Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 14th December 2021

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(21)105	**10/06/2021**	**Local Deployment of the Welsh Immunisation System (WIS) (Reasonable Assurance)**	To share with ARAC, once published, the DHCW All Wales review into WIS.	AT	~~August~~ ~~December~~ ~~2021~~ February 2022	*DHCW have still to finalise their review and lessons learned report; Health Boards are anticipating a draft in September 2021 for comment.* *<u>Update for December 2021 ARAC meeting:</u>* *DHCW have not yet published the report. The specific Audit Recommendation within the WIS report has been closed, as it external to the Health Board.* <u>Update for February 2022 ARAC meeting:</u> DHCW have not yet published the report. The Digital Director has written to the CEO of DHCW requesting an update.
AC(21)118	**22/06/2021**	**Report on the Adequacy of Arrangements for Declaring, Registering and**	To explore other digital solutions for obtaining and collating this information;	HT	~~August~~ ~~October~~ ~~December~~ ~~2021~~ February	*<u>Update for August 2021 ARAC meeting:</u>* *The Digital team is exploring the use of Office 365 as a suitable*

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
		Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship			2022	*solution. Specifically using MS forms and power automation. The discovery phase will be completed within 4 weeks, with a proposal following this phase of work.* *<u>Update for October 2021 ARAC meeting:</u>* *The discovery work has been completed and a SharePoint Developer with skills in Power Automate has been assigned the work package. A proposed solution will be scoped and a beta version will be available by the end of November 2021, for testing.* *<u>Update for December 2021 ARAC meeting:</u>* *The Digital team is still working on the solution, and anticipates that the beta version will be available by mid December 2021.*

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						Update for February 2022 ARAC meeting: Unfortunately, the assigned developer was re-prioritised onto an urgent Executive Team request. The developer has nearly completed the required work and will be placed back onto this task. The re-prioritisation has introduced a 3 month delay on delivery.
AC(21)155	**24/08/2021**	**Radiology Directorate Internal Audit Update**	If not possible earlier, to provide an update to the June 2022 ARAC meeting.	AC	~~June~~ April 2022	Forward planned for ~~June~~ 19th April 2022 meeting.
AC(21)156	**24/08/2021**	**Field Hospital Decommissioning (Advisory Review)**	To provide details of the management lead and timescale for the 'Lessons Learned' exercise.	AC	~~October~~ ~~December~~ ~~2021~~ February 2022	*Update for October 2021 ARAC meeting: The Deputy Director of Operations was party to an initial planning meeting, on 6th October 2021, where the approach to a follow-up workshop involving a broader representation of colleagues involved in the Field Hospital campaign was determined. The workshop is expected to take place in October 2021; the output will be a*

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						short report on lessons learned. *A recap will follow after the Selwyn Samuel Centre is fully decommissioned in 2022.* *<u>Update for December 2021 ARAC meeting:</u>* *The lessons learned workshop was held on 8th November 2021. A written report will follow and will be revisited following final decommission of the remaining two FH sites (expected Q1 2022/23).* Forward planned for 22nd February 2022 meeting.
AC(21)183	**19/10/2021**	**Quality Governance Arrangements**	To review/revise the management response to include interim milestones, and present this to the next meeting.	AC	~~December 2021~~ February 2022	*<u>Update for December 2021 ARAC meeting:</u>* *The management response is being reviewed at a meeting scheduled for 9th December 2021.* <u>Update for February 2022 ARAC meeting:</u> Amended management response attached at Appendix 1.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(21)185	**19/10/2021**	**RCP Medical Records Keeping Standards Internal Audit Update**	To explore potential learning from other organisations who use written records;	PK	April 2022	To be incorporated in update scheduled for 19th April 2022.
			To provide a further update to the April 2022 meeting.	PK	April 2022	Forward planned for 19th April 2022 meeting.
AC(21)212	**14/12/2021**	**Table of Actions: AC(21)187 - Discharge Processes Review**	To feed back to Ms Jill Paterson the issues raised regarding the management response and provide a further update at the next meeting.	JW/JP	February 2022	Amended management response attached at Appendix 2.
			To raise any queries deemed necessary with the authors.	JJ	February 2022	Completed. The action plan has been reviewed and a follow up of this audit work will be discussed with management as part of the 2022/23 planning meetings.
		Table of Actions: AC(21)189 - Medical Staff Recruitment (Reasonable Assurance)	To share the report with PODCC and discuss monitoring actions via its Workplan with Mrs Lisa Gostling.	JW	February 2022	To be included on the forward Workplan for PODCC and will be an agenda item at the 4th April 2022 meeting.
AC(21)215	**14/12/2021**	**Review of Capital Governance Arrangements – Management Response**	To schedule an update on progress with the action plan for SDODC's February 2022 meeting.	LD	February 2022	Forward planned for 24th February 2022 SDODC meeting.
			To discuss rewording those actions which are ongoing, rather than comprise a	CB/PW	February 2022	Completed.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			single resolution, to better facilitate tracking.			
AC(21)217	**14/12/2021**	**Cost Advisor Review from Field Hospitals**	To record dissatisfaction with Pembrokeshire County Council's response in the ARAC Update Report to Board.	PN/JW	January 2022	Completed. Included in ARAC Update Report to 27th January 2022 Public Board meeting.
			To provide an update on progress with queries to the next meeting, via the Table of Actions.	HT	February 2022	<u>Ceredigion County Council</u> <u>FINAL ACCOUNTS REMAIN TO BE FINALISED</u> • Final accounts have not yet been agreed for the Ceredigion Field Hospitals decommissioning costs. The Health Board are in regular contact with Ceredigion County Council to ensure that these are finalised. <u>Pembrokeshire County Council</u> <u>ALL ACTIONS COMPLETE</u> • Re-imbursement has been made following incorrect re-charging of in-house fees through a credit on outstanding charges to the Health Board.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						Total credit of £67k confirmed. • Supporting information has been provided for materials for electrical installations.
AC(21)218	**14/12/2021**	**Financial Assurance Report**	To establish the specifics of STA HDD579, and why this contract had not gone out to tender.	HT	February 2022	Nation Radio has been identified as the only local radio network that can provide adverts specifically for the Ceredigion, Carmarthenshire and Pembrokeshire communities. This campaign is targeted at the non-digital audience as part of the UHB's accessible communication policy. STA covers a period of 4 years but will only be used if budget is available and will be reviewed at the end of the period to check whether alternate suppliers have become available. STA has previously been raised for same supplier, as it has not been possible to identify alternatives.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			To discuss with Mrs Lisa Gostling whether an evaluation of the effectiveness of enhanced rates is required, to be reported to PODCC.	HT	February 2022	The effectiveness of the evaluation was discussed as part of the Gold Command Group decision-making process which was ratified by Board. Agreed no further action is required.
			To include for ratification the requested changes to the Scheme of Delegation in the next Financial Report to Public Board.	HT	January 2022	Completed.
AC(21)219	**14/12/2021**	**Audit Wales Update Report**	To consider the MHLD Directorate a priority in terms of the Operational Governance reviews.	AB	February 2022	Exact scope still to be determined but all directorates will be included.
AC(21)224	**14/12/2021**	**Taking Care of the Carers? How NHS Bodies Supported Staff Wellbeing during the COVID-19 Pandemic**	To add the omitted dates to the action plan.	LG	February 2022	Amended management response attached at Appendix 3.
AC(21)226	**14/12/2021**	**Deployment of WPAS into MHLD (Limited Assurance)**	For the Internal Audit team to reflect on the Committee's comments and reconsider the assurance rating awarded;	JJ	February 2022	Completed. The assurance rating has been reviewed and it is considered that Limited Assurance was appropriate. A note has been included within the Audit & Assurance progress report to confirm this.
			To present a further update to the next meeting,	HT	February 2022	Forward planned for 22nd February 2022 meeting.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			including confirmation that those actions within the management response due for completion by December 2021 have been completed;			
			To invite a representative from the MHLD Directorate to attend the next meeting for discussion of the above;	CM	December 2022	Completed.
			To amend the management response to Recommendation 1.1 to comprise a list of all intended actions, as opposed to examples;	HT	February 2022	Forward planned for 22nd February 2022 meeting.
			To highlight the contents of the report and the Committee's concerns within the ARAC Update Report to Board.	PN/JW	January 2022	Completed. Included in ARAC Update Report to 27th January 2022 Public Board meeting.
AC(21)228	**14/12/2021**	**Financial Planning, Monitoring and Reporting (Reasonable Assurance)**	To share the report with and monitor actions via the Sustainable Resources Committee.	HT	April 2022	Forward planned for 25th April 2022 SRC meeting.
AC(21)242	**14/12/2021**	**Audit Wales Reports**	To consider including audits on nationally-hosted IT systems as part of the Annual Audit Plan for 2022/23, perhaps with a focus on the new data centres.	AB	February 2022	Concerns around data centres raised with Audit Wales leads for Digital Health and Care Wales for consideration as part of the annual audit plan for the strategic authority.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			To raise the issue of concerns regarding management of audit findings relating to national organisations via the All Wales Audit Committee Chairs' Group.	PN	February 2022	Discussion held at AWACC on 9th February 2022. Further conversation to be held at the Audit Working Group with the aim of improving consistency and reporting across NHS Wales
			To raise the issue of concerns regarding management of audit findings relating to national organisations via the Digital IMs Group.	MD	February 2022	The All-Wales Independent Member Digital Network had its inaugural meeting on 26th January 2022. The issue of reviewing audit reports relating to All-Wales digital matters was raised there and was supported.

Archwilio Cymru
Audit Wales

Management response

Report title: Review of Quality Governance Arrangements, Hywel Dda University Health Board

Completion date:

Document reference: 2583A2021-22

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	The Health Board recently issued generic templates for the agendas and terms of reference of sub-groups of the Operational Quality, Safety and Experience Sub-Committee to address operational inconsistencies. We found that records for sub-group meetings are not of a consistent standard and are not readily	Effective management of quality and safety sub-group meetings by operational managers.	Yes	Yes			

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	available when required. The Health Board should: a) mandate the use of the recently issued generic templates with the understanding that the agenda template is a minimum requirement which can be supplemented as appropriate; b) issue guidance on record taking at meetings; and c) ensure that local records are stored in a standard location to facilitate access.				a) The EDONQPE to reissue templates and instruct utilisation at each quality governance meeting at service and directorate meetings. b) Guidance document to be developed and issued with (R1a). c) Include within guidance document (R1b) a reminder of the importance of storing of meeting papers in accordance with corporate records management policy.	31/11/2021	Executive Director of Nursing, Quality and Patient Experience (EDONQPE) Board Secretary Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R2	There are inconsistent leadership arrangements at an operational level for assurance, risk, and safety across the Health Board. The Health Board should either strengthen current arrangements where staff resources for assurance, risk and safety are managed by directorates to improve consistency, or move to a model where those staff are managed centrally, ensuring that support available to the operational teams is consistent across the Health Board.	Clear and consistent local leadership arrangements for assurance, risk and safety, supported by corporate resources.	Yes	Yes	There are consistent leadership arrangements in place at operational level (acute, community and primary care) for assurance, risk and safety, however responding to the pandemic has impacted on the capacity of the leadership teams to be able to discharge all their accountabilities effectively. There has been a daily focus on managing risks across the system, however this has not always been reflected in the risks on the Datix Risk System.		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					A review will be undertaken to enhance the capacity across operational and corporate teams to ensure a consistent approach to managing assurance, risk and safety. It is possible there will be a financial impact of the review and therefore this will need to be considered as part of the IMTP for 2022/23. Interim milestones include: • Undertake an assessment of the current approach, both corporately and operationally, to quality governance	31/12/2022 31/03/2022	Executive Director of Operations (EDOO) Head of Quality and Governance

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					(including managing assurance, risk and safety). • Continue to meet with Directorates on a six monthly basis to discuss and scrutinise the risk registers • Through the operational business structure, discuss consistency of operational teams risk registers	31/03/2022 31/03/2022	EDOO and EDONQPE EDOO
R3	Risk register entries are not being updated for many months, limiting the assurance that can be taken from them. Some	Operational managers know which risks they are responsible for and they maintain	Yes	Yes	During the ongoing pandemic, risks continue to be managed on a daily basis		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	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: a) ensuring that operational teams clearly identify the risks for which they are responsible for and update risk registers in line with corporate policy. b) putting arrangements in place to ensure that the management of risks are coordinated across	risk registers in-line with corporate policy, so that they are up-to-date and provide a clear narrative over time. Assurance taken from the identification and management of risks is improved.			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: a) A joint risk review process of risk registers has been instigated with each Directorate by the EDOO and EDONQPE supported by the	31/12/2021	EDOO and EDONQPE

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	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.				Head of Assurance and Risk commencing in October 2021. b) (i) The joint review process will be used to reinforce the role of oversight by the local triumvirate teams. The expectation that there is communication and consultation between services where there are risks and issues that may affect impact more widely will be reiterated. (ii) Risk is now a standard item on the newly established Senior Operational Business Meeting	31/12/ 2021 Completed	EDOO and EDONQPE EDOO

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					and should identify cross directorate risks. The agenda will be based around the Senior Operational Business Meeting's work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from members. iii) Implementation of new Risk Management system (Phase 2 of the Once For Wales). iv) Interim work to be undertaken on the current Datix	31/12/2022 31/12/2021	Board Secretary Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					Risk Module to facilitate the combination of similar risks across the Secondary Care Directorate.		
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.	Greater ownership of risks and risk management at an operational level.	Yes	Yes	This will be addressed as part of the review outlined in R2 and R3.	31/12/2022	EDOO

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
4	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. Task and Finish group to be established as part of the UEC programme under policy goal 6, to set consistent principles and standards, with staff reps from across HB community and acute and work through the recommendations together – appreciating that localities may have differing processes this group could share best practice and consideration given as to whether these practices can be taken forward across HB. This approach may also aid identifying training required.	Assistant Director of Nursing for Quality, Assurance and Professional Regulation Policy Group Lead	March 2022	
4	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. Providing we are able to demonstrate delivery of those standards how the services are constructed should not matter. A baseline assessment has been undertaken previously in relation to these standards and each	SRO UEC Programme		

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
		County System has a plan in place to deliver these (the Carms plan is mentioned in the report). 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. 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.	County Directors Policy Goal Implementation Leads	April 2022 January 2022	
4/ 3.13	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	It is recognised that training is required on regular basis however, discharge planning is a core part of the role of the ward MDT and supported by nursing documentation. Pre pandemic the DU and our improvement team provided support in this area. 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	SRO UEC Programme County Directors / Acute General Managers / Improvement Team	April 2022	

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
	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.	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 Important to note that there is still work to be done on data quality. 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	Policy Goal Implementation Leads	April 2022	

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
		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.			
4	The centralised patient discharge monitoring tool used to monitor complex patients' status and to inform discharge planning, has not been adopted by Bronglais General Hospital.	All three county acute sites now utilise the new Complex Discharge tool although there is more to be done on improving the data quality of recording. A report has been developed to provide performance information that can be shared weekly with WG colleagues via the Delivery Unit monitoring tool and also provide quarterly updates to WG via the Regional Partnership Board on discharge to assess pathways. We have greater granularity and detail in our reporting than the previous DTOC reporting gave. The Board IPAR has regular monthly commentary on non-mental health discharge delays and incorporates performance trend graphs from the Complex Discharge tool.			Complete
4 / 3.25	Suspension of formal DTOC reporting to Welsh Government has resulted in the Health Board no longer monitoring delays internally and not being apprised of performance related issues Whilst IPARs continue to be regularly presented to the relevant statutory committee (The Strategic Development & Operational Delivery Committee as of 1st August 2021) and to the Board, they no longer include non-mental health DTOC due to reporting being suspended by WG.				Complete
4	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.	County Directors / Secondary Care Director alongside Policy Implementation Lead	April 2022	

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
		However a regional solution to share learning should be developed alongside the county approach.			

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
4 / 3.8	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,	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	May 2022 in a phased approach	

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
		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.			

PAGE /REF	KEY FINDINGS	HB MANAGEMENT RESPONSE	RESPONSIBLE OFFICER/S	TIMESCALE	STATUS
4 / 3.12	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.	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	April 2022	
3.13	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	County Directors / Secondary Dare Director alongside Policy Goal Implementation leads	April 2022	

Management Response – Taking Care of the Carers?

Health Body:

Completion Date:

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
R1	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.	The Health Board has in place an expanded Staff Psychological Well Being Service with a comprehensive Staff Psychological Wellbeing Plan, including a new Staff Wellbeing Information Line. A Health and Well Being Champions Network has also been established. Requests from managers regarding staff at high risk from COVID19 are treated as a high priority when managers request occupational health advice.	Complete Complete – process in place	Suzanne Tarrant Leony Davies

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		The number of COVID 19 related enquires from employees/managers has reduced significantly since the start of the pandemic. The Staff Wellbeing Information Line was launched on 19.11.21 and will be evaluated at the end of May 2022.	Complete – ongoing review arrangements in place May 2022	Karen Ryan
R2	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective,	An action plan is being developed to take forward the recommendations of the discovery report, the staff survey and well-being matters survey. The common themes across these 3 pieces of work are: • Growing inspirational leaders • Creating spaces and ways of working that enable our people and services to thrive • Putting Wellbeing at the heart of Hywel Dda	Complete	Christine Davies

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	and high-quality healthcare in the medium to long term.	• Creating a safe and supportive place to work • Building on our Covid team spirit • Enabling learning and innovation The action plan will go to the People Committee in December 2021. The Occupational Health team is working closely with Wellbeing Service partners and HEIW to identify and share appropriate wellbeing services staff may access for wellbeing support. In addition, the Health Intervention Coordinator has been granted funding to develop over 100 peer support wellbeing champions from NHS Charities together budget. 55 have already been trained, with the intention of increasing this number to 100 by September 2022.	Complete Sept 2022	Christine Davies Leony Davies

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
		The aim is to improve access to wellbeing support for all staff by promoting health and wellbeing within the workplace. Champions are ideally positioned to offer initial advice and signposting to appropriate support services . The Health Board will ensure that our recovery plans are aligned to any workforce planning implications that may impact on wellbeing.	March 2022	Tracy Walmsley
R3	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which	User satisfaction feedback and clinical outcomes monitoring is in place for all 121 psychological support services and trend analysis is conducted monthly. User satisfaction and clinical outcomes are monitored on an ongoing basis with monthly reporting to the Wellbeing Dashboard. Evaluation plans are in place for the new Staff Wellbeing Information Line as well as the Staff	The Ecotherapy pilot will be evaluated on completion with a target date of April 2022.	Suzanne Tarrant

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	Ecotherapy Programme. A Well-Being Dashboard is produced monthly. The Occupational Health Service has now started to report on key activity levels and turnaround times within the Occupational Health service to ensure board are aware of risks. KPI's have also been introduced within the Occupational Health service. Evaluation of the wellbeing champions initiative is planned to establish a better understanding of the wellbeing champion role as it develops and the overall impact on staff wellbeing and areas for development.	Complete – process in place First phase of evaluation to be completed by Sept 2022	Karen Ryan Leony Davies
R4	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to	The National Health and Wellbeing Network forum is attended regularly by the Head of Occupational Health, Head of Staff Psychological Wellbeing and Health Intervention Coordinator. Good practice on	Complete – process in place	Karen Ryan

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	wellbeing resources and services is shared. Networking and Benchmarking is encouraged. The effectiveness of services is shared within the forum and cascaded as required. There has been local investment in the size of the Staff Psychological Well Being team.		
R5	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and	KPI's have been introduced on key Occupational Health functions including management referral activity and pre-employment clearance times. The aim is to provide assurance to the board and identify any issues which may impact on staff wellbeing e.g., clearance delays, delayed advice for managers. Progress and impact are assessed across the Health Board and scrutinised by the People, Organisational and Culture Committee.	Complete – process in place	Karen Ryan

Ref	Recommendation	Management Response / Action	Target Completion Date	Responsible Officer
	deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.			
R6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	Exit interviews are in place and "Stay" interviews will be implemented in 2022. 'Working in confidence' platform to support the staff voice will launch in December 2021.	Complete ~~December 2021~~ April 2022	Rob Blake Rob Blake

Please indicate below how the Board Members Checklist will be used to inform debate within your organisation