. Further Actions as per Recommendation 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_012	N/A	R12. The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	Crisis plans are jointly developed between ward/community staff (CMHT/CRHT), patients, families / carers and /or advocates through discharge planning and cover plans for the next 7/14 days including 72 hours follow up (by who and when), medication /crisis numbers and details of any other actions agreed. A Service User information leaflet to support person centred crisis planning has been developed and is currently being piloted. Comprehensive Assessment Tool (CAT) and Care and Treatment Plans (CTP) are reviewed and updated at transfers of care (including discharge from inpatients). An updated Care and Treatment Planning review tool has been developed and is in the process of being implemented. The tool is incorporated within the Electronic Patient Record and is covered within CAT Training and guidance. Older Adult Mental Health Services have a Clinical Risk Management Lead monitoring high-risk presentations and transitions (admissions/discharges) to support & upskill Care Coordinators. Further Actions as per recommendation 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_013	N/A	R13. The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	A discharge checklist is in place across MH/LD inpatient services. This is completed during the discharge process to record information associated with the completion of discharge tasks and notifications. Once complete this is scanned and uploaded to the Electronic Patient Record. Further work to strengthen assurances around consistency and effectiveness of this process will be undertaken through the below actions. Please see overarching Clinical Audit Action (Recommendation 34) Further Actions as per Recommendation 7.	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_014	N/A	R14. The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	Please see response to recommendation 13. The health board has a daily bed conference (twice daily Monday – Friday), originally established in the pandemic and now an embedded process, to review and proactively manage bed utilisation, availability, access and discharge which has MH/LD directorate wide multi-disciplinary input from services across admission and discharge pathways, MH/LD commissioning roles and multi-agency representation (including Police and Local Authority reps). Action notes are made and shared following bed conferences to ensure communication of key outcomes. Electronic Patient Records are updated with patient specific information. Older Adult mental health services also participate in additional discussions about regional admission needs across daily Acute Pathway Meetings (Multi Agency and Health Board wide). MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator provide additional support with coordination of discharges in more unusual circumstances. Further Action as per Recommendation 6 and 7.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_015	N/A	R15. The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	Please see response to recommendation 14 in relation to bed conferences and daily Acute Pathways Meetings. MH/LD Inpatient Senior Nurse roles and the Out of Hours Clinical Coordinator lead on coordination of risk based MDT decisions in the event of contingency plans needed for patients that require return to hospital from leave. Escalation processes are in place to support out of area bed / placement requests. Use of out of area placements by the MH/LD directorate are low. Further Action j)Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_016	N/A	R16. The health board must ensure arrangements are in place to allow for regular discussions between inpatient and community teams in relation to patient flow in and out of the inpatient units.	Please see response to recommendation 15.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_017	N/A	R17. The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	The health boards policy on Discharge and Transfer of Care incorporates definitions and guidance on delayed discharges. Delayed discharges in MH/LD directorate are operationally reviewed at a service level through the daily bed conference process referenced in the response provided to recommendation 15. Delays are identified and actions to address delays are agreed and reviewed with escalation as needed. Monthly reports of delayed transfers of care are produced and reported to the MH/LD Business Planning and Performance Assurance Group. Further Action as per Recommendation 15.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_018a	N/A	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions k)Develop procedural guidance and standards for uploading paper records to the Electronic Patient Record across the MH/LD Directorate	Aug-23	Aug-23	Red	QAST update 07/09/23 all actions chased 10/08/23, no update from service or new target date received.
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_018b	N/A	R18. The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	The health board has a Health Records Management Strategy and Health Records Management Policy, currently under review, which are accessible to all staff on the health boards policy and procedures sharepoint site which includes management and storage of paper records. A central storage facility is in place along with an electronic process for retrieval and tracking of paper clinical records. A number of paper clinical forms are still in use within inpatient mental health services for example NEWS charts, medication charts, MHA paperwork, MFRA falls assessments and Post falls review, Oral Risk assessment, PSPS, Observation and engagement charts. These are scanned on to the Electronic Patient Record system for access on completion or on discharge. Further work is needed to support full transition to paper free clinical records across the MH/LD Directorate. Further Actions l)Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_019	N/A	R19. The health board must provide assurances on the electronic patient clinical records systems in place, within its mental health services, to allow for essential information to be shared electronically between inpatient and community services.	The MH/LD Directorate operates a consistent Electronic Patient Record (Care Partner) across all of its services. The system allows access to contemporaneous records across inpatient and community services and has business continuity plans to guide staff in the event of system outage. Further Action m)Development of process to enable timely access of clinical records for temporary staff eg temporary staff log ins that are issued locally.	Nov-23	Nov-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_020	N/A	R20. The health board must implement actions to mitigate against risks associated with staff from different teams being able to accessing patient information in a timely manner.	Access to Care Partner is overseen by the MH/LD Directorate. Access to information is immediate to all teams in all locations when it has been added to Care Partner. Further Action as per Recommendation 19.	Nov-23	Nov-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_021	N/A	R21. The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010.	Details of discharge plans, including 72 hour follow up are included in discharge Care and Treatment Plans. The inpatient Discharge Checklist includes the need to check and record that discharge notifications have been completed and shared with relevant people. METeD, a system that digitally transfers discharge notifications and details of medication on discharge to GPs is currently being piloted for full roll out across the MH/LD directorate. Standard templates for discharge letters are in place. These require review to ensure they are reflective of NICE guideline standards for Transition between inpatient mental health settings and community or care home settings (NG 53). Work to strengthen assurance of consistency in quality and timeliness of discharge letters and discharge summaries being shared is required. Feedback indicates a regular theme of these not being shared in a timely way. Patient information leaflets outlining rights to re-refer are in use. Scrutiny of trends in cases that re-refer to services and referrals from GPs that could have re-referred themselves under the Mental Health (Wales) Measure 2010 is undertaken through the MH/LD Legislation Scrutiny Group. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_022	N/A	R22. The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_023	N/A	R23. The health board must ensure that discharge summaries are completed and sent out to a patient's GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.	Please see response to recommendation 21. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_024	N/A	R24. The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	Planning for 72-hour contact is undertaken as part of the Care and Treatment Planning process for discharge alongside crisis planning. Please see response to recommendation 12. There is no current system to routinely track and monitor compliance with 72 hour follow up. Previous audit gave good assurance of consistent achievement of this standard. There are no current learning themes from reviews or feedback in relation to 72 hour follow up. Further work is needed in this area to ensure documented standards and to strengthen routine assurance. Further Actions as per Recommendations 7 Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_025b	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions o)Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_025c	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Nov-23	Nov-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_025d	N/A	R25. The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	MH/LD Inpatient staffing is reviewed on a shift by shift basis and regularly, proactively reviewed at a service level. Senior nurses monitor vacancies, sickness and establishments and escalate approvals for, block booking of bank/agency and temporary/deployment contracts. Escalation of immediate staffing deficits or additional needs take place through the Duty Senior Nurse and Out of hours Clinical Coordinator (providing 24/7 cover) who direct staffing resources to priority areas and instigate escalation to bank, overtime agency24/7. Directorate oversight takes place through the MH/LD directorates Business Planning and Performance Assurance Group and board level scrutiny through quarterly Improving Together sessions. Workforce indicators are tracked and monitored through the health boards performance dashboard which includes oversight of vacancies, turnover rates, sickness trends etc. Vacancy rates for inpatient mental health services has improved since a high in September 2022 (22.82 WTE inpatient vacancies) and was reported as -0.3 WTE across inpatient mental health services in March 2023. The health board is engaged in All Wales discussions in relation to the national recruitment and retention challenge across mental health and learning disability services through the All Wales Senior Nurse Advisory Group and work surrounding mental health safe staffing principles and evolution of Welsh Levels of Care being applied across MH/LD settings. Further Actions q)Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_026a	N/A	R26. The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	The MH/LD directorate currently utilises monthly reports on caseload activity and referral rates to monitor capacity needs across community teams at a service level as well as Care and Treatment Planning compliance. A caseload weighting tool is in place, intended for use at a team level within management supervision where discussions about caseload take place and clinical documentation is reviewed and audited. Further work is needed to gain assurance surrounding the use and effectiveness of the caseload management tool. Vacancies are being evaluated to ensure staff are utilised and recruited to the areas required. Staff vacancies have been moved between teams to support areas with higher levels of referrals and care coordination. The impacts of vacancies on service capacity is held as a risk on service level risk registers for specific teams. (Risk 1612) There are currently no delays with allocation of care coordinators. An escalation process is used to highlight and promptly address delays as they occur. There are known breaches to the current 28 day standard for routine assessments of referrals into Adult CMHTs. Breaches are reported to the MH/LD directorate Mental Health Legislation Group which is overseen by the health board Mental Health Legislation Committee. All referrals are screened through a Duty System to review urgency which involves direct contact with the patient. There are no OAMH waiting lists associated with referrals to CMHT. Further Action r)Review application of MH safe staffing principles and version 3 of All Wales Staffing Levels for use across community teams.	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_026b	N/A	R26. The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	The MH/LD directorate currently utilises monthly reports on caseload activity and referral rates to monitor capacity needs across community teams at a service level as well as Care and Treatment Planning compliance. A caseload weighting tool is in place, intended for use at a team level within management supervision where discussions about caseload take place and clinical documentation is reviewed and audited. Further work is needed to gain assurance surrounding the use and effectiveness of the caseload management tool. Vacancies are being evaluated to ensure staff are utilised and recruited to the areas required. Staff vacancies have been moved between teams to support areas with higher levels of referrals and care coordination. The impacts of vacancies on service capacity is held as a risk on service level risk registers for specific teams. (Risk 1612) There are currently no delays with allocation of care coordinators. An escalation process is used to highlight and promptly address delays as they occur. There are known breaches to the current 28 day standard for routine assessments of referrals into Adult CMHTs. Breaches are reported to the MH/LD directorate Mental Health Legislation Group which is overseen by the health board Mental Health Legislation Committee. All referrals are screened through a Duty System to review urgency which involves direct contact with the patient. There are no OAMH waiting lists associated with referrals to CMHT. Further Action s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_027	N/A	R27. The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	The MH/LD Directorate has an established Accommodation Strategy Group that meets monthly. Its remit is: • To ensure that services experiencing the greatest demand and growth are able to access suitable estate. • Govern and oversee the repurposing of current MH&LD estate to minimise impact on service delivery. • Improve access to accommodation to enable sustainable service provision in order to increase efficiency and maximising clinical time. • Ensure MH&LD accommodation is safe and appropriate in which to delivery therapeutic/clinical interventions. • Act as the point of escalation for risks, issues and actions to the MH/LD Business Planning and Performance Assurance Group. • Progress appropriate Capital bids in collaboration with partner agencies and ensure MH&LD Estate is included in Health Board maintenance and refurbishment schedules. • Report formally, regularly and on a timely basis to the MH&LD BP&PAG on options, plans and progress relating to the Group's activities. • Ensure appropriate escalation arrangements are in place to alert the Hywel Dda University Health Board (HDUHB) Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of HDUHB. • To monitor the completion of Point of Ligature Audits, ensuring they are reviewed and completed in a timely manner. • To receive the requests for environmental improvements required and agree a prioritisation process for completion of essential works. CRHT services have identified a current risk in relation to being able to access space within emergency departments which is held on the service risk register. Progress has been made with now just one locality to be resolved. Further Action t) Resolve CRHT access to space within all emergency departments.	Jul-23	~~Jul-23~~ N/K	Red	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_028	N/A	R28. The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	Please see responses to recommendation 6 and 7. Further Actions as per Recommendation 6 and 7 [illegible] Please see overarching Clinical Audit Action (Recommendation 34)	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_029	N/A	R29. The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Actions to ensure sufficient medical capacity across all mental health teams are ongoing within the directorate and active approaches to recruitment and retention are underway through active and frequent review of medical vacancies at the MH/LD Directorate Business Planning and Performance Assurance Group (BPPAG) and Workforce Group, targeted, refreshed, national recruitment campaigns, provision of relocation packages, implementation of a Clinical Fellowship Model, post graduate development support. The MH/LD Directorate holds a risk on its risk register in relation to sustainability of the medical workforce across the MH/LD Directorate (Ref 1525) in response to difficulties and challenges experienced in recruiting doctors and retention risks associated with the age profile of the existing Consultant workforce. The risk is currently mitigated through service awareness and plans to manage impacts through service level risk registers, recruitment, and development of complimentary workforce (for example Advanced Practitioners and introduction of Physicians Associate roles), implementation of an escalation process in the event of medical deficits and through attendance at HEIW Workforce Meetings. The risk is reviewed and updated regularly. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_031	N/A	R31. The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	Capacity and demand work across mental health therapy services is underway to strengthen capacity where needed and develop flexibility in use of skills. Therapy workforce plans are in place across each MH/LD service speciality. Current deficits as a result of being unable to recruit to specialist psychology roles is held as a service level risk (Risk 138). Mitigations and actions include: -Cross Directorate cover to ensure that there is no inequity in the availability of services across both specialities and localities. -Upskilling the wider multi-disciplinary workforce to deliver interventions under the supervision of psychology and psychotherapy and use of CBT Therapy roles. -Continued efforts to recruit to psychology roles and plans for a 'grow your own' scheme coming into place during 23/24 for 3 funded places on the Clinical Psychologist programme. Waiting lists are frequently reviewed to identify and reassess individuals and 'Keeping in Touch' processes are in place. A continued focus on recruitment and retention to include therapy roles across MH/LD directorate will be undertaken through the MH/LD Workforce Group. Further Action (q) as per Recommendation 25	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_032	N/A	R32. The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	A range of developments to ensure that MH/LD directorate inpatient and community mental health staff have the appropriate knowledge and skills to effectively undertake their role are being undertaken including delivery of training to support risk assessment and suicide prevention through WARRN and STORM training. Further work is needed to provide a systematic approach to this to ensure needs are fully assessed and gaps identified, sustainable methods of provision planned and mechanisms for monitoring applied. Further Action u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Nov-23	Nov-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_033	N/A	R33. The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	The Psychological Wellbeing Service is widely promoted by team leaders via Workforce Advisers monthly sickness absence catch up meetings with Team Leaders and during sickness absence meetings and through completion of All Wales Sickness Absence Training. Regular 1:1 meetings are held with managers and the workforce operational team advisers, ensuring appropriate wellbeing advice is given on a case by case basis so they can cascade this information to their staff members. Managers are supported to actively engage and refer staff to Occupational Health for appropriate support. Further Action v)Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	Mar-24	Mar-24	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_034a	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions w)Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- -Testing assurance of consistent implementation of CAT and Physical Health Screening -Testing assurance of appropriate completion of WARRN -Routine reporting and monitoring of compliance with routine offer of carers assessments -Audit of compliance with Ward Round (MDT Review) standards -Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards -Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans -Testing assurance of the quality of discharge letters -Routine reporting and monitoring of compliance with 72 hour follow up	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_034b	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions x)Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_034c	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions y)Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed	Dec-23	Dec-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_034d	N/A	R34. The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Existing audits are routinely shared through Ward Managers Forums and Community Managers Forums and reported through QSEG and MHLC Scrutiny group. Further Actions z)Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	Mar-24	Mar-24	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_035	N/A	R35. The health board must ensure that there is a robust and sustainable audit action management plan in place within its mental health services, to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	Please see overarching Clinical Audit Action (Recommendation 34)	Mar-24	Mar-24	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_036a	N/A	R36. The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. Further Actions aa)Strategic review of forward plan for written control documents across MH/LD services for 2023/24 to identify co dependencies and establish integrated planning and development for documents that span pathways and services.	Sep-23	Sep-23	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_036b	N/A	R36. The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	Written Control Document Group exists to review all new policy and procedural documents and to systematically review and update existing polices. Developments are shared via Global Emails and through Forums such as Ward Manager, Community Manager and Professional Nurse Forums. Further Actions bb)Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	Amber	
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_038	N/A	R38. The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	Social Worker identified incidents are currently reported on Datix via health board managers as direct system access is not currently in place. Further Action dd)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	~~Jul-23~~ N/K	Red	QAST update 07/09/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. A written protocol is to be developed to capture and share the process for consistent implementation. No new target date provided by service.
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_050520 23_039	N/A	R39. The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	The health board has an Incident, Near Miss and Hazard Reporting Procedure and dedicated sharepoint site which can be accessed by all staff. The procedure details roles and responsibilities within the incident management process which for incident mangers includes ensuring feedback to staff who have raised the issue and reported an incident. This includes staff who may have raised concerns through the Speak Up Safely Process. A feedback mechanism is incorporated within the DATIX system which facilitates direct feedback to the incident reporter following the incident review process. Performance against the incident management process is reported and tracked through a board wide performance dashboard which is accessible to all staff via the health boards intranet. Incident management performance is overseen at a directorate level by MH/LD Business Planning and Performance Assurance Group and at a board level through Exec Led Quarterly Improving Together sessions with each directorate leadership team. Standards of system completion are addressed through ongoing engagement with incident reviewers, training and via Ward Manager and Community Manager Forums. MH/LD directorate level incident themes and trends are reviewed by the MH/LD Quality, Safety and Experience Group. Further Action ee)Amend the service line reporting template for MH/LD Quality, Safety and Experience Group to include service line data in relation to incident management process to strengthen consistency of reporting, oversight and monitoring of compliance with Datix incident management and feedback process.	Jul-23	~~Jul-23~~ ~~N/K~~ Oct-23	Red	QAST update 07/09/23 The reporting template used by Heads of Service to report into MH/LD QSEG has been amended to include routine data and updates on incident management for the service to enable oversight and monitoring of compliance with Datix incident management and feedback process. The revised template will be in use by QSEGs next meeting in October 2023.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_MHDR_05052023	May-23	HIW	Mental Health Discharge Review	Open	N/A	Mental Health & Learning Disabilities	Mental Health & Learning Disabilities	Assistant Director of Nursing Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	HIW_MHDR_05052023_040	N/A	R40. The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	Improvement planning meetings are facilitated by the Quality Assurance and Practice Development Team as standard following completion of all Level 4 and 5 incidents which include senior stakeholders and services involved. Where needed, follow on review meetings are also booked to review and ensure implementation. Further cascade of learning and consistent embedding of actions are delegated to service managers for operational implementation. Forums including Ward Manager, Community Manager, Professional Nurse Forums are used to discuss themes from learning and communication methods such as 7 minute briefings are used where wide cascade is needed. Further Action fff)Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	Mar-24	Mar-24	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_001b	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.	To remind staff that the two rooms that can accommodate a bed within MIU is to be considered on a clinical needs and risk basis and discussed during the safety huddles.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_001c	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.	To remind all staff that pressure relieving equipment is available through the TVN service and should be utilised based on the risk assessment for individual patients.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_001d	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	Sep-23	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_002	N/A	R2. A patient with infective eczema self-discharged against medical advice, returning the following morning for antibiotics, in order to have a shower due a lack of facilities on the Unit.	Staff to be reminded that the shower facility based in AMAU can be offered and where required patients should be supported to use the shower.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_003	N/A	R3. There was only one toilet, and no shower facilities available to patients on the Unit. If medical patients continue to be accommodated, access to this provision must be reviewed.	Staff to be reminded that wash bowls and toiletries are available for all patients (this is in place)	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004a	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.	Reminder to be issued to all staff regarding patients not being left unattended in room	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004b	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	~~Aug-23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004c	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.	Advice to be sought from Head of Health and Safety	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004d	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.	Ligature risk assessment to be revisited	Jul-23	~~Jul-23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004e	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.	Site assessment to be undertaken by H&S Team and work plan developed with estates	Jul-23	~~Jul-23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_004f	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.	Report to be presented to the H&S Assurance Committee	Sep-23	Sep-23	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_006a	N/A	R6. We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	To identify a pain Link nurse to act as a point of resource for staff and to liaise with the pain team.	Jul-23	Jul-23	Amber	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_006b	N/A	R6. We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	To undertake an initial baseline audit to identify key areas of improvement relating to assessment, prescribing, action, monitoring and escalation of pain.	Jul-23	Jul-23	Amber	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_006c	N/A	R6. We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	To develop a programme of further audits to monitor practice (pain management	Jul-23	Jul-23	Amber	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_006d	N/A	R6. We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	To develop a training with the pain team for MIU staff, which includes information on how staff can ensure patients' pain is adequately assessed and managed	Aug-23	~~Aug-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_006e	N/A	R6. We saw instances of inconsistent pain relief and pressure area checks for patients at high risk	To engage with clinical colleagues and medical teams to ensure timely patient assessment and prescribing of medication.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007a	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To update the teaching board and provide information on how to fully complete NEWS chart and sepsis screen.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007b	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To identify a sepsis link nurses as point of resource for staff and to liaise with the resuscitation team.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007c	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To undertake an initial baseline audit to identify key areas of improvement.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007d	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To develop a programme of further audits to monitor practice (sepsis management)	Aug-23	~~Aug-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007e	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To send an email to all staff received e-mail to emphasise importance of sepsis screening and action.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007f	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To source additional sepsis book and ensure they are visible to doctors and nurses in all MIU areas	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007g	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To consider and action the findings of the monthly sepsis compliance spot check audits carried out by the resuscitation team.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_007h	N/A	R7. We saw instances of inconsistent sepsis scoring, despite trigger signs of possible infection	To continue the work ensuring that all agency nurses are aware of the resource booklet which incorporates specific knowledge and skills on sepsis screen documentation, recognition and compliance. (Positive verbal feedback has been received from Agency Nurses to PDN regarding the resource file.)	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_008a	N/A	R8. Handover (SBAR) sheets were available on the unit, but were not routinely used. Due to the high level of agency use and transfers out, there use must be increased.	To ensure that all MIU staff are familiar with the SBAR documentation that is embedded in the MIU documentation.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_008b	N/A	R8. Handover (SBAR) sheets were available on the unit, but were not routinely used. Due to the high level of agency use and transfers out, there use must be increased.	Nurse in charge to ensure that the SBAR documentation is used on a daily basis and monitor compliance through the spot check audits (see action 1	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009a	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.	When the MIU is in surge capacity to continue to book and allocate a Registered Nurse and HCSW to manage the surge patients 24 hours a day. In the event of an unfulfilled shift, to identify resource from other area of hospital and deploy accordingly.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009b	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 continue to attend the Patient Flow meetings twice daily at 8:30am and 3pm (this includes RTDC to promote discharge before 2pm) and escalate issues to Manager of the Day, which are communicated on the twice daily Health Board calls	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009c	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 ensure that the Safety Huddles which take place in the AMAU (incorporating MIU) at 12, 5 and 10pm are attended by appropriate MIU staff.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009d	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.	Working alongside DELTA and TOCALS, ensure any unforeseen issues regarding discharge are dealt with promptly to avoid unnecessary admissions.	Jul-23	~~Jul-23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009e	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 implement draft of an escalation flow chart which will assist the escalation of patients that need immediate transfer to other services.	Jul-23	~~Jul 23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009f	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	Sep-23	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_009g	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 continue the work being undertaken as part of TUEC policy goal 5 with regards to the effective functioning of the Hospital 'front door' services	Dec-23	Dec-23	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_010	N/A	R10. We were equally concerned with the wait times involved for the transfer of some acutely unwell or deteriorating patients due to a lack of timely transfer from the Welsh Ambulance Service Trust (WAST) following urgent requests by Unit staff.	To include in the escalation flow chart the management of patients who need immediate transfer (there will need to be a discussion between the clinician in charge of the patients' care and WAST clinical desk)	Sep-23	Sep-23	Amber	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_011	N/A	R11. Overall, we identified a strong theme from staff that there is decreasing capacity from WAST in supporting emergency transfers in a timely manner.	To share the concerns of HIW with WAST Executive colleagues	Jul-23	~~Jul 23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_012a	N/A	R12. Additionally, multiple staff informed us that there are occasions whereby the on-site CRASH response team, at times, do not feel equipped or that they are acting outside of their scope of practice when asked to provide emergency resuscitation for paediatric patients.	To undertake an assessment of PILS and ILS training requirements for nursing staff in MIU and develop a schedule for training.	Jul-23	~~Jul 23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_012b	N/A	R12. Additionally, multiple staff informed us that there are occasions whereby the on-site CRASH response team, at times, do not feel equipped or that they are acting outside of their scope of practice when asked to provide emergency resuscitation for paediatric patients.	To undertake an assessment of PILS and ILS training requirements for MIU GP enhanced medical staff and develop a schedule for training	Jul-23	~~Jul 23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_013a	N/A	R13. Due to the risk for patient safety, there is an immediate need for the Health Board to provide additional assurance regarding the timely conveyance of patients. This will likely require discussions with WAST and, at the minimum, the implementation of a local standard operating procedure (SOP) for the escalation and transfer of patients. •We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the Unit, e.g. overnight. •This creates a high-risk situation for nursing staff and patients due to the issues raised above. There is an immediate need for the Health Board, at the minimum, to implement a local SOP for MIU staff to follow in the event of patient presentations outside of their scope of practice. Overall, these issues apply inappropriate pressures to the functionality of the Minor Injury Unit as an MIU, as the staff and the Unit are not fully equipped in the present situation and pressures to manage all the patients admitted to the Unit.	In this situation, to continue with current process of: • Exploring all available avenues to source medical cover for unexpected absences and the Medical Registrar on-call is advised of the deficit and the added support that is need in MIU • Informing the Health board communications team and information being circulated to WAST, 111 and Police to ensure that they are aware of the reduced service.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_013b	N/A	R13. Due to the risk for patient safety, there is an immediate need for the Health Board to provide additional assurance regarding the timely conveyance of patients. This will likely require discussions with WAST and, at the minimum, the implementation of a local standard operating procedure (SOP) for the escalation and transfer of patients. •We could not be assured that there was sufficient and robust support for Emergency Nurse Practitioners at times when there is an unexpected lack of medical cover on the Unit, e.g. overnight. •This creates a high-risk situation for nursing staff and patients due to the issues raised above. There is an immediate need for the Health Board, at the minimum, to implement a local SOP for MIU staff to follow in the event of patient presentations outside of their scope of practice. Overall, these issues apply inappropriate pressures to the functionality of the Minor Injury Unit as an MIU, as the staff and the Unit are not fully equipped in the present situation and pressures to manage all the patients admitted to the Unit.	To prepare a schedule for the development a suite of Redirection Protocols to assist with the effectiveness of triage and for streaming to take place within MIU to ensure patients are re-directed to the correct services. (This will take time to develop and will need input from other directorates, clinical colleagues including Primary Care.)	Jul-23	~~Jul 23~~ N/K	Red	
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_014a	N/A	R14. Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	To order 2 suitable resuscitation trolleys that can be sealed in line with the which is resuscitation council standard.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_014b	N/A	R14. Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	To remind staff of the requirement to undertake: • daily checks on all trolleys (adult and paediatric) which includes ensuring the seal is secure on a daily basis evidenced by a signature in the handover book • that if the tag has been removed, a full check of the trolley • if the tag is intact, a full check of the trolley every Sunday morning and the checklist must be signed.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_014c	N/A	R14. Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	To remind staff that where equipment is due to expire within 3 months an email must be sent to the Senior sister so that replacements can be sourced in a timely manner.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_014d	N/A	R14. Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	To include a check of resuscitation trolleys in the daily spot checks and take immediate action to address any issues during the spot check.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_PPHMIU_26062023	Jun-23	HIW	Prince Philip Hospital Minor Injuries Unit	Open	N/A	Unscheduled Care (PPH)	Unscheduled Care (PPH)	Senior Nurse Manager	Director of Operations	HIW_PPHMIU_26062023_014d	N/A	R14. Resuscitation trolley checks had not been completed in line with Health Board procedure and Resus UK guidance. We found evidence of gaps, with last checks having taken place on the 21 June in the resus bay on the MIU. There was also a small amount of expired equipment on the paediatric resus trolley. The Health Board must ensure that checks include expiry dates and that these are completed and logged at all times. This must include mechanisms to identify when checks are not completed or logged.	To include a check of resuscitation trolleys in the daily spot checks and take immediate action to address any issues during the spot check.	Jul-23	~~Jul 23~~ N/K	Red	13/09/2023 - The service on AMAT have noted as at Sep 2023 the action has been completed and currently awaiting approval.
HIW_BHMU_26062023	Aug-23	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	HIW_BHMU_26062023_001a	N/A	R1. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	Lead Anaesthetist and the Lead Anaesthetist for Obstetrics for BGH have been informed as a priority and have provided assurance that compliance will be met at the earliest opportunity	Aug-23	~~Aug-23~~ N/K	Red	
HIW_BHMU_26062023	Aug-23	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	HIW_BHMU_26062023_001b	N/A	R1. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	PROMPT Wales have been contacted and an additional PROMPT facilitator training place for an Obstetric Anaesthetist from BGH has been confirmed this will increase the number of anaesthetic facilitators available for PROMPT training in BGH.	Aug-23	~~Aug-23~~ N/K	Red	
HIW_BHMU_26062023	Aug-23	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	HIW_BHMU_26062023_001c	N/A	R1. The health board is required to provide HIW with details of the action taken: •to improve mandatory compliance with Practical Obstetric Multi Professional Training (PROMPT) within the anaesthetists team at Bronglais hospital	Given the nature and value of PROMPT training, it is essential that it is MDT and therefore session take place on a monthly basis. The Health Board acknowledges that to achieve the outcomes they must be SMART and therefore, this will take several months to achieve compliance	Sep-23	Sep-23	Amber	
HIW_BHMU_26062023	Aug-23	HIW	Bronglais Hospital Maternity Unit	Open	N/A	Women and Children's Services	Women and Children's Services	Head of Midwifery	Director of Operations	HIW_BHMU_26062023_002	N/A	R2. The health board is required to provide HIW with details of the action taken: •to promote patient safety in the interim until compliance has improved.	Awaiting management response	Sep-23	Sep-23	Amber	

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_004	High	R4. The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	A review of the procedure for patient identify checks will be undertaken to update the Employer's Procedure (EP).Introduce an audit to be performed on compliance with identity checks.	Apr-23	~~Apr-23~~ N/K ~~Jun-23~~ N/K Nov-23	Red	QAST update 09/05/2023 chased, awaiting progress. 03/07/2023 - QAST chased for update June 23 or new expected date received. QAST update 07/09/23 EPs updated, service has suggested end of November for target date.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_005a	High	R5. The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of the enquiries of individuals of child bearing potential Employer's Procedure will be undertaken and updated with any gender specific reference to be removed.	Apr-23	~~Apr-23~~ N/K ~~Jun-23~~ N/K Nov-23	Red	QAST update 09/05/2023 chased, awaiting progress. 03/07/2023 - QAST chased for update June 23 or new expected date received. QAST update 07/09/23 EPs updated, service has suggested end of November for target date.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_009	High	R9. The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	Apr-23	~~Apr-23~~ N/K ~~Jun-23~~ 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 service advise partially complete awaiting sign off. No new target date provided.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_014	High	R14. The employer is required to provide HIW with details of the action taken to maintain a complete and up to date record of the training, entitlement and scope of practice for entitled duty holders, including non-medical referrers	A review of the entitled duty holder matrix will be undertaken with the suggested change being made to provide a more thorough record.	Jun-23	~~Jun-23~~ 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 progress has been made but still some work on the NMR referrers. No new target date suggested by service.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_015a	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These competencies will be added to matrix.	May-23	~~May-23~~ ~~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.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_015b	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	The Employer's Procedure will be updated to include the justification process.	May-23	~~May-23~~ ~~N/K~~ ~~Jun-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 or new expected date received. QAST update 07/09/23 Sign off sheet for carer and comforter training devised. Service advise completed.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_015c	High	R15. The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: • for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.	Introduce a process to establish dose constraints and add to Employer Procedures.	May-23	~~May-23~~ ~~N/K~~ ~~Jun-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 or new expected date received. QAST update 07/09/23 EPs updated service advise completed.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_016	High	R16. The employer is required to provide HIW with details of the action taken to develop and implement written protocols, where appropriate, for paediatric patients.	A process has been introduced to review all adult protocols. The review will inform the development and implementation of paediatric protocols.	Jun-23	~~Jun-23~~ ~~N/K~~ ~~Jul-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 Task and finish group set up to review protocols - still in progress. No target date provided.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_017b	High	R17. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Sep-23	Sep-23	Amber	QAST update 09/05/2023 chased, awaiting progress. 03/07/2023 - QAST chased for update June 23 no update received.
HIW_160223_DIDGGH	Feb-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	HIW_160223_DIDGGH_018c	High	R18. The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Written examination protocols will be made available to all staff in electronic and paper formats for all areas.	Feb-23	~~Feb-23~~ N/K ~~Jun-23~~ 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 There are paper copies in all areas and electronic in CT but due to IT issues and no written control system they are not available in electronic form in general x-ray areas apart from email to each staff member. The document control system is on the risk register and i am looking for options with IT to solve the issue. Completed.

Reference Number	Date of report	Report Issued By	Report Title	Status of report	Assurance Rating	Lead Service / Directorate	Supporting Service	Lead Officer	Lead Director	Recommendation Reference	Priority Level	Recommendation	Management Response	Original Completion Date	Revised Completion Date	Status (Red- behind schedule, Amber- on schedule, Green- complete)	Progress update/Reason overdue
PSOW_202002558	Sep-21	Public Service Ombudsman (Wales)	202002558	Open	N/A	Nursing	Mental Health & Learning Disabilities	Olivia Barker	Director of Operations	PSOW_202002558_004	N/A	Commissions and completes its planned review of the Health Board's child psychology services and reports the findings back to the Ombudsman.	Action plans held with Ombudsman Liaison Manager. The Clinical Lead for Community Paediatrics and a Health Board Psychologist are undertaking a review of Child psychology services across the Health Board. A representative from Swansea University is supporting this work. The review will be reported to the executive led Children and Young Persons Working Group.	Mar-22	Sep-23	Red	11/03/2022 - The Children and Young Persons Working Group was due to meet 28.02.22 and the initial findings of the review of Child Psychology services across the Health Board was to be reported at this meeting. I have emailed Lisa Humphrey and Tracy Bucknell for an update 01.03.22. This is the only outstanding action for this case. 03/05/2022 - update request sent to PSOW liaison manager 16/05/2022 - The initial findings of the psychology review were shared with the CYP Working group verbally on 28/02/2022. The agenda for this meeting was provided to the PSOW as evidence. The outcome following the meeting of 28/02/2022 - was for the presenters to undertake further work which falls into the wider work being undertaken by the CYP Working Group. The next meeting is 27/05/2022, asked PSOW if I can update after this date. 12/07/2022 Update provided to PSOW, further CYP meeting scheduled for 22.07.22. 04/04/2023 & 05/05/2023 Updates provided to PSOW from Director of Nursing (MR) and Director of Operations (AC). 09/06/2023- Ombudsman Case Manager confirmed this recommendation is not implemented, therefore recommendation turned back to red, a revised implementation date has been requested. 03/07/2023 - Update from Ombudsman Case Manager: Director of Nursing (MR) and Director of Operations (AC) are in contact with the PSOW regarding this recommendation. 05/08/2023 - Director of Nursing responded to PSOW 08/07/23; further information to be sent by end of Sept 2023.
PSOW_202104390	Jun-23	Public Service Ombudsman (Wales)	202104390	Open	N/A	Scheduled Care	Scheduled Care	Lianne Gregory/Helen Sullivan	Director of Operations	PSOW_202104390_002	N/A	R2. Share a copy of this report with its Equality, Diversity and Inclusion Team to take forward the learning points highlighted in this report, and to provide evidence that it has done so.	•NHS Wales Autism awareness training is now mandatory on ESR and was developed with Autism Wales – all staff to complete this training •The Diversity and Inclusion team will include a case study about a patient with autism and reasonable adjustments within its 'Patient Centred Care' induction session for new staff. The session also provides an overview of the Equality Act and the requirements upon all of us to remove disadvantage for those with protected characteristics. •The Diversity and Inclusion team will be delivering training sessions to medical leaders and senior clinicians across the Health Board on bias and prejudice so will include a case study about a patient with autism Also, if the team/department would benefit from a session with the Diversity and Inclusion team about making reasonable adjustments for patients (this could include a variety of needs such as sensory loss, language, not just autism) this can be arranged. We could also link with the Learning and Development team, if it is felt that staff would benefit from more specific autism awareness training, in addition to the e-learning available on ESR.	Sep-23	Sep-23	Amber	15/08/2023 - on track.
PSOW_202203628	Jul-23	Public Service Ombudsman (Wales)	202203628	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202203628_005	N/A	R5. Arrange for the nursing team to have a discussion on the alternatives to oral analgesia for patients with chronic pain and not able to tolerate oral medication.	To be presented at SNMT on 10/08/23	Aug-23	~~Aug-23~~ N/K	Red	07/09/2023- Evidence sent 30/08/23, PSOW have requested further info which has been escalated.
PSOW_202102692	Jul-23	Public Service Ombudsman (Wales)	202102692	Open	N/A	Nursing	Nursing	Amanda Davies/Rebecca Temple-Purcell	Director of Nursing, Quality and Patient Experience	PSOW_202102692_005	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	
PSOW_202102692	Jul-23	Public Service Ombudsman (Wales)	202102692	Open	N/A	Nursing	Nursing	Mandy Rayani	Director of Nursing, Quality and Patient Experience	PSOW_202102692_006	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	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	Olivia Barker	Director of Nursing, Quality and Patient Experience	PSOW_202101889_001	N/A	R1. Apologise for the failings identified.	Copy of Apology letter	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	Paul Smith Clive Weston	Director of Nursing, Quality and Patient Experience	PSOW_202101889_002	N/A	R2. Introduce a lower threshold for decisions on whether to initiate "conscious sedation" during TOE procedures and endeavour to obtain the patient's agreement to receive sedation prior to the passage of the transoesophageal probe.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	Paul Smith Clive Weston	Director of Nursing, Quality and Patient Experience	PSOW_202101889_003	N/A	R3. Remind clinicians undertaking TOE procedures of the importance of adhering more strictly to BSE guidelines by formally recording oxygen and blood pressure measurements before, after and throughout the entire TOE procedure. Furthermore, any medication administered before, during or after the procedure (including local anaesthetic at the back of the throat) should be recorded on a drug administration sheet	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101889_004	N/A	R4. Remind nursing clinicians of the WAASP guidance and what it says regarding patients at moderate and high risk of malnutrition.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101889_005	N/A	R5. Remind nursing staff: (i) of the need to ensure that there is a clear rationale for catheter use (ii) of the need to use catheter care plans from initial insertion and for them to be reviewed daily as per local guidance (iii) that patients should be informed of the risks and benefits of catheterisation so that they are able to give informed consent (iv) of the need to ensure that the patient is questioned about bowel movements when completing the bowel assessment chart (v) if the patient has not opened their bowels for 3 days, that they are asked about their "usual bowel habits" and that this is escalated to the Medical team.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101889_006	N/A	R6. Nurses should receive, as appropriate, training on the use of urinary catheters and bladder washouts.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	TBC	Director of Nursing, Quality and Patient Experience	PSOW_202101889_007	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.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202101	Aug-23	Public Service Ombudsman (Wales)	202101889	Open	N/A	Nursing	Nursing	Paul Smith Clive Weston	Director of Nursing, Quality and Patient Experience	PSOW_202101889_008	N/A	R8. Undertaken a sample audit of TOE documentation to ensure that they are in line with BSE guidelines.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202003536	Aug-23	Public Service Ombudsman (Wales)	202003536	Open	N/A	Public Health	Public Health		Director of Public Health	PSOW_202003536_001	N/A	R1. Share the report with the relevant clinicians for reflection and learning.	Management Response held with PSOW.	Sep-23	Sep-23	Amber	
PSOW_202003536	Aug-23	Public Service Ombudsman (Wales)	202003536	Open	N/A	Public Health	Public Health	Megan Harris	Director of Public Health	PSOW_202003536_002	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.	Management Response held with PSOW.	Feb-24	Feb-24	Amber	

Reports closed on the Audit Tracker since ARAC August 2023

Report name	Lead Executive/Director
HIW: Angharad Ward, Bronglais Hospital 4/5 October 2022 (Publication date 5 January 2023)	Director of Operations
HIW: Glangwili - Maternity Services 28-30 November 2022 (Publication date 02 March 2023)	Women and Children's Services
HIW: Child Protection Rapid Review (November 2022) - report received June 2023	Director of Operations
Internal Audit: Service Reset and Recovery	Director of Operations
PSOW: 202003189	Director of Nursing, Quality and Patient Experience
PSOW: 202100369	Director of Primary Care, Community and Long Term Care
PSOW: 202101488	Director of Nursing, Quality and Patient Experience
PSOW: 202200545	Director of Primary Care, Community and Long Term Care

Reports opened on the Audit Tracker since ARAC August 2023

Report name	Lead Executive/Director	Number of recommendations	Final report received at
Audit Wales: Review of Workforce Planning Arrangements	Director of Workforce & OD	6	Audit and Risk Assurance Committee
Audit Wales: Audit Wales ISA 260 and Letter of Representation 2022/23	Director of Finance	2	Audit and Risk Assurance Committee
Delivery Unit: Review of Memory Assessment Services	Director of Operations	5	Quality, Safety and Experience Committee
HIW: Prince Philip Hospital Minor Injuries Unit	Director of Operations	14	Quality, Safety and Experience Committee
HIW: Bronglais Hospital Maternity Unit	Director of Operations	2	Quality, Safety and Experience Committee
HIW: Child Protection Rapid Review (November 2022) - report received June 2023	Director of Operations	0	Quality, Safety and Experience Committee
Internal Audit: Escalation Status Actions	Director of Corporate Governance	4	Audit and Risk Assurance Committee
Internal Audit: Savings Governance Review	Director of Finance	19	Audit and Risk Assurance Committee
MWWFRS: Letter of Fire Safety Matters Premises: Template 3, Prince Philip Hospital, Dafen	Director of Operations	10	Health and Safety Committee

Road, Dafen, Llanelli. SA14 8QF			
MWWFRS: Letter of Fire Safety Matters Premises: Template 5, Prince Philip Hospital, Dafen Road, Dafen, Llanelli. SA14 8QF	Director of Operations	9	Health and Safety Committee
PSOW: 202102692	Director of Nursing, Quality and Patient Experience	6	Listening and Learning Committee
PSOW: 202203628	Director of Nursing, Quality and Patient Experience	6	Listening and Learning Committee
PSOW: 202101889	Director of Nursing, Quality and Patient Experience	8	Listening and Learning Committee
PSOW: 202003536	Director of Public Health	2	Listening and Learning Committee
Total		**93**	

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Audit Wales - Medicines Management in Acute Hospitals (June 2015)	1 External	June 2016	1 external – awaiting funding confirmation from Welsh Government	Medicines Management	One 'external' recommendation relating to electronic prescribing/discharging. Welsh Government (WG) have provided some funding for a small pre-implementation team that is now in place to develop a local business case to secure funding for Electronic Prescribing and Medicines Administration (ePMA). Nationally there are currently 3 systems that have been approved on the framework, and once funding is approved a mini-procurement process will be undertaken to secure the most appropriate system for the Health Board. The ePMA 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 (SRC) and is awaiting Health Board approval. This is reflected in risk 1171 – Lack of e-prescribing and electronic medication administration system, which has a current risk score of 16 as at September 2023.

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	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 to confirm 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.
Community Health Council - Accident & Emergency Departments in the Hywel Dda Health Board area (November 2022)	1	March 2023	1 - awaiting confirmation for closure	Nursing	Deputy Director of Nursing, Quality & Patient Experience is in the process of clarifying with Heads of Nursing at the acute sites if these recommendations have been implemented, or if revised completion dates are required, with updates to be reflected to ARAC in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Community Health Council - Eye Care Services in Wales, issued March 2020	1 External	June 2022	1 external – awaiting update on national system roll out	Scheduled Care	The Health Board is awaiting a "go live" date following delays in the rollout of the Electronic Patient Record platform. An update on this is expected in Q3 2023. The Ophthalmology service is due to provide an update on the progress of all recommendations to ARAC once the new service management structure has been established and the reports on the Audit and Inspection tracker have been fully reviewed
Delivery Unit- All Wales Assurance Review of Crisis & Liaison Psychiatry Services for Older Adults	1	August 2023	1 - original completion date lapsed since previous meeting	Mental Health & Learning Disabilities	Since the preparation of this report, the service has provided a revised completion date for the recommendation. This update will be reflected in the next Audit Tracker report to due to be presented to ARAC in December 2023.

Commented [RW(DU-HoA1]: As per comment in SBAR, this was noted after Carly and Andrew attended ARAC in April, with an update to be presented to the committee later in the year. Left this in for the time being, but if this isn't on the workplan for the committee let me know and I can remove.

Commented [CW(DHBADo2]: I can see this throughout the report but its not really a reason why its N/K

Commented [RW(DU-HoA3R2]: Service have not yet provided us with a revised completion date so it automatically becomes N/K.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HEIW - General Internal Medicine Bronglais Hospital (BGH)	5 (1 External)	June 2023	1 External – date of HEIW revisit yet to be confirmed 3 – original completion dates lapsed since previous meeting 1 – no revised completion date provided	Medical	This report was re-assigned to the Medical Directorate from BGH in July 2023, and noting that 3 completion dates have recently lapsed. The Assurance Risk Team are currently seeking progress updates from the Head of Medical Education & Professional Standards along with revised timescales. ~~(if applicable~~
HEIW - Obstetrics and Gynaecology Glangwili Hospital (GGH)	5	January 2023	4 - Revised completion date lapsed since previous meeting 1 – original completion date not known	Medical	This report was re-assigned to the Medical Directorate from the Women and Childrens Directorate in July 2023, and noting that 4 completion dates have recently lapsed. The Assurance Risk Team are currently seeking updates from the Head of Medical Education & Professional Standards along with revised timescales. ~~(if applicable).~~

Commented [CW(DHBADo4]: Why would they be N/A? for this rec and for others below?

Commented [RW(DU-HoA5R4]: I can see how this was confusing, I've removed – trying to demonstrate that there may be instances where these recs may be completed therefore a revised timescale not needed.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HEIW - Surgical Specialties GGH	7 (1 External)	April 2023	6 - revised completion date lapsed since previous meeting 1 External - date of HEIW revisit has yet to be confirmed	Medical	Report re-assigned to the Medical Directorate from GGH. A further visit from HEIW is expected in October 2023. The Assurance Risk Team are currently seeking updates from the Head of Medical Education & Professional Standards along with revised timescales. ~~(if applicable).~~
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 QAST Team, 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 December 2023.
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 December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW - Mental Health Discharge Review	1	July 2023	1 – original completion date not known	Mental Health & Learning Disabilities	Timescales are currently being requested from the service via the Quality Assurance and Safety Team (QAST), with updates to be reflected to ARAC in December 2023.
HIW - National Review of Mental Health Crisis Prevention in the Community	3	July 2023	3 - QAST team awaiting update	Mental Health & Learning Disabilities	Awaiting clarification from the service via the QAST Team if the recommendations have been implemented, or if revised completion dates are required. Progress updates will be reflected to ARAC in December 2023.
HIW - St Caradog ward, Withybush Hospital 12 August 2021 (Publication date 16 September 2021)	2	July 2023	2 – QAST team awaiting update	Mental Health & Learning Disabilities	Awaiting clarification from the service via the QAST Team if the recommendations have been implemented, or if revised completion dates are required. Progress updates will be reflected to ARAC in December 2023.
HIW IRMER - Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	5	June 2023	5 - revised completion dates lapsed since previous meeting	Radiology	Awaiting clarification from the service via the QAST Team if the recommendations have been implemented, or if revised completion dates are required. Progress updates will be reflected to ARAC in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
HIW Prince Philip Hospital Minor Injuries Unit	5	July 2023	5 - revised completion dates lapsed since previous meeting	Unscheduled Care (PPH)	Awaiting clarification from the service via the QAST Team if the recommendations have been implemented, or if revised completion dates are required. Progress updates will be reflected to ARAC in December 2023.
Internal Audit – Discharge Processes (December 2021)	7 (2 External)	June 2022	2 – external 3 - revised completion dates lapsed since previous meeting 2 - original completion dates lapsed	Primary Care, Community and 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. The Transforming Urgent & Emergency Care (TUEC) Programme Internal Audit report brief has been delayed with fieldwork expected to be completed during Quarter 3 2023/24, with follow up date to be confirmed by Internal Audit.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Falls Prevention and Management	1 External	June 2023	1 - revised completion date lapsed since previous meeting	Nursing	The Health Board has been asked by the '4 Nations Falls Prevention Collective' group to scope what it has in relation to falls training. The service is currently awaiting the results of the scoping exercise, and 4 Nations/National position on guidance for falls training to identify how the Health Board can progress with the implementation of this recommendation.
Internal Audit - Financial Management	1	August 2023	1 – completion date has lapsed since previous meeting	Finance	Since the tracker report was run, a further update has been received by the service with a revised timeline committed to delivering all framework elements. This update will be reflected in the next Audit Tracker report to due to be presented to ARAC in December 2023.
Internal Audit - Fitness For Digital - Use of Digital Technology	1	August 2023	1 – revised timescale has lapsed since previous meeting	Digital and Performance	The new Head of Digital Operations will be providing an update on this recommendation once handover discussions are carried out with the Digital Director in September 2023. These updates will be reported at the next ARAC in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Follow-up: Welsh Language Standards	1	July 2023	1 - revised timescale has lapsed since previous meeting	CEOs Office (Welsh Language)	Internal Audit have requested evidence of the action plans proposed in order to close this recommendation. The Digital team have advised that they will be in contact with the Welsh Language team to develop a specific action plan related to a lack of compliance recently highlighted in the switchboard teams during several spot-checks throughout 2023.
Internal Audit - Glangwili General Hospital Fire Precautions Works: Phase 1	1	July 2023	1 - original completion date lapsed since previous meeting	Estates	Since the audit tracker was run off for this report, confirmation has been received from the service that the recommendation has been implemented. This update will be reflected in the next Audit Tracker report to due to be presented to ARAC in December 2023.
Internal Audit - Individual Patient Funding Requests	1	March 2023	1 - original completion date lapsed since previous meeting	Medical	Internal Audit are currently reviewing the evidence provided by the service to confirm whether the recommendation has been fully implemented, the outcome of which will either allow the recommendation to be closed, or confirm that a revised completion date is required. The Assurance and Risk Team are in contact with both the service and Internal Audit.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - IT Infrastructure	2	August 2023	2 – revised completion dates lapsed since previous meeting	Digital and Performance	This report falls under the asset workstream of Digital's cyber programme and a weekly meeting has been set up to review these tasks. It is expected that an update on these recommendations will be provided ahead of the next ARAC meeting in December 2023.
Internal Audit - Job Planning	4	June 2023	1 - original completion date lapsed since previous meeting 3 – No revised completion date provided	Medical	The Assurance and Risk Team are currently seeking updates and revised timescales from the Head of Medical Education and Professional Standards on all recommendations contained in this report, with updates to be provided ahead of the next ARAC meeting in December 2023.
Internal Audit – Records Digitisation	1	July 2023	1 - original completion date lapsed since previous meeting	Central Operations	Report re-assigned to Central Operations from the Digital Directorate since the previous meeting as agreed by the Digital Director and the Health Records Manager. The Assurance and Risk Team will be seeking updates on this recommendation in preparation for the next ARAC meeting in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Records Management	1	May 2023	1 - revised completion date lapsed since previous meeting	Central Operations	The Assurance and Risk Team are requesting clarification from Internal Audit to establish if this recommendation can be noted as implemented. A progress update will be provided, along with a revised completion date if required, for presentation at the next ARAC meeting in December 2023.
Internal Audit - Regional Integration Fund (RIF)	1	July 2023	1 – original completion date lapsed since previous meeting	Finance	Since the tracker report was run, a further update has been received by the service with a revised timeline for this recommendation based on the successful recruitment of a new Regional Partnership Board Lead (end of September 2023). This update will be reported at the next ARAC in December 2023.
Internal Audit - Safety Indicators – Pressure Damage & Medication Errors	3	April 2023	3 – awaiting confirmation for closure	Nursing	Deputy Director of Nursing, Quality & Patient Experience is clarifying with Heads of Nursing if these recommendations have been implemented, or if revised completion dates are required, and updates will be reflected in the next Audit Tracker report to ARAC in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Internal Audit - Strategic Change Programme Governance	2	July and August 2023	2 – original completion date lapsed since previous meeting	Finance	The Finance Team are currently awaiting an update from the Executive Director of Strategy and Planning to update these recommendations. The Assurance and Risk Team will liaise with Finance to seek an update in preparation for the next ARAC in December 2023.
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	1	August 2023	1 - original completion date lapsed since previous meeting	Estates	Since the audit tracker was run off for this report confirmation has been received from the service that the recommendation has been implemented. This update will be reflected in the next Audit Tracker report to ARAC in December 2023.
Peer Review – Respiratory Cancer (June 2016)	1	July 2016	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, Current Score 8). This reflects the current challenge of a sustainable service model to which the recommendation refers to. The risk includes an action to recruit middle grade doctors which should reduce the risk score.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Hywel Dda UHB Lung Report, issued January 2020	1	January 2020	1 – workforce challenges	Unscheduled Care (PPH)	A risk regarding 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)	1 External	October 2021	1 – awaiting national roll out	Women and Children's Services	This recommendation cannot progress until the roll-out of a national standardised template for transferring children and young people across or between networks and ensuring they are accompanied with high quality and accurate information has been completed. The Congenital Heart Defect Network have confirmed there is no further action required by the Health Board at this time.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
Peer Review - Getting It Right First Time (GIRFT) General Surgery Review	4	July 2023	4 – awaiting input from clinical leads to determine revised completion dates	Scheduled Care	Progress updates on this report have been obtained from the service since the previous ARAC meeting, with the exception of 4 recommendations that were reported as N/K at the last ARAC which require detail from clinical leads to determine revised timescales. The Assurance and Risk Team will continue to work with the service to update this report, and updates will be reflected in the next Audit Tracker report to ARAC in December 2023.
Peer Review - Llwynhendy Tuberculosis Outbreak External Review	7 (6 External)	June 2023	6 external – original completion date lapsed since previous meeting 1 - original completion date lapsed since previous meeting	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 not provided an expected date for their updates. Progress against the remaining recommendation which is within the gift of the Health Board to implement from this report is due to be presented at Quality, Safety and Experience Committee (QSEC) meeting in October 2023, and updates to be reflected in the next Audit Tracker report to ARAC in December 2023.

Report	Number of N/K Recs	Date rec became N/K	Reason rec is N/K	Service Area	Progress Update
PSOW - 202203628	1	August 2023	1 – PSOW requested further information	Nursing	Evidence was sent to PSOW in August 2023 to confirm the implementation of the recommendation raised, however further information has been requested prior to closing the recommendation. An update will be reflected in the next Audit Tracker report to ARAC in December 2023.
Royal College of Physicians Cymru Wales – Visit to Ysbyty Bronglais: Follow Up Report (September 2019)	3	December 2020	3 - awaiting service update	Medical	Report re-assigned to Medical Directorate from BGH since the previous meeting. The Assurance and Risk Team will be seeking updates on these recommendations in preparation for the next ARAC meeting in December 2023.
Total number of N/K Recs	**89**				