

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 February 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Tracker
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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.

Asesiad / Assessment

The attached report will aim to provide assurance on the progress in respect of the implementation of recommendations from audits and inspections, and provide assurance on the effectiveness of the internal escalation framework arrangements in respect of driving improvements in the Health Board's progress in implementing recommendations from auditors.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements.

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 Termiau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CIW – Care Inspectorate Wales 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

Purpose of the report

This report aims to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of processes in place across the Health Board in the tracking of progress made to implement external recommendations as raised by auditors, inspectorates and regulators.

Context

The Health Board is currently in Targeted Intervention (TI) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, service delivery and organisational performance. In order to achieve de-escalation from TI, the Health Board have to meet set criteria, which includes:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan; and
- Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.

Overview

All reports from audits, reviews and inspections carried out across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence requested to be uploaded to demonstrate their progress and full implementation.

AMaT allows services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow.

Progress is monitored via the utilisation of a traffic light system based on performance against **original completion dates**. The criteria for this system is as below:

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (<i>AMAT Status: Complete and awaiting approval / Fully Complete</i>)
Amber	Recommendation is currently in progress, and within the agreed original timeframe for implementation (<i>AMAT Status: Partially Complete / In Progress</i>)
Red	Recommendation is in progress, but has exceeded its agreed original timeframe for implementation (i.e. overdue) (<i>AMAT Status: Overdue / Partially Complete (Overdue)</i>)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation. Due to current system limitations, the action title has been amended to include the phrase "external" to denote this status. (<i>AMAT Status: In Progress</i>)

The Assurance and Risk Team and Quality, Assurance and Safety Team (QAST) liaise directly with services and review the status of the monitored reports to support the provision of progress updates and revised completion dates where applicable, and to provide technical support as required. Training is also offered to service leads on AMaT's 'Inspection Recommendations and Actions' module by both the Assurance and Risk Team and QAST.

For the purpose of this report, data reported is as at the most recent analysis point at the time of preparation (31 December 2024).

	August 2024	December 2024	Trend	Variation*
Total number of reports	174	187	N/A	N/A
Number of overdue reports	54 (31%)	71 (38%)	↑	■
Number of reports overdue by more than 6 months	34 (20%)	33 (18%)	↓	■
Total number of recommendations	1,499	1,638	N/A	N/A
Number of Green recommendations (completed)	840	997	↑	■
Number of recommendations classified as ' External '	48	35	↓	■
Number of open recommendations	611	641	↑	■
Number of Amber recommendations (in progress and in line with original timescales)	369	332	↓	■
Number of Red (overdue) recommendations	242	274	↑	■
Number of recommendations overdue by more than 6 months	121	118	↓	■
Number of recommendations without revised timescales (N/K)	106	157	↑	■

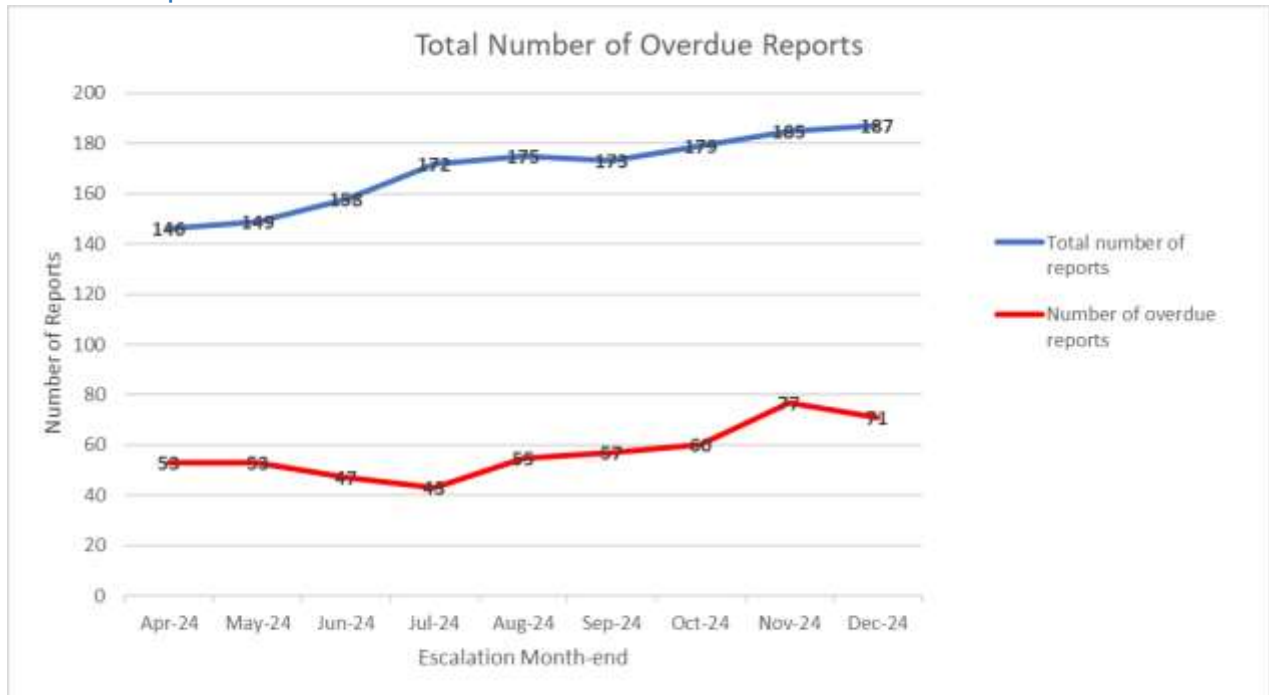
*A summary of the variation icons as below:

Variation	■	Concerning trend = a decline that is unlikely to have happened by chance
	■	Usual trend = common cause variation / a change that is within our usual limits
	■	Improving trend = an improvement that is unlikely to have happened by chance

A breakdown per auditor / inspectorate / regulator is provided overleaf.

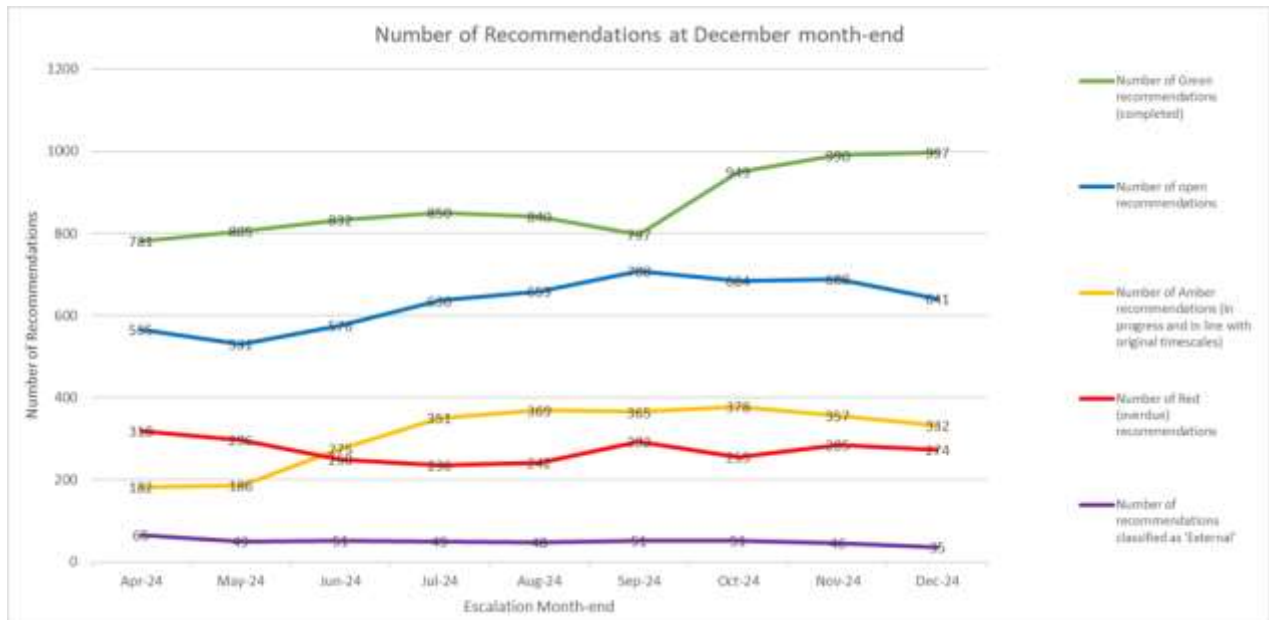
Inspectorate / Regulator	Open reports as at month-end August 24	Open reports as at month-end December 24	Open reports which are overdue	Red recommendations	Red recommendations overdue by more than 6 months
Audit Wales (AW)	10	10	5	7	5
Care Inspectorate Wales (CIW)	2	3	3	8	2
Health Education and Improvement Wales (HEIW)	3	3	2	7	4
Health Inspectorate Wales (HIW)	14	11	6	37	34
Human Tissue Authority (HTA)	1	1	1	2	0
Internal Audit	29	33	14	35	17
Llais	4	1	1	2	2
Mid and West Wales Fire and Rescue Service (MWWFRS)	78	95	21	67	2
Natural Resources Wales	0	1	1	17	0
NHS Wales Cyber Resilience Unit	1	1	0	0	0
NHS Wales Executive	8	4	3	12	6
Peer Reviews	11	10	7	39	38
Public Services Ombudsman for Wales (PSOW) – S21	5	5	2	5	0
Public Health Wales	1	1	1	0	0
Royal Colleges	1	1	1	2	2
Shared Services Partnership	1	3	0	13	1
Welsh Risk Pool (WRP)	2	1	1	2	2
Welsh Language Commissioner (WLC)	1	1	1	0	0
Welsh Government	2	2	1	19	3
TOTAL	174	187	71	274	118

Overdue reports



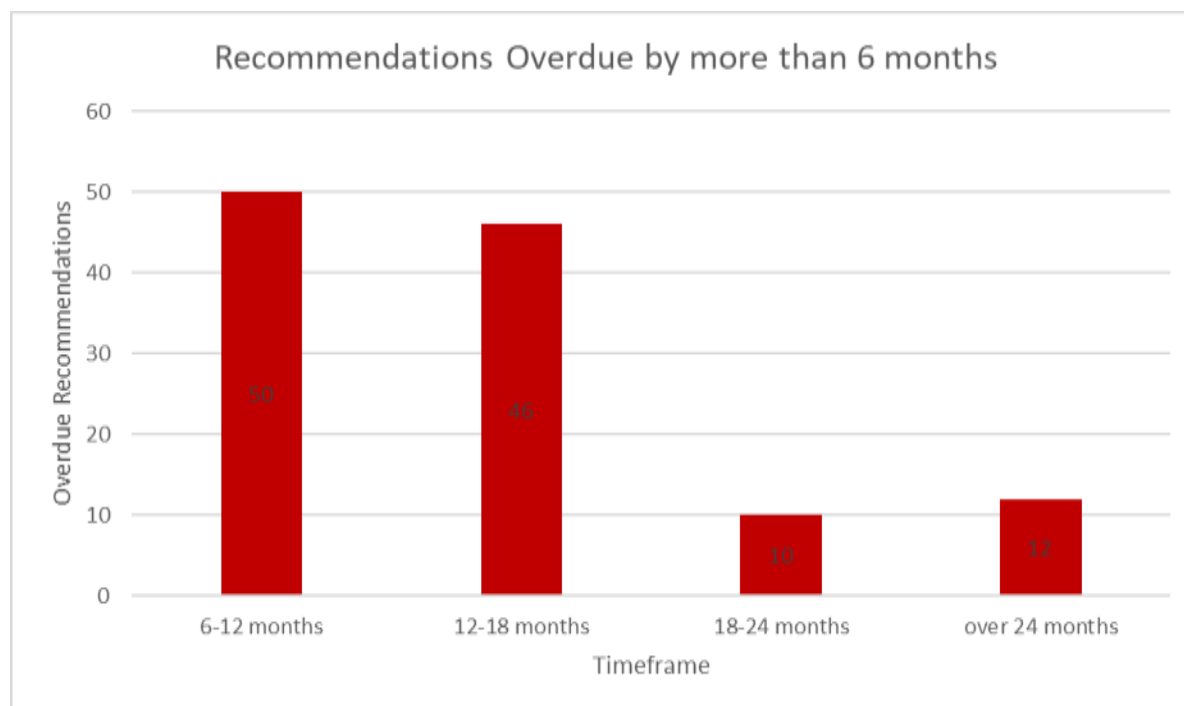
There has been an increase in the total number of open reports and overdue reports since the previous report presented in October 2024, with a notable increase in November 2024, primarily due to an increased number of Letters of Fire Safety received in July 2024, having passing their original completion date of 3 months.

Overdue recommendations



The graph above illustrates the trend in the number of overdue recommendations. The fluctuating performance of the number of overdue recommendations, along with a consistent trend in the number of recommendations overdue by more than 6 months ([see graph below](#)) suggests that the Health Board is not consistently achieving a sustainable reduction in the closure of overdue recommendations, and therefore minimal improvement in addressing long-standing recommendations. This is a result of historical reports where unrealistic timescales were

originally provided in management responses to recommendations, and recommendations which cite financial challenges as a barrier to their implementation. This is further exacerbated by current resource and capacity challenges within services, and ageing estate and infrastructure.

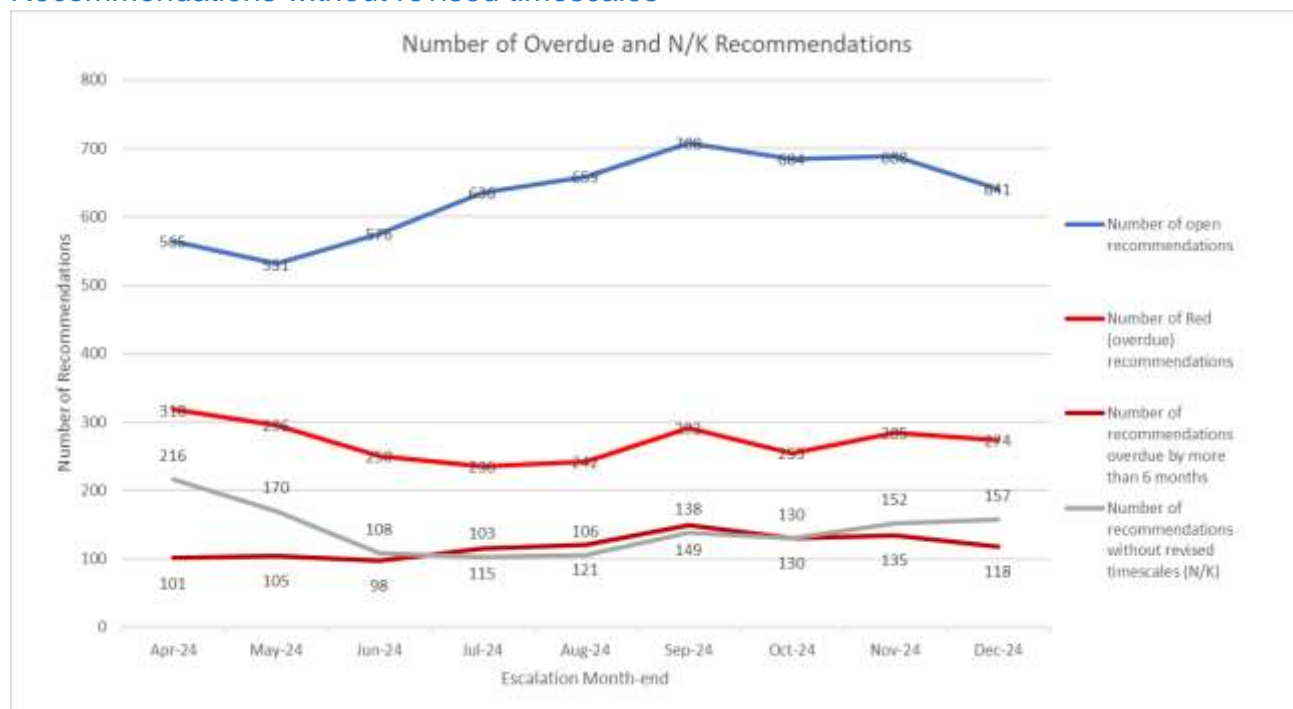


Of all 118 recommendations overdue by greater than 6 months, 32% are attributable to Mental Health and Learning Disabilities, and 31% to Planned Care. Of the 12 recommendations noted as being overdue by greater than 24 months, 7 are attributable to the Ophthalmology service, and a further 3 to Mental Health. These Directorates have been in Level 3 for the Governance domain within the Health Board's internal escalation framework since April 2024, with focussed support provided to these Directorates during November and December 2024 (detailed later in the report).

Analysis of the recommendations overdue by greater than 6 months per regulator highlight that 34 (29%) are from reports issued by Health Inspectorate Wales (HIW), 26 of which are overdue within the 12-18 month time-frame. A further 27 (23%) recommendations are from Getting It Right First Time (GIRFT) reports, all within either the 6-12 month or 12-18 month time-frame.

The Assurance and Risk Team will be reviewing the current escalation criteria within the Governance domain per the internal escalation framework to include more detail on those services with long-standing overdue recommendations, with these to be implemented during Q4 of 2024/25.

Recommendations without revised timescales



There were 157 (24%) recommendations without revised timescales as at December 2024 (August 2024: 121 (20%)).

Recommendations without revised timescales are mainly attributed to the following:

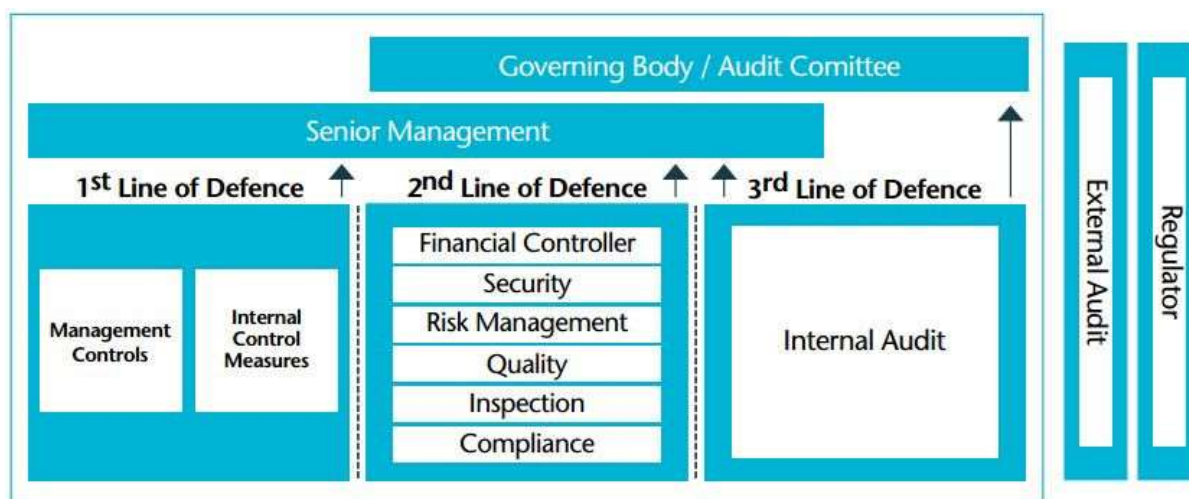
- Reliance on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems to inform revised completion dates;
- Recommendations previously noted as 'complete' being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- 27 recommendations lapsed since November 2024 which have yet to be updated with a revised completion date during December due to operational pressures;
- Directorates have reviewed recommendations but have not provided a revised completion date when providing progress updates. This may be due to a combination of factors including financial challenges / resource and capacity challenges which require resolution or clarification in order to provide revised dates. The lack of a specific 'revised date' field on the AMaT system, which could also serve as a prompt, may also be a contributing factor.

Directorates are able to note on AMaT the specific barriers to the full implementation of recommendations. Training materials and sessions highlight the requirement for recommendation owners to include revised completion dates where appropriate when providing progress updates. Guidance is also available on the team's Sharepoint site. The Assurance and Risk team continue to remind services of the need to include revised completion dates within the Assurance and Risk overview reports presented to directorate quality governance groups, and continue to review recommendations where progress updates have not been obtained, with the relevant business partner for those services prioritising the support offered.

Scoping work has commenced to explore the opportunity to develop performance dashboards on the data captured on AMaT via 'Power BI' with colleagues in QAST and the Performance Team. This would provide services with improved oversight of their performance, including the number of recommendations without a revised timescale, and would support the internal escalation framework.

Three Lines of Defence

The Health Board operates within the widely accepted "Three Lines of Defence" model, which provides a simple and effective way to delegate and coordinate roles and responsibilities within an organisation to ensure the appropriate responsibility is allocated for the management, reporting and escalation of the implementation of recommendations.



Operational Management (1st line)

First line of defence are functions which own and manage risk, with operational staff responsible for maintaining internal controls such as processes, procedures and identifying risks, addressing as required.

Progress on implementation of recommendations is discussed by services and directorates via quality governance meetings for operational areas, or senior management meetings for corporate functions. The frequency of these meetings varies but are either monthly or bi-monthly. Local governance arrangements are considered when assessing the escalation status for Governance.

Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are provided to management and service leads via e-mail to enable them to address any areas of concern.

The table overleaf provides a summary of open reports, and the status of recommendations per Directorate as per the internal escalation framework structure, further detail of which can be found [later in the report](#).

Area	Total number of reports as at December month end 2024	Total number of recommendations as at December month end 2024	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6 months	Total number of N/K recommendations
Director of Operations					
Director of Operations (<i>including Central Operations, Acute Services, and USC: Health Board wide</i>)	6	44	11	10	0
Facilities	109	869	93	8	44
Mental Health and Learning Disabilities	8	148	44	36	32
Oncology	2	11	1	1	1
Pathology	2	26	15	3	15
Radiology	4	48	20	2	20
Planned Care (<i>including Audiology & Endoscopy</i>)	8	156	36	35	6
Unscheduled Care: Bronglais General Hospital	0	0	0	0	0
Unscheduled Care: Worthybush General Hospital (<i>including Stroke and COTE</i>)	2	53	3	0	3
Unscheduled Care: Prince Philip Hospital (<i>including Diabetes and Respiratory</i>)	1	1	1	1	1
Unscheduled Care: Glangwili General Hospital (<i>including Cardiology, Gastro and Renal</i>)	0	0	0	0	0
Women and Children	2	27	0	0	0
Director of Primary, Community and Long Term Care					
Ceredigion (<i>including Palliative Care</i>)	0	0	0	0	0
Carmarthenshire	0	0	0	0	0
Pembrokeshire	0	0	0	0	0
Medicines Management	2	35	6	0	6
Primary Care Management (<i>Long Term Care and Chronic Conditions</i>)	1	4	2	2	1
Primary Care (<i>All other Primary Care services</i>)	3	8	1	0	1
Director of Finance					
Finance	2	11	0	0	0
Digital	3	18	6	6	3
Director of Nursing					
Nursing	11	58	10	2	7
Director of Public Health					
Public Health	2	7	2	0	2
Director of Strategy and Planning					
Strategic Planning	8	46	10	4	10
Director of Therapies and Health Sciences					
Therapies	0	0	0	0	0
Director of Workforce and Organisational Development					
Workforce and Organisational Development	3	16	1	0	1
Medical Director					
Medical	7	47	11	7	4
Corporate Services					

Area	Total number of reports as at December month end 2024	Total number of recommendations as at December month end 2024	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6 months	Total number of N/K recommendations
Governance	1	5	1	1	0
CEO Directorate	0	0	0	0	0
Total:	187	1638	274	118	157

Oversight of Recommendations (2nd Line)

Internal Escalation Framework

The Health Board has an internal escalation process, as part of the Directorate Improving Together (DIT) Framework, whereby Directorates are assessed on a monthly basis against the following six domains to drive improvement in performance:

- Quality;
- Governance;
- Workforce;
- Finance, Strategy and Planning;
- Fragile Services; and
- Performance and Outcomes.

The following ratings applied to each of the above domains:

Level	Definition
3	No assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
2	Limited assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
1	Reasonable assurance that there are no significant concerns within the Directorate

The implementation of recommendations, as detailed within this report, is one of the criteria considered within the Governance domain. Consideration is also given for each Directorate with their risk management arrangements, the implementation of Welsh Health Circulars (WHCs) and Ministerial Directions (MDs), compliance with Freedom of Information requests, and the management and review of policies and procedures.

This in turn informs the wider escalation framework, where Directorates are assessed via the 3As assessment approach, and awarded an Alert, Advise or Assure status:

3A Status	Definition
Alert	There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action, or intervention required.
Advise	There are areas of concern where assurance has been taken on actions in place but requires closed monitoring. An early warning of an emerging and potentially serious concern.

Assure	There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.
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Escalation meetings are held for Directorates where an 'alert' status has been awarded for three or more domains, chaired by the Director of Finance and report to the Targeted Intervention Working group. For those Directorates where less than three of the six domains within the internal escalation framework that have been awarded "no assurance", but are awarded a level 3 for Governance, the Director of Corporate Governance meets with relevant service leads to discuss concerns, and determine next steps for de-escalation. Whilst escalation meetings were stood down in November and December for Directorate Improvement Together Sessions to be held, additional support was provided by the Assurance and Risk Team to Planned Care and MHLD to:

- critically evaluate and review outstanding recommendations, allowing the identification of barriers to their implementation to date, and highlighting what measures are in place to manage the recommendation at present;
- review the current completion dates, and whether they required revision; and
- whether recommendations of a more historic nature are still valid.

Proposed amendments to agreed implementation timescales, will need to include a credible and deliverable plan to fully implement these recommendations within realistic timescales, will require the approval of the Executive Team. Proposals are due to be submitted for consideration and approval at Formal Executive Team in February 2025.

A summary of each Directorate's performance for the Governance domain since the previous report submitted to ARAC in October 2024 can be found in the following table:

Service	August 2024	September 2024	October 2024	November 2024	December 2024
Director of Operations	3	2	3	3	3
Facilities	2	2	2	2	2
Mental Health & Learning Disabilities	3	3	3	3	3
Cancer & Oncology	2*	2	2	2	1
Pathology	1	2	3	3	3
Radiology	1	2	2	3	3
Planned Care (incl. Audiology and Endoscopy)	3	3	3	3	3
Bronglais Hospital	1	1	1	1	1
Glangwili Hospital	1	1	1	1	1
Prince Philip Hospital	1	1	1	1	1
Withybush Hospital	1	1	1	1	1
Women & Children	3	3	3	3	2
Carmarthenshire County	1	1	1	1	1
Ceredigion County	1	1	1	1	1
Pembrokeshire County	1	1	1	1	1
Primary Care	1	1	1	1	1
Primary Care Management	1	1	1	1	2
Medicines Management	1	1	1	2	2
Director of Therapies and Health Sciences	1	1	1	1	1

Director of Finance	2*	2	2	2	2
Director of Nursing	2*	2	1	2	2
Director of Public Health	1	1	1	1	1
Director of Strategy and Planning	1	1	2	2	2
Director of Workforce & OD	1	1	1	1	1
Medical Directorate	1	2	2	2	2
Corporate Services	1	1	1	1	1

*Escalated for Governance due to factors outside the remit of this paper e.g. compliance with WHCs / timely review of policies

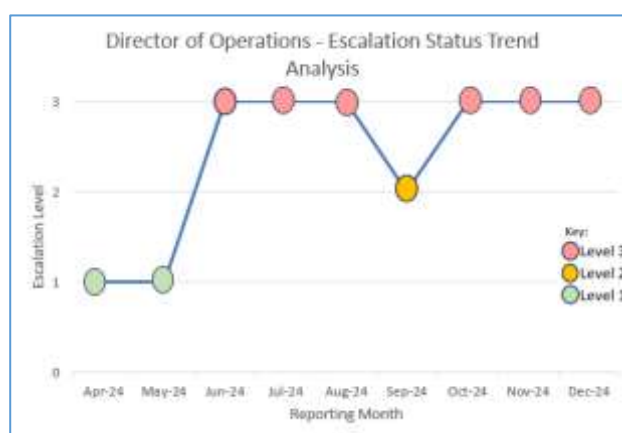
Along with risk management, the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews has been the dominant factor in assessing directorate's escalation level. The minimum requirement for a service to be de-escalated to Level 2 is that 80% of audit and inspection recommendations are implemented within agreed timescales, and 90% to achieve Level 1 status.

Detailed analysis of those Directorates who have been awarded either Level 3 or 2 status as at December 2024 is provided below, based on performance in the management of recommendations.

Level 3: Alert Status - Services with No Assurance

Director of Operations

As at 31 December 2024, the Directorate had 6 open reports with 11 recommendations noted as overdue (25%), of which 10 were overdue by more than 6 months (23%). There are no recommendations without a revised completion date. 7 of the overdue recommendations relate to the Out of Hours Peer Review undertaken in April 2023. As of January 2025, the service has been re-aligned to Primary Care as part of the operational restructure, therefore going forward will be aligned accordingly for onward monitoring.

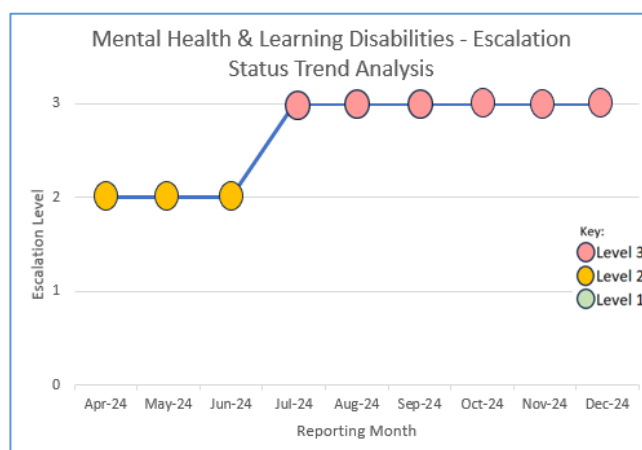


Escalation meetings were stood down during November and December 2024, with the meeting scheduled between the Chief Operating Officer, Director of Corporate Governance and the Assistant Director of Assurance and Risk for January 2025 postponed to 12 February.

The Assurance and Risk Team attend governance meetings for each operational area as part of the business partnering arrangements in place to ensure more detailed discussions are held regarding the progress of recommendations within the remit of the Chief Operating Officer. In addition, the Head of Assurance and Risk meets monthly with the Business and Governance Manager in Central Operations to provide an overview of progress being made in the implementation of recommendations.

Mental Health & Learning Disabilities (MH&LD)

As at 31 December 2024, MH&LD had 8 open reports, with 44 (30%) overdue recommendations, 36 of which by more than 6 months. 32 (22%) of their recommendations were without revised completion dates. Of the 8 open reports, a new HIW report re Bryngolau Ward, Prince Philip Hospital, has been added to the tracker, with 40 recommendations (3 of which are overdue). The Directorate have closed 5 reports since the previous report presented to ARAC, which had a total of 56 recommendations.



Additional scrutiny meetings took place in December 2024 in the absence of formal internal escalation framework meetings in November and December between MH&LD, the Assurance & Risk Team and the Quality & Safety Team (QAST). The Directorate are currently working on an SBAR summarising the progress made as a result of these meetings for presentation to Executive Team in February 2025 for consideration and approval of revised completion dates where appropriate.

Barriers noted to the full implementation of recommendations include:

- provision of supporting evidence to enable formal approval of closure;
- funding constraints;
- lack of staff capacity to undertake project work;
- absenteeism of nominated recommendation owners (due to sickness/annual leave);
- reliance on supporting services to complete recommendations, i.e., Facilities and Women and Children's;
- implementation of national systems; and
- legacy of older report with unrealistic completion dates set.

Established governance arrangements are in place whereby the Assurance and Risk Overview Reports are presented by the Assurance and Risk Officer to MH&LD Quality Safety & Experience group and Business Planning and Performance Assurance Group (BPPAG) meetings. Regular monthly meetings are also held with the Assistant Director of Nursing MH&LD to review risks and recommendations and there is regular communication with the individual service leads, with advice and support provided by the Assurance & Risk Officer. The Assurance and Risk Overview reports are also submitted on a monthly basis, for information and review.

Pathology

As at 31 December 2024, 2 (100%) open reports are overdue, with 15 (58%) overdue recommendations, 3 of which by more than 6 months. 15 (58%) of their recommendations are without revised completion dates. This position has remained unchanged since the previous report presented to ARAC in October 2024.

Barriers noted to the full implementation of recommendations include:

- absenteeism of nominated recommendation owners (due to sickness/annual leave);
- reliance on supporting services to complete recommendations, such as facilities, security; and
- implementation of national systems in order to further progress recommendations.

Established governance arrangements are in place whereby the Assurance and Risk Overview Reports are presented by the Assurance and Risk Officer to the Pathology Business Operation (PBO) meetings bi-monthly. There is regular communication with the individual service leads, with advice and support provided by the Assurance & Risk Officer. The Assurance and Risk Overview reports are also submitted on a monthly basis for information and review to service leads. An escalation meeting has been scheduled for the Director of Corporate Governance to meet with the Service Delivery Manager on 3 February 2025.

Planned Care (including Audiology & Endoscopy)

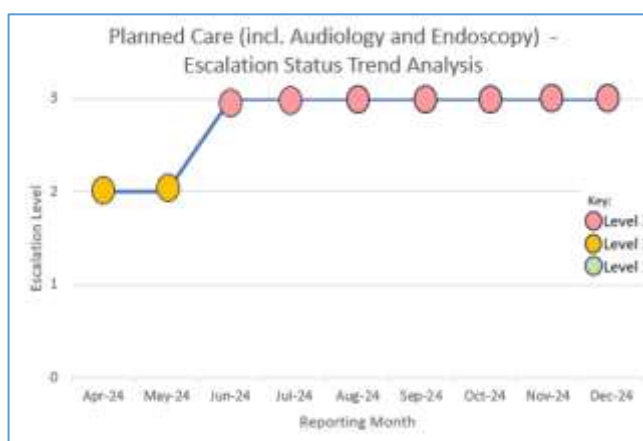
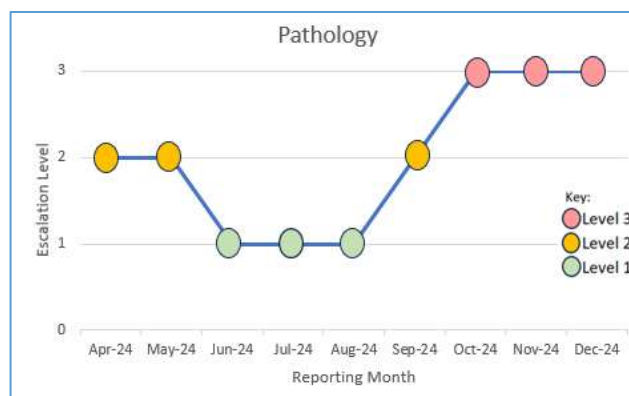
As at 31 December 2024, 36 (23%) recommendations were overdue, 22 relating to the Getting It Right First Time (GIRFT) report on Ophthalmology.

Whilst positive progress is noted from the previous report where 38% recommendations were overdue, the directorate does not meet the 20% target to be de-escalated to Level 2. The number of recommendations overdue by more than 6 months has increased from 21 (12%) at August month end to 35 (22%).

Barriers noted to the full implementation of recommendations include:

- Staffing challenges including difficulties recruiting substantive consultants and optometrists;
- delays in the rollout of national systems; and
- difficulties in balancing Ministerial Priorities against Eye Care Measures (tackling long waiting lists vs prioritising emergency patients).

Bi-monthly Quality Safety and Experience meetings are in place, with a report provided by the Assurance and Risk Officer summarising open reports assigned to the Directorate, and recommendations that require updating. Where meetings have not been held, the paper is disseminated to attendees for information and action.

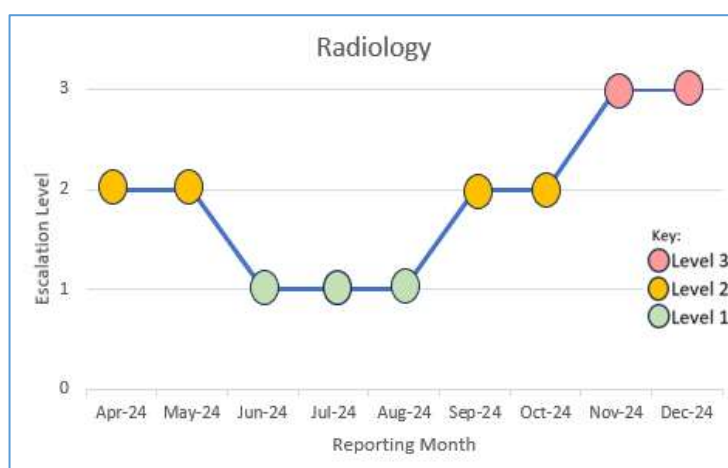


The Head of Assurance and Risk meets on a monthly basis with the Directorate's General Manager and Head of Nursing to review escalation outcomes and provide steer and support in order to achieve a de-escalated position in the near future.

Additional meetings took place in December 2024 between Planned Care and the Assurance & Risk Team. The Directorate are drafting a report summarising the outcome of this review for Executive Team in February 2025.

Radiology

As at 31 December 2024, 2 of the 4 open reports are overdue, with 20 (42%) recommendations overdue. 17 recommendations relate to the Natural Resources Wales report on "Withybush Hospital RSR Site Inspection follow up visit report", previously noted as complete by the Directorate and awaiting formal approval for closure. Further evidence has been requested to formally approve, therefore the report has been re-opened.



Bi-monthly Quality Safety and Experience meetings are in place, with a report provided by the Assurance and Risk Officer summarising open reports assigned to the Directorate, and recommendations that require updating. Where meetings have not been held due to availability, or where the report has not been formally presented at a meeting, a paper is disseminated to attendees for information and action.

Barriers to implementing recommendations include:

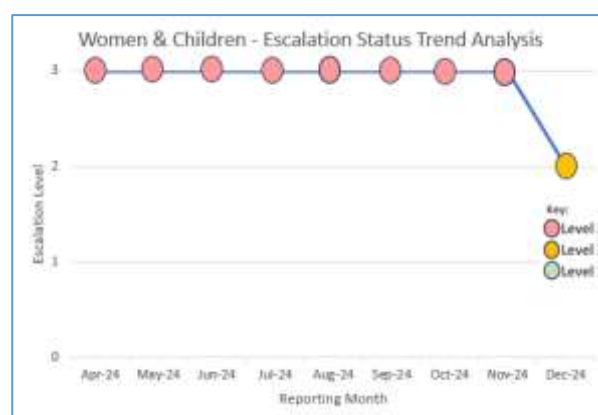
- Key staff absence;
- Operational pressures and lack of capacity to progress actions;
- Lack of Quality Leads; and
- Reliance on rollout of electronic referral system.

Services de-escalated from Level 3 to Level 2 since previous report to ARAC

Women & Children

As at 31 December 2024, an improved performance has been noted for the Women & Children's Directorate.

The Directorate have 2 open reports (August 2024: 4) 1 of which is fully complete and awaiting approval, and the other which is noted as overdue and has 1 outstanding recommendation with an 'external' status. All recommendations on the GIRFT report on Gynaecology have been noted as complete and are awaiting upload of evidence to AMaT before seeking formal approval for closure.



Monthly Quality Safety and Experience meetings are held (with the exception of September and December 2024), and a report provided by the Assurance and Risk Officer outlining progress and timescales of audits and inspections. There has been positive engagement from the Directorate, with an additional scrutiny meetings held in December 2024 with the Assurance & Risk Team to review outstanding recommendations.

Level 2: Advise Status - Services with Limited Assurance

The following services were awarded a Level 2: Advise Status as at December 2024:

Service	Reason for award of L2	De-escalation Criteria
Facilities	Governance arrangements: Concerns remain on the internal governance arrangements within the Directorate to identify and address issues within their responsibility	To achieve de-escalation to Level 1, the outcome and implementation of recommendations from the governance review is required to provide assurance.
Director of Finance	Improved position, however 6 recommendations (33%) are overdue, 28% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Medicines Management	17% of recommendations noted as overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Medical Directorate	23% of recommendations noted as overdue, 15% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Director of Nursing	Deteriorating position noted, with 10 recommendations (17%) overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Primary Care Management	2 recommendations (50%) overdue by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Director of Strategy and Planning	10 recommendations (22%) overdue, 9% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales

The Director of Corporate Governance has written to directorates where there has been limited progress in the previous 3 months to offer additional support.

Board and Committee Oversight

Responsibility for oversight of the timely implementation of external recommendations has been devolved to the Board Committees, Sub-Committees and Groups. On receipt of reports from inspectorates and regulators, these should be presented to the relevant committee for awareness of their findings, highlighting recommendations which have been raised. It is recognised that this process is followed for reports issued by Internal Audit, External Audit, HIW and CIW. Since the previous report presented to ARAC, the process of obtaining formal approval for the closure of Peer Reviews has been strengthened, with the relevant Lead Executive required to confirm that all recommendations have been appropriately implemented. Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Thematic Analysis

As part of the second line of defence, themes are assigned to each recommendation, which allows the Health Board to analyse groups of similar recommendations.

The table below provides a thematic analysis for all open recommendations per theme as at month-end December 2024:

Theme	August 2024	December 2024	Trend
Fire	34%	37%	↑
Health and Safety	4%	12%	↑
Quality	8%	11%	↑
Safe	1%	6%	↑
Workforce	8%	7%	↓
Governance	10%	3%	↓
Patient Safety	5%	2%	↓
Finance	2%	2%	→
Training	3%	1%	↓
Performance	2%	1%	↓
Reputation	1%	1%	→
Infection Control	1%	1%	→
Information & Data Capture	1%	1%	→
Security	1%	1%	→
NICE/National Guidance	0.5%	1%	↑
Partnerships	0.5%	0.5%	→
Safeguarding	0.5%	0.5%	→
Capital	<0.5%	<0.5%	→
Estates	1%	<0.5%	↓
Medication	<0.5%	<0.5%	→
Environmental	<0.5%	<0.5%	↓
Service Delivery	11%	0%	↓
Consent and Mental Capacity	3%	0%	↓
IM&T	2%	0%	↓
Information Governance	0.5%	0%	↓

It is noted that 95 of the 187 (50%) reports currently open, have been issued by Mid and West Wales Fire and Rescue and Service (MWWFRS), resulting in a large proportion of recommendations being assigned the theme of "Fire".

During quarter 3 of 2024/25 the Assurance and Risk Team commenced sharing recommendations with themed subject matter experts (replicating the process undertaken of

sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMAT.

Independent Assurance (3rd line)

The third line of defence are those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies. Since the previous report to ARAC in October 2024, the following report has been received by the Health Board relating to governance arrangements, specifically referencing arrangements relating to the tracking and implementation of recommendations, by external regulators and inspectorates:

- *Audit Wales – Structured Assessment 2024*: The report was presented to ARAC at its meeting in December 2024. A key focus of the review was on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, with specific focus on areas including corporate systems of assurance. AW concluded that the Health Board continues to have appropriate arrangements for corporate oversight of tracking recommendations.

Next steps

This report has identified a number of areas that could be strengthened, and further work is already underway to address these:

- To review the escalation criteria within the Governance domain of the internal escalation framework to consider the length of time recommendations have been overdue;
- Where system improvements have been identified in relation to the recording, reporting and monitoring implementation of recommendations on AMaT, to follow up requests with the national systems team to address these gaps;
- To work with the Performance Team and explore and confirm timescales, when capacity allows, to develop performance dashboards via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework, so that this information is readily available to users across the Health Board; and
- Further development of the Assurance and Risk Sharepoint site to provide guidance and support based to services and Directorates, including the development of material detailing the purpose and benefits of tracking recommendations and supporting processes within the Health Board to ensure transparency and accountability.