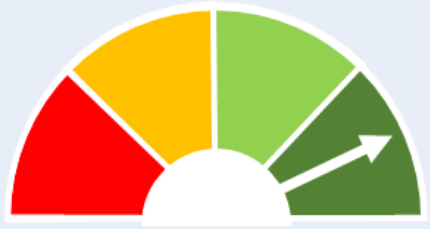
Escalation Governance

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Substantial Assurance

Contents

Review Reference	HDU-2526-24
Fieldwork	August – December 2025
Executive Sign Off	5 February 2026
Audit Committee	February 2026
Executive Lead	Phil Kloer, Chief Executive Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of this review was to assess and provide independent assurance over the effectiveness of governance arrangements in place for the closure of escalation actions.

Overview

Escalation arrangements continue to be embedded within the Health Board's operational and assurance governance structure with clear lines of reporting from sub-groups and formal reporting groups via the organisation's assurance level approach. During 2025, new statutory committees of the Board and Clinical Care Groups were established with criterion accurately realigned to ensure assigned responsibilities and escalation continuity were maintained.

The formal reporting groups and statutory committees continue to review the progress and performance levels of allocated targeted intervention (TI)/escalation criterions with the Audit and Risk Assurance Committee providing overarching scrutiny of TI/ escalation action progress. Given the maturity of current reporting arrangements, an opportunity to streamline reports to focus on key actions requiring immediate attention should be considered and is highlighted for management information.

The monitoring and reporting of the performance measures at the appropriate committee was evident and a review of the source data confirmed the accuracy of the figures reported to the Health Board and submitted to Welsh Government to support their progress against de-escalation. Whilst positive steps and actions have resulted in some domains being de-escalated during 2025; challenges still face the Health Board in the delivery of level 4 (finance and A&E performance) and level 3 (planned care and cancer) TI actions.

We have therefore concluded **substantial** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Appropriate governance arrangements have been established to manage the six domains of the *NHS Wales Escalation and Oversight Framework*	-	**Substantial**
2	Targeted Intervention actions are only closed on approval of the Targeted Intervention Coordination Group on the basis that they are (i) supported by sufficient and appropriate evidence demonstrating completion, or (ii) subject to alternative 'business as usual' monitoring arrangements with mechanisms in place to provide assurance over progress and completion.	-	**Substantial**

Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements have been established to manage the six domains of the *NHS Wales Escalation and Oversight Framework*	**Substantial**

Overview / Summary of Observations

The Health Board has an established governance structure in place to monitor and manage the delivery of TI/escalation actions in line with the Welsh Government (WG) *Escalation Framework 2025/26* document. The Director of Delivery continues to play a key role within the escalation governance process having responsible for collecting and validating evidence for each TI criterion, demonstrating the impact of remedial measures, assess outcomes against set indicators and working closely with directorates and WG.

Operational Governance Arrangements

The Executive Team is supported by three formal reporting groups – Integrated Quality, Finance and Performance Delivery (IQFPD), A Healthier Mid & West Wales (AHMWW) and Value & Sustainability – in addition to an overarching TI Coordination Group. Terms of reference (ToR) are in place and are supported by designated sub-groups for each reporting group.

In April 2025, a reorganisation within the Operations Directorate resulted in the formation of five Clinical Care Groups (CCGs) that report into the IQFPD Group. The reporting arrangements of the CCGs was reflected in the revised ToR for IQFPD Group. Testing confirmed regular update papers were submitted by all sub-groups and CCGs into the formal reporting groups for the period April to December 2025 – detailed testing on the content of update papers was undertaken in the Operational Governance Arrangements (HDU-2526-02) and Internal Escalation Level 3/4 (HDU-2526-03) Internal Audit reports.

A review of update papers to the formal reporting groups and Executive Team provided a clear progress and implementation of each TI/ escalation action within through the '3A' assurance level approach.

Assurance Governance Arrangements

The statutory committees of the Board were restructured in April 2025 with the Strategic Development and Operational Delivery Committee and Sustainable Resources Committee being stood down and replaced with the following committees:

- Digital, Data and Innovation Committee
- Finance and Performance Committee
- Strategy and Planning Committee

A mapping exercise confirmed that following the restructure, TI/ escalation criterion was realigned to the new committees ensure assigned responsibilities and continuity were maintained. To enhance the monitoring and capture of evidence of actions, all criterion aligned against the statutory committees are recorded on the AMAT system.

A review of the statutory committee minutes and papers for the period April to December 2025 confirmed evidence of (i) regular TI/ escalation progress and update reports, (ii) scrutiny of the reports by members of the committees, and (iii) decisions or actions noted in minutes being recorded in the action log for addressing.

Objective 2: Targeted Intervention actions are only closed on approval of the Targeted Intervention Coordination Group on the basis that they are (i) supported by sufficient and appropriate evidence demonstrating completion, or (ii) subject to alternative 'business as usual' monitoring arrangements with mechanisms in place to provide assurance over progress and completion.	**Substantial**

Overview / Summary of Observations

TI/ escalation criterions are allocated a formal reporting group and statutory committee that are responsible for reviewing the progress and performance levels with the aim of de-escalation. The Audit and Risk Assurance Committee continue to receive regular update reports on the de-escalation progress of criterion.

An escalation update paper submitted to the Executive Briefing meeting in July 2025, highlighted the following criterions that had been de-escalated due to meeting their required targets:

- Criterion 21: Enhanced Monitoring 60% performance maintained for three months against SCP target
- Criterion 36: 80% of LPMHSS mental health assessments within 28 days
- Criterion 37: 70% of therapeutic interventions started within 28 days
- Criterion 38: 85% of residents in receipt of secondary mental health services with valid care treatment plan
- Criterion 42: A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care
- Criterion 44: Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny
- Criterion 46: A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care
- Criterion 47: Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity
- Criterion 48: Positive staff engagement in NHS Wales surveys

We can confirm the monitoring and reporting of the above performance measures at the appropriate committee, whilst a review of the source data confirmed the accuracy of the figures reported to the Health Board and submitted to WG to support their progress against de-escalation.

On 16 December 2025, the WG confirmed that Hywel Dda had been de-escalated to level 1 (routine) for Leadership and Governance.

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Hywel Dda University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services